United States General Accounting Office

GAO

Report to Congressional Requesters

March 1995

DEFENSE HEALTH CARE

Issues and Challenges Confronting Military Medicine

GAO/HEHS-95-104

United States
General Accounting Office
Washington, D.C. 20548

Health, Education, and
Human Services Division

B-260741

March 22, 1995

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Chairman
The Honorable Robert C. Byrd
Ranking Minority Member
Subcommittee on Personnel
Committee on Armed Services
United States Senate

The Honorable Robert K. Dornan
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Ranking Minority Member
Subcommittee on Military Personnel
Committee on National Security
House of Representatives

The nation's health care system continues to change substantially as governments, employers, and consumers try to address significant increases in medical care costs and issues of access to high-quality medical care. As a large component of this system, the Department of Defense's (DOD) military health care system is also confronting significant challenge and change. This system performs many difficult and interrelated missions, including providing medical services and support to active-duty members of the armed forces both in peacetime and in war and health care to the families of active-duty personnel, military retirees, their dependents, and survivors. Post-cold war contingency planning scenarios, efforts to reduce the overall size of the nation's military forces, federal budget reduction initiatives, and base closures and realignments have heightened scrutiny of the size and makeup of DOD's health care system, how it operates, who it serves, and whether its missions can be satisfactorily carried out in a more cost-effective way.

In preparation for your Subcommittee's authorization and oversight responsibilities for military health care, you asked us to describe the Military Health Services System (MHSS), past problems faced by DOD as it operated the system and its efforts to overcome those problems, and the management challenges now confronting DOD.

This report is based on our past and ongoing work along with studies done by others. The work for these reports and studies was conducted at DOD

and Service headquarters in Washington, D.C., military installations overseas, and many hospitals and offices nationwide. We conducted the work for this review in accordance with generally accepted government auditing standards.[1]

Results in Brief

The MHSS is one of the nation's largest health care systems, offering health benefits to about 8.3 million people and costing over $15 billion annually. Its primary mission is to maintain the health of 1.7 million active-duty service personnel[2] and to be prepared to deliver health care during times of war. Also, as an employer, DOD offers health care services to 6.6 million nonactive-duty beneficiaries. These services are provided through a system of medical centers, smaller hospitals, and clinics worldwide, and through a DOD-administered insurance-like program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In fiscal year 1995, DOD expects to spend about $11.6 billion providing care directly to its beneficiaries and about $3.6 billion for CHAMPUS.

We and others have reported on concerns about DOD's ability to meet its wartime mission, most recently following the Persian Gulf War. These reports described problems such as inadequate training, missing equipment, and large numbers of nondeployable personnel as serious threats to the Department's ability to provide adequate medical support to deployed forces. The changing world environment—which generates different demands for care with a smaller force—poses continuing challenges to medical readiness. DOD is currently examining the impact of these new challenges to determine the optimal size and structure of the medical force.

DOD, in the past decade, has experienced many of the same challenges confronting the nation's health care system—increasing costs, uneven access to health care services, and disparate benefit and cost-sharing packages for similarly situated categories of beneficiaries. In response to these challenges, DOD initiated, with congressional authority, a series of demonstration programs around the country designed to explore various means by which it could more cost effectively manage the care it provides and funds. The experiences of these demonstration programs provided

[1]An annotated bibliography of the reports we have published about the MHSS, its problems, and DOD's responses to management and operational challenges appears in appendix IV.

[2]Includes members of the Coast Guard and the Commissioned Corps of the Public Health Service and of the National Oceanic and Atmospheric Administration who are also eligible for military health care.

many valuable lessons and has enabled DOD to become one of the nation's leaders in the managed care arena.

These experiences also led the Department, in 1993, to begin a nationwide managed care program, called TRICARE, to improve beneficiary access to high-quality care while containing the growth of the system's costs. This program, which, because of its complexity, is being implemented over a 3-year period, calls for coordinating and managing beneficiary care on a regional basis using all available military hospitals and clinics supplemented by contracted civilian services. As DOD implements its TRICARE program, several operational challenges are emerging that must be addressed if the program is to achieve its goals. These range from deciding the appropriate authorities of regional health administrators to constructing networks adequate to serve all beneficiaries in each region.

As the Congress and the Department plan for the future, decisions about the appropriate size of the military health care system will be of paramount importance. DOD's ability to use TRICARE to adequately augment a downsized medical care system and its ability to successfully address the operational challenges to TRICARE are key to the program's future utility as the principal means by which DOD will provide care to its beneficiaries. If TRICARE falls short of its stated objectives, other options, such as including military beneficiaries under the Federal Employees Health Benefits Program, may serve as an alternative to TRICARE.

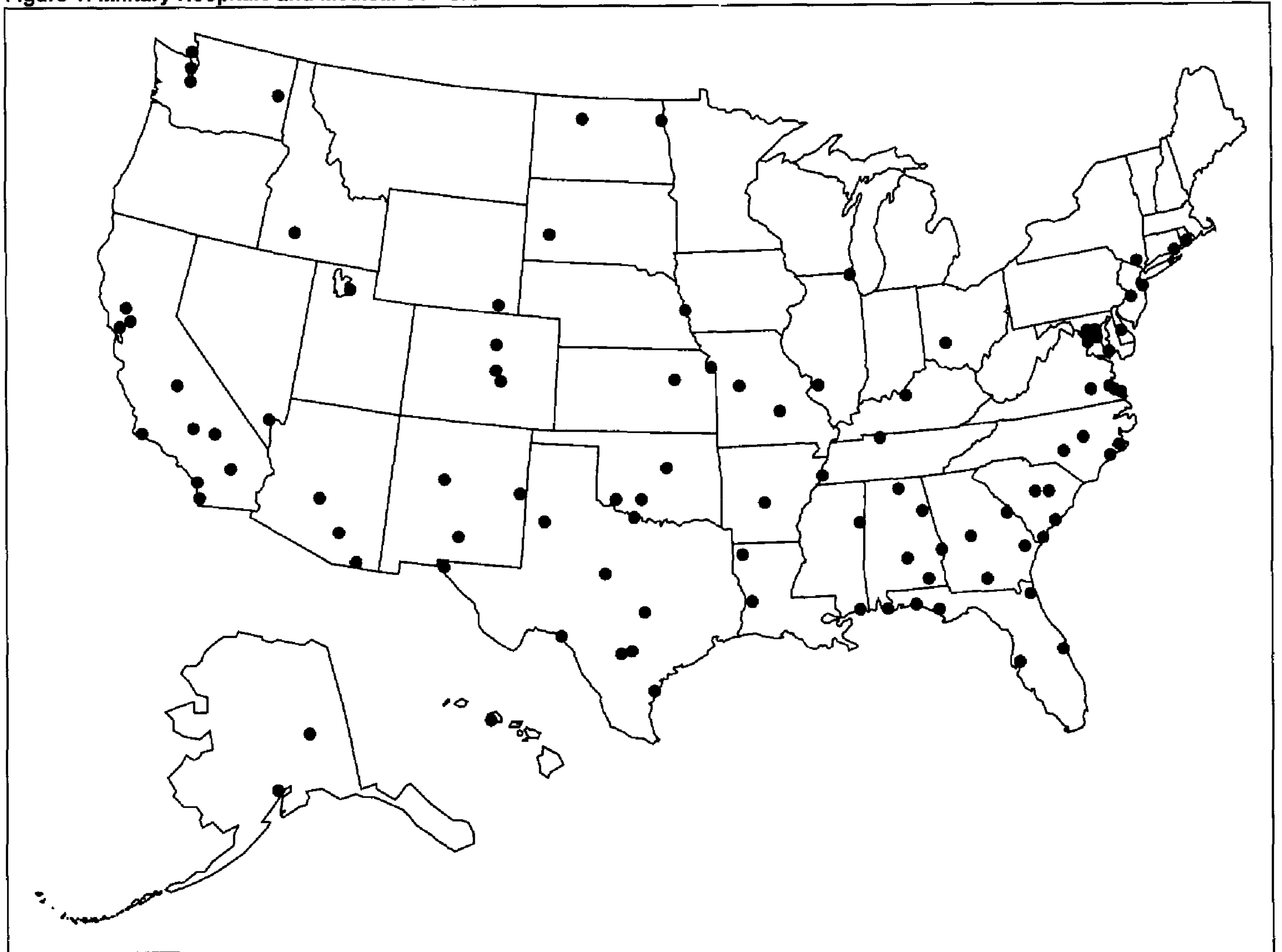
The MHSS Serves Multiple Missions and Must Meet a Wide Variety of Health Care Needs

The MHSS provides health care in peacetime and wartime settings, reflecting DOD's responsibility both as an employer and as a provider of national security in military contingencies and other emergencies of national concern. These responsibilities require a unique medical care system that can successfully deliver high-quality care, ranging from preventive health maintenance to rapid and sophisticated treatment of casualties in wartime and emergency situations. These wide-ranging requirements have led to the creation of a complex organization and costly infrastructure that was designed primarily to meet the needs of a large military force expecting to face a prolonged and casualty-intensive European war.

The system consists of 127 military hospitals and medical centers and 500 clinics worldwide and employs about 183,000 military personnel and civilians with an additional 91,000 medical personnel in the National Guard

and Selected Reserves. Figure 1 shows the locations of military hospitals and medical centers in the United States.

Figure 1: Military Hospitals and Medical Centers in the United States

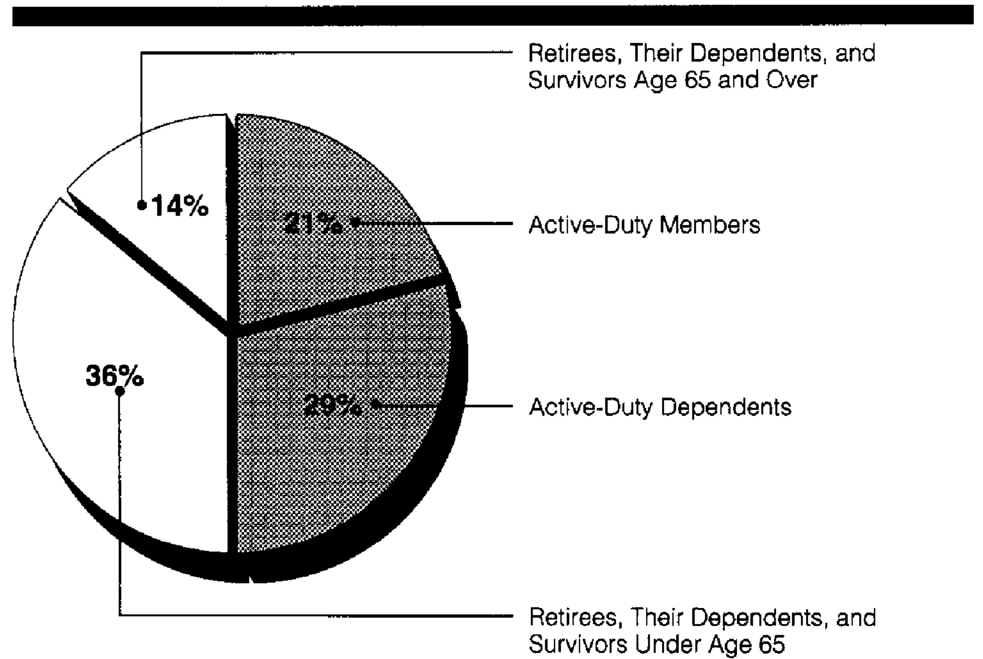


About 19,500 physicians serve in the military of which 13,000 are active-duty members. Most of the active-duty physicians received their medical education through DOD-paid scholarships to civilian medical

schools or through DOD's own 4-year medical school. In addition, many physicians receive specialty training through DOD's extensive graduate medical education program, which offers 77 medical specialties and subspecialties. DOD also conducts an extensive medical research program in environmental and social disease and critical injury care.

Active-duty members and their dependents make up one-half of the eligible beneficiary population, as shown in figure 2. The remaining 50 percent are retirees and their dependents and survivors. Because many of those eligible for care either have difficulty accessing the system or have other options, such as private insurance from another employer or eligibility for other federal programs, only three-quarters of them regularly use the MHSS.

Figure 2: 1995 MHSS Population by Beneficiary Category



A more complete description of the MHSS, its wartime and peacetime operations, beneficiary population, and costs appear in appendix I.

Past and Current Problems Facing Military Health Care

By most accounts, the DOD medical system has provided adequate care for both its missions, but doing so has been difficult at times.

Readiness Issues

Had the Services incurred the predicted number of casualties during the Gulf War, their combat medical care units may not have been able to provide adequate care. To illustrate, combat medical units were assigned wartime missions they were not prepared to fulfill. They were neither staffed nor equipped to care for the number of casualties, provide noncombat medical care, support the evacuation of casualties, or treat large numbers of chemically contaminated casualties.

These problems were attributable to several factors. First, mobilization plans were out of date and untested. Second, large numbers of medical personnel were undeployable because of poor physical condition or insufficient training. Third, medical equipment, supplies, and evacuation assets were insufficient. While the Services have efforts under way to address these deficiencies, the changing world environment will continue to challenge medical readiness.

Additionally, a recent DOD study mandated by the National Defense Authorization Act for fiscal years 1992 and 1993 and known as the "733 study" questions the size of the current military health care system, suggesting that DOD has as many as twice the number of physicians it needs to meet wartime requirements. Although the Services have not disagreed with the 733 study results, their individual estimates produced higher numbers of physicians needed during peacetime to ensure wartime readiness. We are currently evaluating the reasonableness of the 733 study and the Services' response to it.

Peacetime Care Issues

Several significant problems have consistently plagued DOD in its efforts to provide peacetime care—some dating back to the 1970s. Many of the challenges parallel those that the nation is facing, while others are unique to the military. In the 1980s, for example, MHSS costs rose more than the nation's, 225 percent to 166 percent, respectively. During this period, the medical portion of the Defense budget doubled, from 3 percent of the total to 6 percent, a trend that concerns many military leaders. Figure 3 shows the cumulative percent change in the total defense budget versus the MHSS budget since 1989. Based on the number of those beneficiaries estimated

by DOD to rely on the MHSS for their health care, per capita costs, adjusted for inflation, have changed only slightly since 1989, as shown in figure 4.

Figure 3: DOD Total and MHSS Budgets, Fiscal Years 1990-1995
(Nominal Dollars)

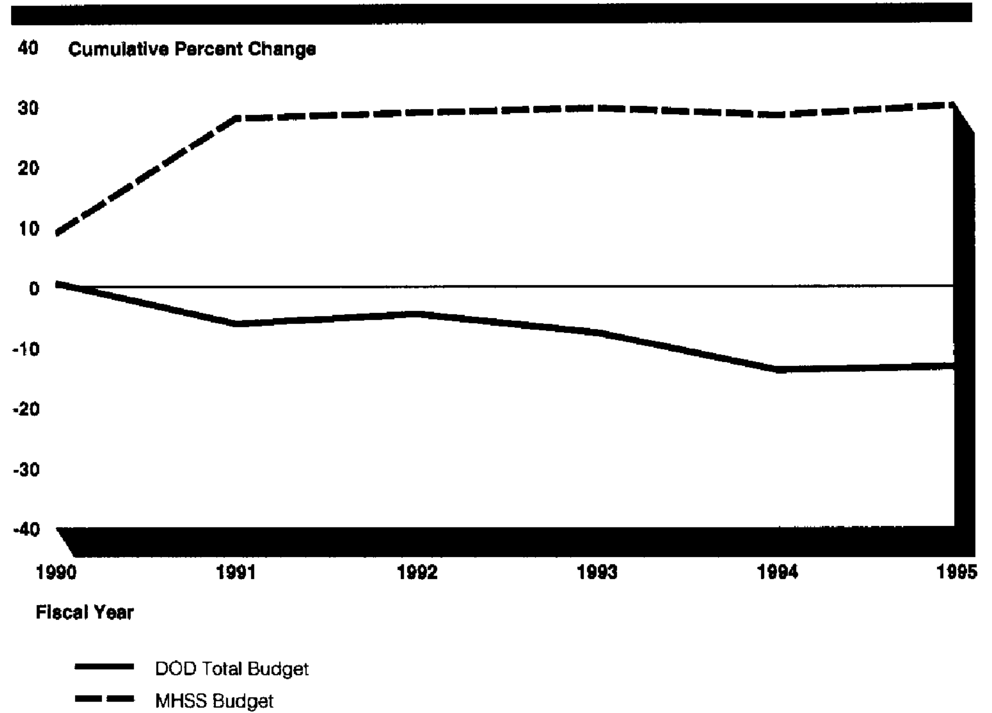
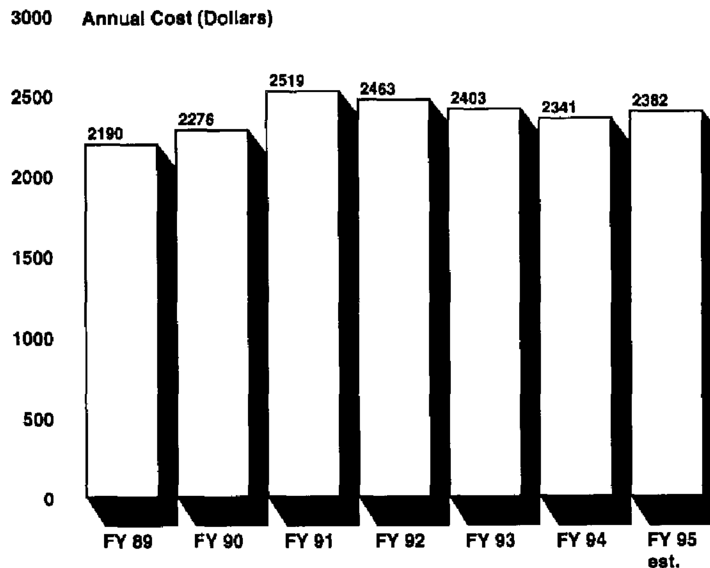


Figure 4: DOD Cost Per MHSS User, Fiscal Years 1989-1995 (Constant 1995 Dollars)



Beneficiaries have long complained about difficulties accessing care in military facilities and an inequitable health benefits package. Military hospitals vary significantly in size and medical sophistication and therefore the availability of health care services also varies from facility to facility. DOD tests of health care alternatives have contributed to health benefits and cost-sharing requirements varying around the country, causing inequity and confusion among beneficiaries.

Other management problems that have hampered improvement efforts include long-standing inter-Service rivalries and overlapping responsibilities, inadequate information systems, and fraud and abuse in the CHAMPUS program. Appendix II describes these matters in more detail.

TRICARE Still Faces Challenges

For several years, with congressional authorization, DOD has been testing alternative approaches to delivering health care that incorporate managed health care techniques. As a result of these tests, DOD designed TRICARE, a managed care program offering beneficiaries alternatives to the current CHAMPUS program, such as a health maintenance organization (HMO) option that will lower cost sharing when beneficiaries agree to limitations on their choice of physicians. Beneficiaries will be assigned a primary care

physician to manage their care. TRICARE is intended to control costs, improve beneficiary access to care, and provide high-quality care.

To implement and administer TRICARE, DOD has reorganized the military delivery system into 12 new, joint-Service regions, each headed by a military health care administrator, or lead agent, who is responsible for monitoring and coordinating all care in the region. TRICARE incorporates cost control features found in civilian sector managed care programs, such as capitation budgeting and utilization management. These features provide managers and caregivers incentives to limit the use of health care resources to appropriate amounts. Except for active-duty members, enrollment in the TRICARE HMO is optional. Care in military hospitals will be supplemented by civilian providers under contract to DOD on a regional basis. Over a 5-year period, DOD estimates these contracts will cost about $17 billion.

DOD's goal is to have TRICARE implemented nationwide by May 1997. One regional contract with a civilian health care company has been awarded, and implementation began in that region in March 1995. Several other procurements are under way and in various stages of completion.

As the midpoint of transition to TRICARE approaches, DOD faces a number of challenges and concerns:

- Several studies have suggested that more cost-effective ways than TRICARE exist to provide or arrange for health care services to beneficiaries, such as the Federal Employees Health Benefits Program.
- Military medical officials have expressed concern that the regional structure established in TRICARE does not provide sufficient regional authority and control over resources to effectively manage the delivery of care.
- DOD has encountered many problems in obtaining civilian health care services because of a cumbersome and contentious procurement process.
- Beneficiary groups are concerned that DOD will impose limits on enrollment in the HMO option, reducing access to care in military facilities for retirees and their dependents.
- TRICARE will not fully eliminate differences and inequities in cost-sharing requirements for beneficiaries because outpatient care received in military facilities will remain free, but similar care obtained from civilian providers will require copayments.

Appendix III describes TRICARE and its challenges in more detail.

Conclusions

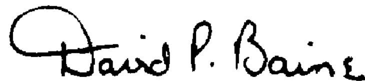
One of the most crucial tasks facing the Congress and DOD as they plan for the future of the MHSS is to agree on the size and structure of the medical force needed to meet wartime requirements. This decision will drive the combination of military physician specialties, the number of hospitals and clinics, and the training and experience that medical personnel need to achieve the appropriate level of readiness. Subsequent decisions must also be made on the cost-effectiveness of maintaining a military medical capacity larger than that needed for readiness purposes to help meet the health care demands of nonactive-duty beneficiaries.

DOD is addressing difficult and costly health care problems with many implications for all those affected by the military health care system. It needs time to decide the most equitable arrangement for those affected, while containing military health care cost growth. TRICARE is in the early stages, and predictions about the ultimate success of its meeting its objectives are premature. Nevertheless, the already identified operational challenges to TRICARE must be addressed quickly to achieve the hoped for results.

Agency Comments

We did not obtain agency comments, but we did discuss the information in the report with agency officials. The officials generally agreed with the data presented, and we incorporated their comments as appropriate.

We are sending copies of this report to the Secretary of Defense and will make copies available to others upon request. Please contact me on (202) 512-7101 if you or your staff have any questions concerning this report. Contributors to this report are listed in appendix V.



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Abbreviations

AIDS acquired immune deficiency syndrome
CBO Congressional Budget Office
CHAMPUS Civilian Health and Medical Program of the Uniformed Services
CHCS Composite Health Care System
CRI CHAMPUS Reform Initiative
DEERS Defense Enrollment Eligibility Reporting System
DOD Department of Defense
GME graduate medical education
HMO health maintenance organization
MHSS Military Health Services System
RFP request for proposal
USTF Uniformed Services Treatment Facility

The Challenges and Complexities of the Military Health Services System

The Military Health Services System (MHSS) is a large and complex organization with multiple responsibilities. Throughout the year, DOD provides health care for millions of active-duty troops and other beneficiaries through a worldwide system of hospitals and a major insurance-like program; it operates a 4-year medical university and an extensive graduate medical education program; it trains physicians and other health professionals to provide combat health care; it conducts medical research on a wide range of social and environmental diseases; and it oversees the operations of several hundred medical personnel on operational assignments around the world. Through these activities, DOD responds to its two missions: wartime readiness, that is, maintaining the health of service members and treating wartime casualties; and peacetime care, providing for the health care needs of the families of active-duty members, retirees and their families, and survivors. These missions are carried out with an annual budget of more than $15 billion, representing about 6 percent of the total defense budget.

Wartime medical readiness is the primary mission of the MHSS; however, caring for families and retirees makes up the bulk of services it provides. These nonactive-duty beneficiaries comprise almost 80 percent of the 8.3 million people eligible for military health care. The number of eligible beneficiaries will decline only slightly through the year 2000, even as active-duty forces are reduced because the number of retiree families will increase. Active-duty members must receive nearly all of their health care in military facilities, but other beneficiaries have choices. Some use other federal programs, such as Medicare, Department of Veterans Affairs hospitals, or civilian providers funded by DOD; others obtain care through insurance provided by their employer. Because of these choices, and other factors such as difficulties accessing military facilities, about 25 percent of nonactive-duty beneficiaries do not rely on the MHSS; that is, they receive medical care from other sources.

Dual Mission of the MHSS

DOD Has Wartime and Peacetime Medical Responsibilities

The MHSS is considered to have a dual mission: it must provide medical services and support to the armed forces, in peacetime and in war, and also care for the families of active-duty personnel, military retirees and their dependents, and survivors.

The readiness mission is the primary mission. According to a draft of DOD's Medical Readiness Strategic Plan, the military medical organization exists to support combat forces in war and, in peacetime, to maintain and sustain the well-being of the fighting forces in preparation for war. Military medical personnel care for wounded and ill personnel in combat areas or evacuate and treat them at military medical facilities outside the combat areas. The MHSS also contributes to maintaining the forces' readiness by providing medical care to active-duty armed forces personnel not involved in combat operations, including routine preventive care as well as treating injuries and illness.[3] In recent years the U.S. military role, and the mission of the medical departments, has expanded to include peacekeeping and humanitarian missions, such as deployments to Somalia and Haiti and care to the victims of Hurricane Andrew, the Los Angeles earthquake, and the California floods.

In addition, since 1956 DOD has been authorized to treat nonmilitary people in the MHSS. Legislative actions in 1956 and 1966[4] gave dependents of active-duty military personnel, retirees and their dependents, and survivors of military personnel access to care in military medical facilities on a space-available basis. When care is not available in the military facilities, nonactive-duty beneficiaries can also get care from private-sector health care providers through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

DOD Oversees the MHSS, but Each Service Has Its Own Medical Department

The Assistant Secretary of Defense (Health Affairs) is responsible for planning, policy development, and oversight of the MHSS. These responsibilities include developing guidance on DOD health plans and programs; ensuring that medical programs and systems meet operational readiness requirements; establishing requirements and standards for DOD medical and acquisition programs; programming and budgeting all MHSS resources and funds, except for personnel and construction funds; and administering CHAMPUS.[5]

[3]Members of the Reserves and National Guard, and their families, are also covered by the MHSS while on active duty.

[4]Dependents' Medical Care Act (P.L. 84-569), in 1956 and the Military Medical Benefits Amendments of 1966 (P.L. 89-614).

[5]DOD medical program funds are provided through a single Defense Health Program appropriations account. This account provides funds for operation and maintenance, procurement, research and development, and CHAMPUS, but excludes funds for active and reserve medical personnel (funded through the Services) or for military construction (funded through a separate account). The Assistant Secretary of Defense (Health Affairs) directs the distribution of the funds to the Services, which allocate the funds to their facilities.

Each Service has its own medical department headed by a surgeon general. Each of the Services' medical departments prepares a medical program budget for the Assistant Secretary, develops Service-specific programs within the guidance and parameters established by Health Affairs, and operates the Services' medical facilities. Each Service also recruits and funds its own medical personnel to administer the medical programs and provide medical services to beneficiaries.

Many People Are Involved in Providing Care

For fiscal year 1995, DOD medical personnel total 274,000, including about 135,000 active-duty members and 48,000 civilians. In addition, about 91,000 personnel in the Selected Reserves and National Guard are assigned to medical missions. Table I.1 shows the breakdown of active-duty and civilian personnel levels by each Service.

Table I.1: Medical Personnel Levels by Service Affiliation, Fiscal Year 1995

	Army	Navy	Air Force	Total
Active-duty	51,024	42,205	41,666	**134,895**
Civilian	28,436	12,155	7,623	**48,214**
Total	**79,460**	**54,360**	**49,289**	**183,109**

DOD medical personnel include physicians, dentists, nurses, administrators, medical technicians, veterinarians, and corpsmen. The Services recruit and train all of these personnel, preparing them to serve in both peacetime and wartime environments. Since fiscal year 1991, the number of medical personnel has decreased by about 8 percent and is expected to decrease an additional 8 percent by the year 2000.

There are about 13,000 active-duty physicians. They receive their initial medical training from either a DOD or civilian medical school. In 1972, DOD established the Uniformed Services University of the Health Sciences, a 4-year, tuition-free medical school created in response to congressional concern about DOD's ability to attract and retain physicians.[6] The university has graduated about 2,000 medical students since its inception who comprise about 12 percent of active-duty physicians. The legislation that established the university also authorized DOD's Health Professions Scholarship Program, under which DOD pays tuition, fees, and a stipend for program participants enrolled in civilian medical schools. About 1,000 scholarship recipients enter military service each year. Those on active duty comprise about 60 percent of current military physicians. The

[6]The university was created as part of the Uniformed Services Health Professions Revitalization Act of 1972 (P.L. 92-426).

remaining 28 percent of active-duty physicians are volunteers who enter the military as licensed physicians.

Military physicians also receive additional training and experience through an extensive graduate medical education (GME) program and major medical research efforts conducted by DOD. In 1994 DOD operated about 300 GME programs with an enrollment of about 3,300 physicians. The medical specialties offered include primary care programs, such as internal medicine, family practice, pediatrics, emergency medicine, and obstetrics and gynecology; and those related to the wartime mission, such as surgery, orthopedics, anesthesiology, radiology, and psychiatry. Primary care specialties comprise about 42 percent of all physicians in training, and wartime-essential specialties account for another 40 percent. Military physicians also contribute to major research efforts conducted by DOD and the Services in such areas as Acquired Immune Deficiency Syndrome (AIDS), breast cancer, and blood research programs.

Delivery of Medical Care to Active-Duty Troops in Wartime

Providing medical care to members of the armed forces during wartime involves a complicated structure of medical forces, differing modes of transportation and operations, and complex evacuation policies. When conflicts arise, the Services are responsible for responding to the medical requirements of the combat theater Commanders-in-Chief. To fulfill these requirements, the Services must train, supply, and equip a medical system that can mobilize and deploy in any theater. Currently, the Services must be ready to medically support two major regional contingencies simultaneously.

In combat, the primary goal of the medical departments is to enable personnel to return to duty as soon as possible and to safeguard those who cannot be returned to duty. The theater of combat operations has four levels, or echelons, of medical support, which become progressively more sophisticated with distance from the battlefield. Wartime medical support begins with echelon one, which consists of basic first aid and emergency care in the forward areas. The second echelon involves care at an Aid Station where the casualty is examined and evaluated to determine priority for continued movement to the rear. The third echelon involves treating the casualty in a medical installation staffed and equipped for resuscitation, surgery, and postoperative treatment. The fourth echelon, far from the combat area, involves treating the casualty in a hospital staffed and equipped for definitive care.

An evacuation policy specifies the number of days that patients may be held within the theater for treatment and rehabilitation; those who cannot be returned to duty status within the period prescribed are evacuated. The evacuation policy impacts greatly on the wartime medical resources required; a long evacuation policy will require more facilities and medical personnel in the combat theater, and a short policy will require more evacuation beds and personnel in hospitals in the United States.

The wartime medical support structures vary among the Services depending on the missions of their combat forces. Each Service structures and sizes its medical organization to support its own forces. The Army, for example, must plan to meet a variety of wartime environments, from a sophisticated battlefield with an infrastructure of communications and facilities, to a relatively unsophisticated battlefield in which it may have to create an infrastructure or choose to fight without one. The Army's primary mission is preparing for sustained ground combat with a rapidly moving enemy. Forward deployed forces, such as U.S. forces in Korea, may have to fight with only a few hours notice. This requires the Army Medical Department to provide mobile, flexible support across long distances in a variety of environments.

The medical forces of the Navy provide wartime support to both the Navy and Marine Corps. The Navy is generally called upon to conduct prompt and sustained combat operations at sea, while the Marines conduct both amphibious and land operations. These missions are global, and contingencies may occur under climatic extremes and austere conditions. The Navy's dual mission requires that its medical forces be prepared to provide flexible and rapidly responsive forces to support both the Naval Fleet and the Marine Corps. The Navy is unique in that its daily operational missions require a large percentage of its active-duty force, including medical personnel, to be deployed throughout the year.

The Air Force must perform prompt and sustained offensive and defensive air operations, both independently and in support of the other Services. Historically, the Air Force has not required extensive medical resources to conduct its wartime mission because its bases were relatively safe from any opposing forces, far to the rear of the combat area. Consequently, it anticipated, and received, very few casualties. However, in certain scenarios the enemy's offensive capability has increased, making Air Force bases in wartime theaters more vulnerable. This could result in more Air Force casualties than projected in the past. Air Force medical forces must

be prepared to provide air transportable hospitals for operations bases and most of the air evacuation in wartime.

Direct Care System and CHAMPUS Serve Beneficiaries in Peacetime

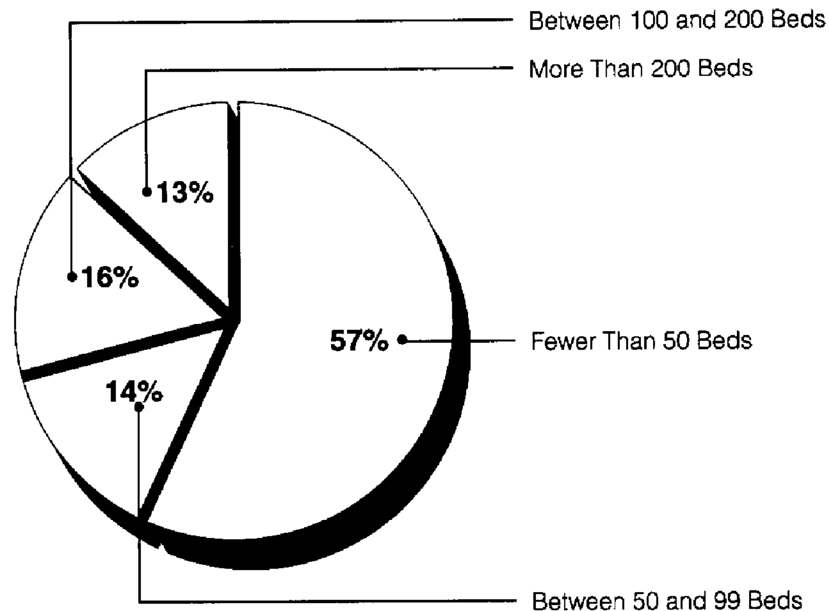
Peacetime health care is delivered to military beneficiaries and active-duty members through a system of DOD-operated hospitals and clinics staffed by civilian and military medical personnel, known as the direct care system. DOD also operates CHAMPUS, an insurance-like program that pays for a portion of the care military families and retirees receive from private-sector health care providers. Military facilities provide about three-fourths of all care and CHAMPUS about one-fourth. Table I.2 shows the distribution of care provided in fiscal year 1994.

Table I.2: Source of Care Provided by the MHSS in Fiscal Year 1994, by Beneficiary Category

	Inpatient admissions	Outpatient visits
In military facilities		
Active-duty members	191,323	16,810,464
Nonactive-duty beneficiaries	498,761	27,103,382
Through CHAMPUS		
Active-duty members	0	0
Nonactive-duty beneficiaries	230,976	11,285,928
Total MHSS	**921,060**	**55,199,774**

The direct care system includes 14 medical centers, 86 hospitals, and over 400 clinics operated by the three Services nationwide. The capacity and level of care vary among the types of facilities, as described below and shown in figure I.1.

Figure I.1: MHSS Hospitals in the United States by Size



- Medical centers are large, tertiary care facilities, ranging in size from about 200 to 1,000 beds, offering both inpatient and outpatient care.
- Community hospitals, typically with fewer than 200 beds, also offer inpatient and outpatient care but usually handle less complex cases than the medical centers.
- Clinics are generally small facilities offering a limited range of primary care services usually only on an outpatient basis.

Although fewer in number, the medical centers provide a larger portion of direct care. In 1992, about 57 percent of the inpatient workload and about one-third of the outpatient workload in the direct care system were handled in medical centers. Community hospitals handled about 43 percent of the direct care inpatient workload and about 60 percent of the outpatient workload. The remaining outpatient care was delivered in military clinics.

In some areas, the direct care system also includes former Public Health Service medical facilities and contractor-operated clinics. Ten former Public Health Service hospitals and clinics, now called Uniformed Services

Treatment Facilities, provide care to more than 100,000 nonactive-duty beneficiaries. The Military Construction Authorization Act, 1982 (P.L. 97-99), included these facilities in DOD's health care system.

In 1985 DOD further expanded its direct care system to include off-base primary care clinics operated by civilian contractors. These clinics, called PRIMUS and NAVCARE, were established to expand access to primary care and to relieve the overcrowding of the military medical facilities. All beneficiaries eligible to receive care in military facilities can be treated at PRIMUS and NAVCARE clinics, including active-duty members. Twenty-one PRIMUS and NAVCARE clinics operate nationwide.

DOD requires minimal cost sharing from most beneficiaries for inpatient care provided in the direct care system but no cost sharing for outpatient care. Active-duty personnel receive nearly all of their medical care through the direct care system and pay $4.75 for each day of inpatient care. Retired officers pay the same amount as the active-duty members, but retired enlisted members receive inpatient care at no cost. The families of retirees and active-duty personnel, as well as survivors, are subject to slightly higher cost sharing, paying $9.50 per day for inpatient care.

Most nonactive-duty beneficiaries can also receive care outside the direct care system through private-sector health care providers. In those cases, DOD pays a portion of the cost of care through CHAMPUS. CHAMPUS is automatically available to families of active-duty personnel, retirees and their dependents, and survivors under the age of 65. At age 65, beneficiaries are no longer eligible for CHAMPUS because they become eligible for Medicare. CHAMPUS is comparable to private-sector indemnity (fee-for-service) health benefits plans, requiring beneficiaries to pay for care up to an annual deductible amount, and then pay a portion of the remaining costs; however, beneficiaries are not required to pay premiums for CHAMPUS. The amount of the deductible and copayment varies by the type and source of care and by different beneficiary groups, ranging from $50 to $300 for the deductible and 20 to 25 percent for copayments. The beneficiary cost-sharing requirements of CHAMPUS and the direct care system are shown in table I.3.

Table I.3: Cost-Sharing Requirements for Military Facilities and CHAMPUS

Inpatient		Outpatient	
Military facility	CHAMPUS	Military facility	CHAMPUS
Active-duty			
$4.75 per day	Not eligible	$0	Not eligible
Active-duty dependents			
$9.50 per day	$25 for each admission or $9.50 per day (in fiscal year 1995), whichever is greater	$0	E-4 and below: Annual deductible of $50 per dependent or $100 per family and then 20% of allowable charges Above E-4: Annual deductible of $150 per dependent or $300 per family and then 20% of allowable charges
Other beneficiaries			
$0 for enlisted retirees $4.75 per day for retired officers $9.50 per day for others	25% of billed hospital charges or $323 per day (in fiscal year 1995), whichever is less, and 25% of other providers' allowable charges	$0	Annual deductible of $150 per person or $300 per family and then 25% of allowable charges

Note: Beneficiaries annual copayment liability is capped at $1,000 for active-duty families and at $7,500 for all other CHAMPUS-eligible families.

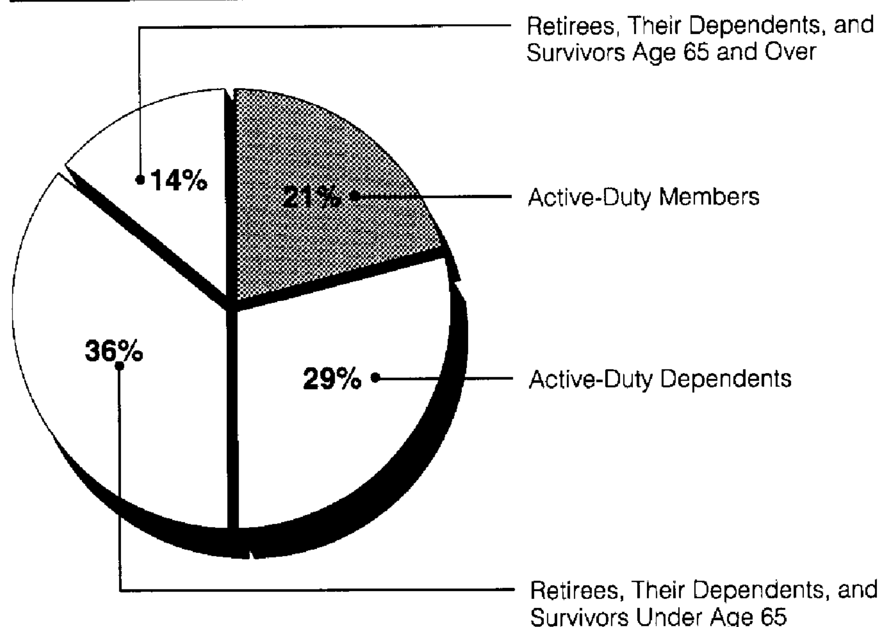
To help ensure fuller utilization of the direct care system, CHAMPUS will not pay for private-sector inpatient hospital care and some high-cost outpatient care provided to beneficiaries living within a 40-mile radius of a military medical facility unless those beneficiaries receive prior approval from the facility. This approval, called a statement of nonavailability, indicates that the military facility could not provide treatment within established time frames or did not have resources available. Beneficiaries living outside the 40-mile radius are not required to get prior approval for private-sector care.

During the late 1980s and early 1990s, DOD tested alternative health care delivery mechanisms using managed care techniques as a means to control costs and improve access. In 1993, DOD established a joint-Service, systemwide managed care program called TRICARE, which more closely integrates the direct care system and CHAMPUS and adopts several private-sector practices. Appendix III describes TRICARE in detail.

Beneficiary Profile

Of the 8.3 million people eligible for care from the MHSS worldwide in fiscal year 1995, active-duty personnel comprise a small percentage. Currently, the 1.7 million active-duty members[7] represent 21 percent of the eligible population. Figure 1.2 shows the percentage breakout of the MHSS eligible population. Active-duty members receive almost all of their care in military facilities and are not eligible for CHAMPUS. They have first priority for care in military facilities. Those active-duty members have 2.5 million dependents, representing almost 30 percent of the total eligible population. Active-duty dependents are eligible both for CHAMPUS and care in military facilities on a space-available basis.

Figure I.2: 1995 MHSS Population by Beneficiary Category

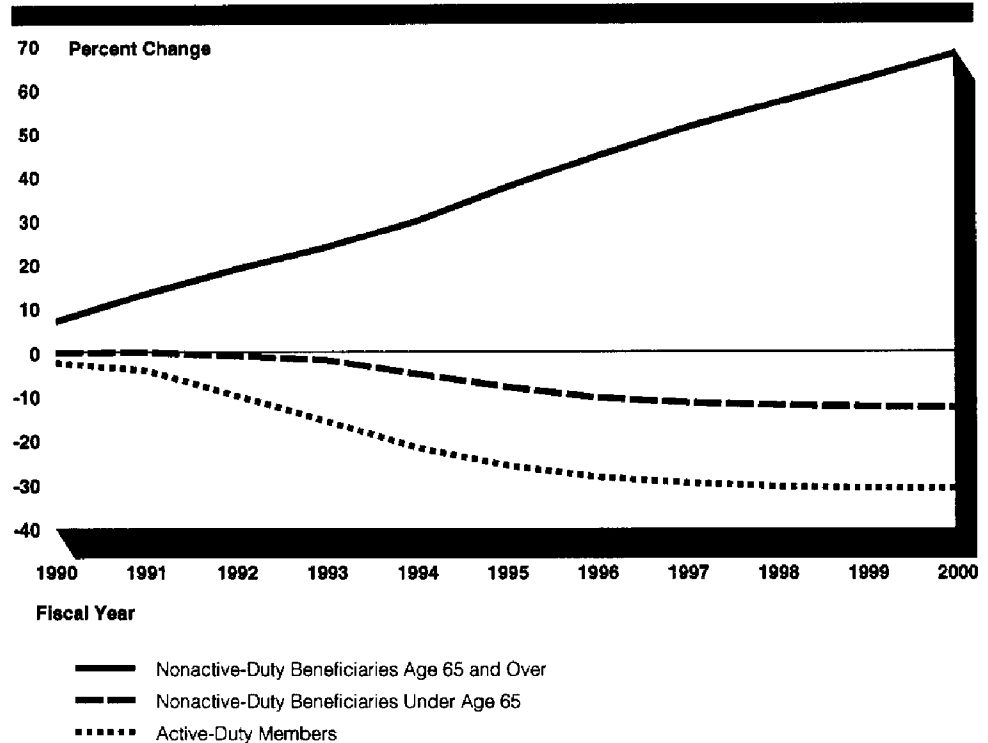


Retirees and their dependents and survivors of deceased members make up almost 50 percent of all MHSS beneficiaries. Three million of these are under 65 and therefore eligible for care provided in military facilities as well as through CHAMPUS. However, they are entitled to care in military facilities only on a resource-available basis. Nonactive-duty beneficiaries

[7]Includes members of the Coast Guard and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of the Public Health Service who are eligible for care in the MHSS.

who are over 65 are eligible for care only in military facilities because at age 65 they lose their CHAMPUS eligibility and become eligible for Medicare. This group numbers almost 1.2 million and is expected to grow by 22 percent to just over 1.4 million by the year 2000. At the same time, the rest of the beneficiary population will shrink by almost 6 percent. Figure I.3 illustrates the percentage change in beneficiary population since 1989 through 2000.

Figure I.3: MHSS Beneficiaries, Fiscal Years 1990-2000



Note: Data for fiscal years 1995 through 2000 are projections.

DOD estimates that about 6.4 million beneficiaries currently use the MHSS. Almost all active-duty members and their families use the system at some time during the year, and about two-thirds of retirees and their dependents under 65 regularly use either the direct care system or CHAMPUS. In contrast, only about a third of the beneficiaries over age 65 regularly use military facilities.

Many beneficiaries have alternatives to the MHSS. For example, DOD estimates that about one-fourth of beneficiaries (about 2 million people) have private insurance. If beneficiaries with insurance seek care in military facilities or submit claims under CHAMPUS, this insurance must pay the military facilities, or, in the case of CHAMPUS, the insurance must pay first, with CHAMPUS paying any remaining amounts. VA estimates that 1.7 million military retirees are eligible for care in VA hospitals. In addition, 1.2 million retirees and dependents over age 65 are eligible for Medicare, and the most recent DOD survey found that over 50 percent have private insurance. Some beneficiaries are eligible for multiple programs.

Military Health System Costs Have Stabilized Since 1991

For fiscal year 1995, DOD's budget for the MHSS is just over $15.2 billion, consisting of about $6.0 billion in operations and maintenance funds for the direct care system, $3.6 billion for CHAMPUS, $5.0 billion for military personnel, $330 million for procurement of medical equipment and supplies, and $319 million for construction.[8] The defense health budget has leveled off in recent years, with growth of about 1 percent per year since 1991. Per capita health costs have also remained stable. Medical spending has however, consumed a greater proportion of the total defense budget. In 1990, the medical budget represented about 4 percent of the total defense budget, increasing to about 6 percent in 1995. DOD has requested $15.5 billion for fiscal year 1996.

[8]In 1994, the Institute for Defense Analyses estimated that about 16 percent of MHSS costs (roughly $2.5 billion) supported the system's mission of maintaining the readiness of the armed forces.

MHSS Has Faced Many Difficult Issues

For years DOD has encountered many difficult issues and problems as it has carried out its dual mission and responsibilities. We and others have identified several issues related to the deployment of medical personnel to the Persian Gulf, ranging from the nondeployability of large numbers of medical personnel to inadequacies in the medical evacuation procedures for casualties. Had the Services incurred the predicted number of casualties during the Gulf War, their combat medical units may not have been able to provide adequate care. DOD has acknowledged these problems and reports that it is taking steps to address them, including developing a new medical readiness strategic plan.

As it carried out its peacetime care role in the 1980s, the cost of operating the MHSS increased significantly. Part of this cost growth was due to the overall nationwide escalation of medical care costs and part was due to military beneficiaries' greater use of medical care services than their civilian counterparts. In the late 1980s, DOD began a series of demonstration programs around the country to contain the growth in its medical care costs and gain greater control of beneficiaries' utilization of their health care benefits. DOD also hoped to improve beneficiary access to care and enhance beneficiary satisfaction with the care they received. The demonstration programs, each of which was authorized by the Congress, were designed to test the use of managed care principles such as establishing primary care managers and case management services, developing networks of private-sector providers, and experimenting with different organizational and financing arrangements for beneficiaries' care. The programs highlighted difficult conceptual and operational issues confronting the Department as it moved to convert its health system into a large managed care system. These issues, which ranged from how to establish the appropriate health benefit package to how to deal with long-standing inter-Service rivalries, are discussed in this appendix.

Gulf War Revealed Wartime Readiness Issues

The ability of DOD to meet its wartime medical mission was questioned by us and the DOD Inspector General in studies conducted after the Gulf War. Both studies examined the ability of DOD to provide adequate, timely medical support during contingencies and found problems with the planning and execution of these efforts.

We found that medical units in the Gulf War may have had difficulty providing care to the predicted number of casualties because of understaffed units and inadequate supplies and equipment. Also, medical units were not staffed and equipped to provide noncombat medical care,

support the evacuation of casualties from the battle line to outside the theater of conflict, or receive large numbers of chemically contaminated casualties. We found other medical force problems, including (1) large numbers of nondeployable personnel due to unacceptable physical condition, lack of required skills, and mismatches in medical specialties; (2) a widespread lack of training for the wartime mission; and (3) inadequate or missing equipment and supplies.

The DOD Inspector General found similar problems. Mobilization plans were out of date, largely untested, and invalidated. Inaccurate requirements, misassignments, and insufficient training hampered availability of medical personnel. Insufficient and incompatible communication equipment and problems with the management of war reserves hindered the effectiveness of the medical forces. Shortfalls in transportation assets and the lack of automation of the DOD blood program hampered medical logistics support.

DOD is working to correct the deficiencies and is developing a strategic plan to address the shortcomings. All three Services have major reengineering efforts under way to respond to contingency requirements that involve training, leader development, organization, doctrine, and material and equipment changes.

With the dissolution of the Soviet Union and the emergence of regional threats, however, DOD's wartime requirements for the MHSS may have drastically changed. A recent DOD study, mandated by the Defense Authorization Act for Fiscal Years 1992 and 1993 and known as the "733 study," estimates that DOD has as many as twice the number of physicians it needs to meet wartime requirements. Although the Services have not disagreed with the 733 study results, their individual estimates produced higher numbers of physicians needed during peacetime to ensure wartime readiness. Theater commanders use different planning factors that result in higher estimates of casualties and rely more on the MHSS to treat patients requiring long-term care than the 733 study does. Differences also exist in estimates of how many physicians are needed during peacetime to ensure wartime readiness, including the number of physicians needed for GME, rotation of overseas medical personnel, and staffing overseas military hospitals.

Demonstration Programs Highlighted Peacetime Issues

Many of the peacetime challenges facing DOD were identified or highlighted through its managed care demonstration programs during the late 1980s and early 1990s. Others have persisted much longer. These challenges are difficult to overcome and reflect both operational and policy issues. Some are problems that mirror the challenges facing health care nationwide, but others are unique to the military. The problems include

- significant increases in health care costs and utilization,
- inter-Service rivalries and competing responsibilities that have hindered improvement efforts,
- varying health care benefits and cost-sharing requirements causing beneficiary confusion and inequitable treatment,
- uneven access to care in military hospitals resulting in beneficiary dissatisfaction,
- inadequate information systems that have long hampered attempts to analyze the MHSS and develop strategies to overcome problems and monitor progress,
- fraud and abuse in the CHAMPUS program, and
- variations in the quality of care.

Health Care Costs Grew Significantly Between 1980 and 1990

Throughout the 1980s, MHSS costs have significantly escalated, including large CHAMPUS cost overruns. The DOD health care budget grew by almost 225 percent between 1980 and 1990; the greatest portion of growth occurred in the CHAMPUS program, which grew by about 350 percent during the period. In comparison, national health expenditures increased by about 166 percent from 1980 to 1990. Furthermore, because DOD could not accurately predict its rapidly increasing spending requirements, major shortfalls in CHAMPUS funds totaled well over $3 billion in the late 1980s and early 1990s.

The chief drivers of the cost growth were increased health care prices nationwide, a growing military beneficiary population that made greater use of health care services than its civilian counterparts, and a system of resource allocation for military hospitals that encouraged managers to increase hospital workload.

Lewin/ICF reported in 1989 that a major cause of cost growth in the MHSS was increases in the price of CHAMPUS services.[9] For example, the average CHAMPUS cost per inpatient admission rose from $2,388 in fiscal year 1981

[9] The Appraisal of Managed Care Practices in CHAMPUS, Lewin/ICF (Vienna, Va.:1989).

to $5,395 in fiscal year 1990. The average cost of a CHAMPUS outpatient visit also doubled during this period. These price increases, Lewin concluded, were due to high medical inflation, new technologies, and cost shifting to the CHAMPUS program by doctors and hospitals facing reimbursement limits from other payers.

An increasing population of eligible beneficiaries and an increased percentage of eligible beneficiaries who actually used the MHSS drove the growth in the total volume of CHAMPUS-provided services. The number of CHAMPUS users grew by 162 percent from 1981 to 1990. While CHAMPUS hospital admissions remained almost constant, the increase in CHAMPUS users caused an increase in CHAMPUS outpatient visits, which grew over 200 percent in this period.

DOD health care services are highly utilized. A recent DOD study of the military health care system found that DOD beneficiaries use health care services as much as 50 percent more than civilians in fee-for-service health care plans. Experts attribute this to the availability of virtually free care in the military facilities.

In addition to high utilization, DOD's resource allocation methods have provided incentives for military health care providers to deliver more care. DOD has traditionally allocated resources to hospital commanders on the basis of historical workload: The more admissions, bed-days, and outpatient visits the hospital produced, the more resources it would receive the following year. This method provided incentives to hospitalize patients for long periods of time, even more than medically necessary. Military providers often hospitalized patients who in a civilian setting would have received outpatient treatment. For example, in the past, military physicians have hospitalized patients for tooth extractions. In addition, hospital commanders had no incentive to control CHAMPUS usage because this budget was not under their control, nor were they held accountable for its use. Therefore, complicated or costly procedures could be referred to civilian care without affecting military hospital costs.

Inter-Service Rivalries and Competing Responsibilities Have Hindered Improvement Efforts

DOD has had difficulty coordinating efforts to improve its system because of traditional rivalries among the Services and their diverse organizational structures and responsibilities. We and many others have reported on difficulties arising from the conflicts between these roles and responsibilities, and some studies have suggested unifying the medical departments to resolve inefficiencies.

The lines of authority and accountability between hospital commanders, the Services, the Service Surgeons General, and the Assistant Secretary of Defense (Health Affairs) are complicated and sometimes conflict. Funding of the MHSS, for example, is controlled by two different entities. The Assistant Secretary controls funding for operations, while the Military Departments control funding for the personnel who operate the system.

These conflicting responsibilities and authorities have led to divergent approaches to improving the MHSS. The Army, for example, established a servicewide managed care effort that gave responsibility for managing care to individual hospital commanders and held them accountable for the funds spent on the care in their area. The Air Force experimented with a similar servicewide approach, but the Navy did not establish its own servicewide effort. As a result, the Services now have varying degrees of expertise in implementing managed care efforts.

Past studies have suggested changes in the way military medicine is organized, including consolidating the Services' medical departments into a single defense health agency.[10] However, the Services have always resisted these efforts. In a 1991 report on the status of DOD's improvement efforts,[11] we noted that the Services had resisted major organizational changes in favor of maintaining their own health care systems, primarily on the grounds that each has unique medical activities and requirements. However, others have pointed out that the Navy handles sea, land, and air functions, indicating that one system can perform all functions. Furthermore, in wartime, the U.S. military fights and provides medical care under the authority of unified and specified commands, not as individual Services. In some hospitals, the Services have been experimenting with joint-Service staffing for greater efficiency or to fill needs created by deployments.

Health Care Services and Cost Sharing Are Not Uniform

Beneficiaries' access to services and their cost-sharing responsibilities have traditionally differed depending on where they lived. Because health care services vary by size and location of facility, so does beneficiaries' ability to get free care from the direct care system versus paying for a portion of the costs through CHAMPUS. DOD's managed care initiatives contributed to these differences, producing a variety of different benefits

[10] See The Feasibility of Uniting the Medical Services of the Various Branches of the Armed Forces Into a Single Corps, Congressional Research Service (Washington, D.C.: Aug. 1993).

[11] Defense Health Care: Implementing Coordinated Care—A Status Report (GAO/HRD-92-10, Oct. 3, 1992).

and cost sharing. When active-duty members and their families move from one base to another, they often have to relearn how their health care benefits and cost-sharing responsibilities have changed. These variations in health care offerings have caused confusion and inequities among beneficiaries.

Beneficiaries Are Dissatisfied With Access to Military Facilities

Military beneficiaries have frequently complained about their access to military facilities. Historically, the demand for care in the direct care system has exceeded the capacity of military medical facilities, resulting in long delays for appointments and excessive waiting times for outpatient care.[12] This is one reason that beneficiaries turn to CHAMPUS for medical care, even though it costs more than care in military facilities.

In a recent DOD survey,[13] beneficiaries voiced their concerns about access. Beneficiaries who used civilian facilities reported having better access to care than those who used military facilities. Specifically, beneficiaries using civilian facilities for their most recent outpatient visit had less trouble scheduling appointments, shorter intervals between making the appointment and the actual visit, and less time spent in the waiting room. For example, 13 percent of military facility users waited more than 1 hour in the waiting room, versus only 6 percent of civilian facility users. In fact, one of the most frequently cited reasons for not seeking care in military facilities, according to the DOD survey, was, "it was too hard to get an appointment."

Information Systems Are Inadequate

Lack of adequate, timely, local information on health care provided to beneficiaries has impeded improvements to the cost-effectiveness of the MHSS, as we and others have reported. Military hospital commanders have commented that inadequate information systems hamper their effectiveness in performing their job and implementing change. The demands of managing health care require, at a minimum, accurate information about individual physician practice patterns and charges, beneficiary enrollment, patient outcomes, budgeting and resource allocation, and patient and physician scheduling.

[12]The term "capacity" refers to staffed hospital beds or the ability of DOD medical facilities to meet demand with not only beds but also physicians and support staff.

[13]The Economics of Sizing the Military Medical Establishment, Department of Defense, Office of Program Analysis and Evaluation (Washington, D.C.: Apr. 1994).

Several times we have reported problems with DOD's development and deployment of its Composite Health Care System (CHCS).[14] Military health care facilities are supported by CHCS, a state-of-the-art integrated, automated medical information system used in facilities worldwide. CHCS currently supports patient appointment scheduling, pharmacy, laboratory, radiology, patient administration, outpatient order entry by physicians, inpatient/outpatient medical test result reports, and managed care. In July 1994, we reported that DOD was not managing CHCS performance as effectively or economically as was warranted for a state-of-the-art system. For example, the performance management tools DOD was using did not collect all the data needed to detect response-time problems, diagnose causes, or determine significance. Instead DOD relied largely on user complaints to identify performance concerns with response times. Also, we reported on problems that physicians were experiencing when entering orders in CHCS for treating hospitalized patients. Physicians viewed the order entry process as unacceptable because of the many steps involved.

Analyses conducted as part of DOD's recent study of the MHSS cited many other problems with current MHSS information systems.[15] One of these analyses found that military systems generate higher estimates of use than those reported in beneficiary surveys. For example, military facility visit rates estimated from military information systems were 200 percent higher for active-duty personnel than rates reported in surveys of those personnel. While some inaccuracy in self-reported visit data may occur, this discrepancy casts doubt on the validity of DOD health systems data. In addition, they found that military information systems could not be relied upon to produce geographically specific analyses.

CHAMPUS Has Been Vulnerable to Fraud and Abuse

The CHAMPUS program has been vulnerable to fraud and abuse, as reported by us and DOD audit agencies as far back as the 1970s. CHAMPUS psychiatric benefits, in particular, have been targets of fraud and abuse.

Concerns over CHAMPUS fraud and abuse led to DOD's developing the Defense Enrollment Eligibility Reporting System (DEERS). Before DEERS

[14] Medical ADP Systems: Defense's Tools and Methodology for Managing CHCS Performance Needs Strengthening (GAO/AIMD-94-61, July 15, 1994); Medical ADP Systems: Changes in Composite Health Care System's Deployment Strategy Are Unwise (GAO/IMTEC-91-47, Sept. 30, 1991); Medical ADP Systems: Composite Health Care System Is Not Ready to be Deployed (GAO/IMTEC-92-54, May 20, 1992).

[15] Cost Analysis of the Military Medical Care System, Institute for Defense Analyses (Alexandria, Va.: Sept. 1994). The Demand for Military Health Care: Supporting Research for a Comprehensive Study of the Military Health Care System, RAND Corporation (Santa Monica, Cal.: Jan. 1994).

implementation, it was estimated that DOD lost $40 million annually under CHAMPUS for services to ineligible people. DOD created DEERS to track the eligibility of military beneficiaries and the Office of Program Integrity (which was established in the organization administering CHAMPUS) to investigate fraud and abuse. Despite these improvements, DOD has continued to detect fraud and abuse cases.

We have reported several times on CHAMPUS's vulnerability to fraud and abuse by psychiatric providers. Among such problems under CHAMPUS have been unnecessary hospital admissions, excessive lengths of stay, poor quality of care, and unauthorized or duplicate payments. In recent years, federal investigative agencies have significantly increased resources devoted to reviewing health care fraud and abuse, and investigations of psychiatric providers have increased. One of these investigations yielded a 1994 repayment to the federal government by a psychiatric hospital chain of $324.8 million, $54 million of which is earmarked for DOD. DOD too has made significant improvements in its oversight of psychiatric providers.

Quality of Care Is Generally Good, but Varies

Those studying DOD have noted variations in the quality of care around the country. The most recent DOD survey of beneficiaries shows overall high levels of satisfaction with the quality of care in military facilities, but beneficiaries give higher ratings to civilian care.

Past studies have reported weaknesses in DOD's quality assurance programs. The DOD Inspector General in 1985[16] and we in 1987 and 1989[17] cited a lack of centralized databases and oversight as well as weaknesses in the implementation of quality assurance programs. As described in the previous section, concerns about the quality of psychiatric care provided to DOD beneficiaries under the CHAMPUS program are the most recent examples of such problems.

DOD has addressed these concerns and is improving its quality of care. DOD operates two databases to track claims and adverse actions against DOD physicians,[18] the Defense Practitioner Data Bank and the DOD Risk

[16] Defense-wide Audit of Medical Quality Assurance, DOD Office of the Inspector General (Washington, D.C.: June 1985).

[17] DOD Health Care: Better Use of Malpractice Data Could Help Improve Quality of Care (GAO/HRD-87-30, June 4, 1987) and DOD Health Care: Occurrence Screen Program Undergoing Changes, but Weaknesses Still Exist (GAO/HRD-89-36, Jan. 5, 1989).

[18] Adverse actions refer to actions taken that reduce, restrict, suspend, revoke, or deny a provider's clinical privileges or membership in a health care entity.

Management Database, and also participates in the National Practitioner Data Bank, administered by the Department of Health and Human Services. These systems allow DOD to identify health care providers who receive a disproportionate share of adverse actions. As a supplement to internal hospital-based quality assurance programs, DOD's Civilian External Peer Review Program contracts with a private-sector organization to monitor the effectiveness of internal quality assurance efforts, assist with the development of clinical health care guidelines, and identify areas for quality improvement. DOD also requires all its hospitals to be accredited by the Joint Commission on Accreditation of Healthcare Organizations and reports that military hospitals regularly score well above the national average in accreditation reviews. In addition, DOD has programs to monitor the quality of civilian care provided through the CHAMPUS program, such as the National Quality Monitoring Contract, which reviews claims and medical records of both medical and psychiatric CHAMPUS providers.

Appendix III describes DOD's plans for dealing with the problems outlined in this appendix.

TRICARE—The MHSS' Managed Care Program

Following years of demonstration programs that tested alternative health care delivery mechanisms, DOD designed TRICARE, a managed health care program. The program is intended to ensure a high-quality, consistent health care benefit, preserve choice of health care providers for beneficiaries, improve access to care, and contain health care costs.

TRICARE is significantly changing the military health care system. It offers beneficiaries alternatives to the current CHAMPUS program, providing alternatives such as a health maintenance organization (HMO) that will lower cost sharing when beneficiaries agree to limitations on their choice of physicians. To implement and administer the TRICARE program, DOD has reorganized the military delivery system into 12 new, joint-Service regions. A new administrative organization, the lead agent, has also been created in each region to monitor and coordinate the delivery of health care. One significant feature that has been maintained from the demonstration programs is the use of contracted civilian health care providers to supplement the level and type of care provided by the MHSS on a regional basis. DOD estimates that these contracts will cost about $17 billion over the 5-year contract period. TRICARE also incorporates several cost control features of civilian sector managed care programs.

DOD expects to have TRICARE implemented nationwide by May 1997. One regional contract with a civilian health care company had been awarded, and TRICARE implementation in that region began in March 1995. Several other regional procurements are in process.

As DOD approaches the midpoint of its transition to TRICARE, several issues and concerns about the design and implementation of TRICARE have been raised:

- Military medical officials have expressed concern that lead agents lack sufficient authority and control to effectively manage health care delivery in the regions because the individual Services still retain control over their medical funds, facilities, and personnel.
- DOD has had many problems so far in procuring civilian health care services through the managed care support contracts.
- Beneficiaries are concerned that they may not have access to the same benefit options as others in their region or across the country due to limitations on the number and type of military and civilian providers.
- Military officials are also concerned that delivering and installing a critical managed care information system may be delayed as have other

information systems, which could seriously impact TRICARE's successful and timely implementation.

Additionally, beneficiary groups and others have suggested that more cost-effective alternatives to TRICARE exist.

TRICARE Offers Three Options for Health Care

TRICARE features a triple-option benefit, offering beneficiaries eligible for CHAMPUS two new options for health care in addition to the CHAMPUS program.[19] The options vary in the choices beneficiaries have in selecting their physicians and the amount beneficiaries are required to contribute toward the cost of their care received from civilian providers.

The first option, TRICARE Standard, is the current fee-for-service CHAMPUS program. This option provides beneficiaries with the greatest freedom in selecting civilian physicians, but requires the highest beneficiary cost share. For example, beneficiaries using Standard must meet an annual deductible for outpatient care ranging from $100 for families of active-duty personnel at or below the E-4 level to $300 per family above the E-4 level, retirees, their dependents, and survivors. Active-duty dependents are expected to pay 20 percent of the cost of outpatient care and $25 per inpatient admission or $9.50 per day, whichever is greater. Retirees, their dependents, and survivors contribute more toward their care, paying 25 percent of outpatient costs and the lesser of $323 per day of inpatient care or 25 percent of the hospital charges, as well as 25 percent of related professional medical services.

The second option, TRICARE Extra, is a preferred provider option, through which beneficiaries receive a 5-percent discount on the Standard option cost of care when they choose a medical provider from the contractors' network. The outpatient deductibles are the same as the Standard option, but active-duty dependents pay a 15-percent copayment, with other beneficiaries paying a 20-percent copayment. Active-duty dependents pay the same amount for inpatient care as under the Standard option, but retirees and others have a reduced cost share under Extra, paying the lesser of $250 per day or 25 percent of the hospital charges, as well as 20 percent of related professional medical services. Beneficiaries are not required to enroll in the Extra option or exclusively use network providers, but may use network providers on a case-by-case basis.

[19]The Federal Register of February 8, 1995, contains DOD's proposed rule describing TRICARE and establishing requirements and procedures for implementing the program.

The third option, TRICARE Prime, represents the greatest change in MHSS health care delivery. TRICARE Prime is an HMO-like alternative that provides comprehensive medical care to beneficiaries through an integrated network of military and contracted civilian providers. Beneficiaries selecting this option must enroll annually in the program, agreeing to go through an assigned military or civilian primary care physician for all care. Low enrollment fees and copayment features provide financial incentives for beneficiaries to select this option, the most highly managed of the three options. For example, Prime enrollees are not required to meet an annual deductible, but retirees, their dependents, and survivors enrolled in the option must pay an annual enrollment fee of $230 for an individual and $460 for a family. Cost-sharing requirements for care provided by civilian providers range from $6 a visit for active-duty dependents of lower rank military personnel to $12 a visit for dependents of higher rank personnel, retirees, their dependents, and survivors. Cost-sharing requirements for inpatient care are significantly lower than for the other options. Regardless of their beneficiary category, all enrollees pay the greater of $25 per admission or $11 per day.

Limitations and Priorities for TRICARE Options

Establishing an HMO option, such as Prime, depends on the availability of sufficient medical resources to adequately address the health care needs of all enrollees. At a minimum, DOD expects that integrated networks of military and civilian providers for the Prime and Extra options can be established within the 40-mile area surrounding military hospitals and medical centers. Establishing networks in areas farther from the hospitals and medical centers may also be feasible if the area has a sizeable beneficiary population and a sufficient number of civilian medical providers. In some areas of the country, however, establishing a provider network to support Prime or Extra will not be feasible, and beneficiaries will only have the TRICARE Standard option.

Even in areas where provider networks for Prime can be established, if sufficient military and civilian medical resources are not available to provide care to all anticipated enrollees, DOD will limit the number of beneficiaries that enroll in the Prime option. For those situations, DOD has established a priority system for enrollment. Because active-duty members must receive nearly all of their care in military facilities, they will have first enrollment priority and will be automatically enrolled in the Prime option. Dependents of active-duty personnel have the next priority, followed by retired military personnel, their dependents, and survivors under age 65.

Retirees, their dependents, and survivors age 65 and over cannot enroll in Prime.

Beneficiaries not selecting the Prime option continue to be eligible to receive care in military facilities on a space-available basis (as discussed in app. I).[20] However, the introduction of the Prime option designed to maximize the use of military facilities by those enrolled in the option has resulted in a differentiation in some beneficiary categories. DOD has established a sublevel of priority in the active-duty dependent beneficiary group, with active-duty dependents enrolled in Prime given priority for military care over nonenrollees. However, active-duty dependents not enrolled in Prime still have priority to receive care in military facilities over retirees, their dependents, and survivors, even if those retirees and others are enrolled in Prime. No differentiation based on enrollment status has been made in the beneficiary category of retirees, their dependents, and survivors.

New Regional Structure Developed for TRICARE

To implement TRICARE, DOD has reorganized its medical facilities into new health care regions and established a new administrative structure to oversee the delivery of health care within the regions. Military medical facilities are organized on a geographic basis into 12 health care regions, encompassing medical facilities from all three of the Services. The number and Service affiliation of the facilities vary among regions, as well as the number of eligible beneficiaries in each region's boundaries. In each region, a military medical center commander has been designated as the region's lead agent, or health administrator, supported by a joint-Service staff drawn from the region's military medical facilities and DOD medical program offices. Table III.1 presents information on the 12 TRICARE regions, including the designated lead agents, the states included in the regional boundaries, the estimated number of eligible beneficiaries, and the number of military hospitals and medical centers in each region.

[20]Retirees, their dependents, and survivors age 65 and over are not eligible to enroll in Prime but remain eligible to receive care in military medical facilities.

Table III.1: Information on the 12 TRICARE Regions

Region	Lead agent	States in region	Beneficiary population	Hospitals and medical centers[a]
1	National Capital (Bethesda, Walter Reed, Malcolm Grow Medical Centers)	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Northern Virginia	1,093,918	12
2	Portsmouth Naval Hospital	North Carolina, Southern Virginia	872,011	8
3	Eisenhower Army Medical Center	Georgia, South Carolina, parts of Florida	1,063,770	12
4	Keesler Air Force Medical Center	Alabama, Tennessee, parts of Florida and Louisiana	595,024	10
5	Wright-Patterson Air Force Medical Center	Illinois, Indiana, Kentucky, Michigan, Ohio, West Virginia, Wisconsin	653,328	5
6	Wilford Hall Air Force Medical Center	Arkansas, Oklahoma, parts of Louisiana and Texas	949,778	14
7	William Beaumont Army Medical Center	Arizona, Nevada, New Mexico, parts of Texas	323,058	8
8	Fitzsimons Army Medical Center[b]	Colorado, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming, parts of Idaho	732,821	14
9	San Diego Naval Hospital	Southern California	710,461	7
10	David Grant Air Force Medical Center	Northern California	382,590	5
11	Madigan Army Medical Center	Oregon, Washington, parts of Idaho	350,439	4
12	Tripler Army Medical Center	Hawaii	151,750	1
Total			**7,878,948**	**100**

[a]Does not include hospitals and medical centers scheduled for closure in 1995.

[b]On DOD's list of military facilities recommended for closure.

Lead agents have broad responsibilities for planning, coordinating, and monitoring the care delivered throughout the region by medical facilities from all three Services as well as by contract providers. An initial responsibility of the lead agent is developing an integrated plan for delivering health care to beneficiaries in the region. Following general

topics prescribed by the Assistant Secretary of Defense (Health Affairs), the plan describes how the lead agent and the military medical facilities will address and implement managed care in the region. For example, plans must discuss the extent to which military facilities can provide primary care physicians, how the enrollment process will be established, and the capacity of the military facilities to implement programs to control and monitor utilization of direct care system resources. Lead agents develop the plan in collaboration with the commanders and staff of the other medical facilities in the region. Although the lead agents do not command or control the facilities in their region, they oversee the operations of the three Services' staff through developing and implementing the regional health plan.

TRICARE's Managed Care Support Contracts

In addition to providing new options for health care and a new regional structure, TRICARE expands DOD's prior experiences in using contracted civilian physicians in demonstration programs to the entire MHSS. Under TRICARE, seven managed care support contracts will be awarded for the 12 TRICARE regions.[21] Each support contract will be awarded to a single private-sector health care company to supplement the care available in the military medical facilities in the region and to provide administrative support to the lead agent and medical facility commanders and staff. The contracts are for a 5-year period (1 year plus 4 option years), and DOD estimates that they have a combined value of about $17 billion. After the 5-year period, contracts will be resolicited. DOD plans to award all seven contracts by September 30, 1996, with the TRICARE program fully implemented in all regions by May 1997. As of February 1995, one contract had been awarded, with the request for proposals (RFP) issued for another three contracts. The status of each region's support contract and the expected TRICARE implementation date appear in table III.2.

[21] Some of the contracts will cover more than one region. Single contracts will cover Region 1; Regions 2 and 5; Regions 3 and 4; Region 6; Region 11; Regions 7 and 8; and Regions 9, 10, and 12.

Table III.2: TRICARE Support Contract Status and Expected TRICARE Implementation Dates

Region	Contract status	TRICARE implementation date
11	Awarded to Foundation Health Corporation September 1994	March 1995
9, 10, and 12	Evaluating proposals	October 1995
6	Evaluating proposals	November 1995
3 and 4	Evaluating proposals	May 1996
7 and 8	RFP pending	November 1996
1	RFP pending	May 1997
2 and 5	RFP pending	May 1997

The TRICARE managed care support contracts are procured centrally by the Office of CHAMPUS, within the Office of the Assistant Secretary of Defense (Health Affairs), not by the lead agents of each region. To ensure uniformity across the regions, the Office of CHAMPUS has developed a standard RFP for all contracts, describing the program requirements the contractor must meet. For example, the RFP includes a detailed description of the TRICARE program requirements and services to be provided by the contractor, including the following:

- implementing and operating a comprehensive health care delivery system for all CHAMPUS beneficiaries, including TRICARE Prime and Extra;
- implementing and operating TRICARE service centers that provide enrollment, physician assignment and referral, and appointment functions;
- providing medical personnel and resources to the military facilities if needed to lower overall program costs;
- conducting comprehensive utilization and quality management programs;
- conducting programs to educate providers and beneficiaries on the features of the TRICARE program;
- developing procedures to maintain services in the event of the mobilization of military medical personnel from the region; and
- performing fiscal intermediary services for care provided outside the military facilities, including claims processing and data reporting.

The lead agents include in the RFP any unique or region-specific requirements that they identify beyond those included in the standard RFP.

The contracts are bid on a competitive basis and considered fixed-price, at-risk contracts. However, only the administrative portion of the contract has a fixed price, while the health care price is subject to adjustments on

the basis of risk-sharing provisions in which the contractor and the government share contractor losses and gains beyond a certain level. Price adjustments can be based on factors such as inflation, beneficiary population, and military treatment facility usage. The risk-sharing and bid price adjustment features are intended to protect both the contractor and the government from the large risks associated with these complex contracts.

Capitated Method to Allocate Funds

TRICARE, like other managed care programs, uses a capitation method to allocate health care funds. Capitation is a strategy for containing the cost of health care by allocating resources based on a fixed amount per beneficiary in the population. In the past, DOD medical facilities were funded on the basis of historical workload, which rewarded high resource utilization with increased budgets. However, as part of its transition to TRICARE, in 1994 DOD adopted a modified capitation method, with the Assistant Secretary of Defense (Health Affairs) allocating some resources to the Services' medical departments on a per capita basis.

DOD's model is a modified capitation approach because funds for some functions are not provided on a per capita basis. Funding for medical support functions not related to the size of the military force, such as the air evacuation system and overseas medical activities, are not capitated. Medical functions that are unique to the military and related to military readiness and the size of the military force are capitated on the basis of the active-duty population. Funding for operating and maintaining the direct care system and CHAMPUS will be capitated, using a fixed-dollar amount for each beneficiary DOD estimates is using the MHSS system. The Services' medical departments pass the direct care funds on to the individual medical facilities using their own Service-unique capitation methodologies, making each medical facility commander responsible for providing health services to a defined population for a fixed-dollar amount per beneficiary. This approach is intended to remove incentives to prolong hospital stays, inappropriately increase the number of services provided, or otherwise provide more costly care than is medically appropriate. CHAMPUS funds are not provided to the medical facilities but are pooled together at the Service level to fund the TRICARE managed care support contracts in each region.

Utilization Management Under TRICARE

Following the lead of private-sector managed care programs, TRICARE includes a plan to implement a comprehensive utilization management program for the MHSS. Utilization management programs are designed to ensure appropriate use of medical resources, to support quality care, and to ensure that beneficiaries receive appropriate and coordinated health care services. The primary components of utilization management include precertification, concurrent and retrospective review, case management, and discharge planning. Through utilization management, health care administrators evaluate the use of medical resources on an ongoing basis. DOD, lead agent, and military medical facility officials view utilization management as a key to containing costs and ensuring health care quality and access.

Each lead agent will develop a written utilization management plan for care provided throughout the region, whether in the direct care system or through the managed care support contract. The lead agent's plan must be consistent with the DOD utilization management policy, issued in November 1994.[22] The managed care support contractor is required to develop and implement utilization management programs consistent with the DOD policy for care provided outside of the military facilities.

In developing their utilization management plans, lead agents review the capabilities and capacity for each military medical facility in their region to perform the required utilization management functions for the direct care system. Lead agents may choose to contract for utilization management services for the direct care system, or the military medical facility may retain those functions. According to DOD, regardless of who performs these functions, the activities will be carried out following uniform DOD utilization management policy guidance.

Implementing TRICARE Will Be Challenging

We and others have reported in the past that managed care offers DOD the chance to gain more control over costs, improve beneficiary access, and maintain high-quality care. However, implementing and institutionalizing TRICARE entails many difficult operational decisions for DOD. Some of the more significant issues facing DOD are summarized below.

[22]This guidance, issued on November 23, 1994, is the first DOD-wide utilization management policy. The policy, developed jointly by the Services and Health Affairs, provides uniform criteria and standards for utilization management programs in the direct care systems as well as for care provided by the support contractor.

Lead Agent Authority and Control

The reorganization of medical facilities into joint-Service regions and establishment of the new lead agent structure represents a significant change to the administrative structure of the military health system. DOD policy for TRICARE states that the success of the program relies to a great extent on inter-Service cooperation and the administrative skills of the lead agents. Officials from lead agent offices and military hospitals have expressed general satisfaction with the cooperative and collaborative attitude of the facilities in their region. However, the officials are concerned about the degree of control or authority the lead agents and medical facilities will have and the extent to which they can effectively manage the delivery of care in the region. They also believe that clearer lines of responsibility and accountability for organizational performance are necessary.

Issues related to lead agent control and authority are inherently complex because TRICARE calls for the lead agent to coordinate all care provided in the region (including care provided by the contractor). However, the Services retain command and control over their military facilities and personnel, with each facility accountable to its parent Service. Therefore, the lead agent does not control the funds that flow from the Services to their respective facilities or the CHAMPUS funds, which are controlled by DOD and the contractor.

The lead agents must also overcome the effects of inter-Service rivalries that have historically hampered efforts to establish efficient health care delivery systems. The lead agent must foster teamwork that crosses traditional Service boundaries. For example, the Air Force lead agent in one region will oversee and manage the delivery of health care by 19 Army, Navy, and Air Force military hospitals and clinics and the civilian contractor. Although communication among the Services appears to have improved, the lead agents' challenge will be to convince other Services' hospital officials and headquarters commands to participate in initiatives to improve health care delivery in the entire region.

Some DOD and Service officials have questioned whether lead agents will have the authority necessary to improve health care delivery. Some of those officials, particularly those more experienced in managed care demonstrations, believe that lead agents and medical facilities need more control over the use of CHAMPUS money, what is to be contracted out, and contractor activities and functions. On the other hand, some prospective contractors have expressed concern that DOD is seeking control over issues that the contractor should decide.

Health Care Contracting Process Is Cumbersome and Contentious

Contracting for private-sector health care services, a key feature of TRICARE, is proving to be cumbersome, complex, and costly, resulting in protests, schedule delays, and an overall lengthy procurement process. For example, the one awarded contract took almost 2 years. Prospective contractors have expressed much frustration with the process, stating that the level of detail in the RFPs and the number of changes to the requests contribute to contract delays and increase their costs of preparing responsive proposals. Offerors estimate it costs between $1 and $2 million just to prepare a proposal. Because of the size and complexity of the contracts, competition may be limited to only the largest health care companies, according to prospective offerers. DOD officials acknowledge the complaints but consider the benefits of implementing a uniform program nationwide to be a worthwhile trade-off. Further, DOD officials consider the problem of changes to the RFPs to be a diminishing one as they continue to gain experience with this type of contract.

Several protests have been filed during the managed care support contracting process. One of the protests was upheld by GAO, resulting in the contract's rebidding and DOD's changing several of its procurement procedures to address the protested issues. The other protests, filed after the changes were made, were denied. DOD officials hope the changes will prevent future protests from being upheld. We are examining DOD's procurement process to determine whether additional changes are needed and expect to report on these matters at a later date.

Capitation and Enrollment Features in TRICARE

Two features of private-sector managed care programs are the use of a capitated method to allocate resources and the requirement that beneficiaries enroll and pay premiums in a specific health care plan. These features work together, with enrollment and associated premiums providing a definition of the population that will use the plan and capitation providing a mechanism to budget health care funds on the basis of the number enrolled rather than the type of medical care to be provided. These features create strong incentives for beneficiaries to exclusively use plans in which they are enrolled and have paid premiums and for health care providers to more efficiently serve beneficiaries. Concerns have been raised, however, that the capitation method and enrollment requirements under TRICARE may not yield the same benefits as those private-sector plans because of design differences.

The capitation method adopted by DOD could perpetuate existing inefficiencies in the system because the per capita rates are based on past

levels of military spending, according to the Congressional Budget Office (CBO). CBO reported that projecting future resource requirements on the basis of historical spending patterns could lock past inefficiencies into the system, especially given higher-than-average use of medical care by military beneficiaries. Furthermore, the capitated amounts are not based on the actual number that used the system but on an estimate determined from surveys of military beneficiaries. DOD acknowledges that it does not know the number of actual users because it does not require beneficiaries to select and enroll in a single health care plan but expects that it will be able to address any disparities as TRICARE matures.

Under TRICARE, beneficiaries are not required to select between civilian care and military care, nor must they select a single plan within the three options offered by DOD. Without a universal enrollment system that would lock beneficiaries into a single plan, beneficiaries may move freely between DOD sources of care and private insurers or other programs or health care providers such as Medicare, the Federal Employees Health Benefits Program, and the VA. Even beneficiaries enrolled in the PRIME option are not locked into a single choice; they may use other health care providers, although at a considerably higher cost share.

The lack of a universal enrollment system to identify the population that uses the MHSS also makes it more difficult for lead agents and support contractors to create provider networks and plan the medical services necessary to best meet the health care needs of the population using the MHSS. According to CBO and other managed care experts, the absence of universal enrollment makes it unlikely that TRICARE will achieve its maximum efficiency.

According to DOD, universal enrollment in the civilian sector does not inherently restrict a beneficiary to a particular source of care if other insurance programs and providers are available to the beneficiary. The principle mechanism that restricts the use of multiple programs in the civilian sector is charging beneficiaries a sufficient premium for care, and DOD has included a premium for some beneficiaries in TRICARE Prime in the form of an enrollment fee. However, at this early stage of TRICARE implementation, whether the capitation and enrollment features of TRICARE will address the concerns of CBO and others is uncertain.

Program Availability and Cost-Sharing Requirements

We and others have reported on the need for uniform benefits and cost sharing for each category of beneficiary, regardless of residence or

location of health care provider. Additionally, the fiscal year 1994 authorization and appropriations acts for the Department of Defense required DOD to develop, to the extent practical, health benefit options including a uniform health benefit modeled after private-sector HMOS.[23] DOD has made significant progress on this issue. TRICARE offers beneficiaries three health benefit options, and, in December 1994, DOD announced a fee structure for beneficiaries that enroll in Prime, regardless of residence.

Despite this progress, however, true uniformity in benefits and cost sharing has yet to be achieved, and some inequities still remain. For example, all beneficiaries will not have access to the three health benefits options because medical resources do not exist in some areas to support establishing provider networks for the Prime and Extra option. As a result, those beneficiaries will not have access to the benefits and cost savings that the Prime and Extra options offer. Secondly, in some places where TRICARE Prime is established, DOD expects that availability will be limited and not all eligible beneficiaries will be permitted to enroll, creating another inequity. Finally, beneficiaries who do enroll in Prime may not receive all their care within military facilities but can be assigned a civilian primary care physician and referred to civilian specialists. This creates another inequity for Prime enrollees because those using civilian providers must bear a greater cost share than those assigned or referred to military physicians.

Availability of Critical Management Information Systems

The long-standing concerns about DOD health care management information systems continue and are even more critical with the implementation of TRICARE. In particular, the Managed Care Program module of DOD's Composite Health Care System (CHCS) is designed to support the administration and delivery of health care in each region. The module tracks the enrollment of beneficiaries in the Prime option, patient appointment bookings, and patient referrals—all functions needed at the onset of TRICARE implementation. DOD has a schedule for installing the module into CHCS within the military medical facilities nationwide, but lead agents and medical facility officials are concerned that it will not be available when needed, given the long development history and pattern of delivery schedule delays of the CHCS.

Is TRICARE the Most Cost-Effective Option?

The 733 study conclusion (described in app. II) that DOD may be able to reduce its medical force by as much as one-half has significant

[23]The National Defense Authorization Act for Fiscal Year 1994 (P.L. 103-160) and Department of Defense Appropriations Act, 1994, (P.L. 103-139).

implications for peacetime medical care. To the extent that the current peacetime capacity exceeds that which is required for war, economic factors will become a principal determinant of the size and structure of the peacetime medical force and of the best means for delivering care to military beneficiaries.

DOD has certified to the Congress that its managed care approach is the most efficient method of providing health care. We have reported that the analyses conducted in support of DOD's certification were done in a reasonable way and fairly represented the likely impact of DOD's managed care approach on costs, quality, and access. Other studies, however, suggest that more cost-effective alternatives to TRICARE exist that will better meet the future health care needs of all beneficiaries, while maintaining a required readiness posture. CBO reported that DOD's certification analyses likely understated costs and that it was possible that net costs could increase substantially. The 733 study concluded that an attractive MHSS benefit, such as that offered in TRICARE, attracts more people than the system can cost effectively accommodate. They determined that to implement such a benefit, which would increase demand for military care, DOD would need to seek reimbursement from other employers and the Health Care Financing Administration for care provided to employed or Medicare eligible beneficiaries. Otherwise, DOD would have to bear the additional costs of this demand effect. A study by RAND of the CHAMPUS Reform Initiative, one of DOD's early managed care experiments that had many similarities to TRICARE found that the increased demand resulting from the program's very generous benefit resulted in costs to the government greater than would have been incurred without the program.

Beneficiary groups have proposed a broader health benefits program that would permit beneficiaries to also choose from among the options offered in the Federal Employees Health Benefits Program. They believe this would not only improve access to care but would be more cost-effective than DOD's current plans. A DOD-contracted study, conducted in 1993, concluded that such a proposal might cost DOD less compared with current MHSS costs. Both CBO and the Commission on the Roles and Missions of the Armed Forces have been studying the cost and feasibility of this option, and their reports are expected in the near future.

GAO Reports and Testimonies on Military Health Care

Managed Care Planning and Implementation

Defense Health Care: Challenges Facing DOD in Implementing Nationwide Managed Care (Testimony, GAO/T-HEHS-94-145, Apr. 19, 1994). DOD has made progress in implementing TRICARE, but some questions remain about its potential cost-effectiveness. In addition, implementation issues need to be addressed, such as the unclear role and authority of lead agents, DOD's ability to evaluate contractor proposals sufficiently, and problems resulting from rigid time frames for implementation of TRICARE.

Defense Health Care: Expansion of CHAMPUS Reform Initiative Into DOD's Region 6 (Report, GAO/HEHS-94-100, Feb. 9, 1994). The analyses conducted in support of DOD's certification for expanding the modified CHAMPUS Reform Initiative (CRI) program to DOD's region 6 were done in a reasonable way and fairly represent the likely impact of the program on cost, quality, and access.

Defense Health Care: Expansion of the CHAMPUS Reform Initiative Into Washington and Oregon (Report, GAO/HRD-93-149, Sept. 20, 1993). DOD's comparison of the modified CRI program and standard CHAMPUS was done in a reasonable way. However, the certification based on this comparison did not address other health care delivery methods.

Defense Health Care: Lessons Learned From DOD's Managed Health Care Initiatives (Testimony, GAO/T-HRD-93-21, May 10, 1993). The lessons learned from DOD's managed care initiatives can provide useful information as DOD proceeds in implementing managed care throughout its health care system. These lessons emphasize the need for uniform health care benefits, improvements in accountability, budgeting and resource allocation, and information systems, as well as the establishment of safeguards to ensure high-quality and accessible care that protects the beneficiaries and the government.

Defense Health Care: Obstacles in Implementing Coordinated Care (Testimony, GAO/T-HRD-92-24, Apr. 7, 1992). DOD faces significant challenges as it tries to restructure its health care system, such as budget constraints, building a consensus for the changes needed, and lack of reliable data upon which to base decisions. In addition, DOD needs to address significant implementation issues in both program features, such as beneficiary cost sharing, and administrative functions, such as information systems.

Defense Health Care: Implementing Coordinated Care—A Status Report (Report, GAO/HRD-92-10, Oct. 3, 1991). Although DOD has made significant advances in moving to a managed health care system, some questions

remain: DOD does not know how it will measure military hospital commanders' performance; adequate budgeting and resource allocation systems may not be developed quickly enough; limited start-up resources have been allocated; and benefits and cost-sharing requirements vary.

The Military Health Services System: Prospects for the Future (Testimony, GAO/T-HRD-91-11, Mar. 14, 1991). DOD has tested managed care models in its demonstration programs and has found that features, such as local accountability, strong utilization management and quality assurance programs, and good information and claims processing systems, are necessary in a managed care environment.

Mental Health

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays Is Needed for Federal Health Programs (Report, GAO/HRD-93-92, Sept. 17, 1993). Some control weaknesses exist and other controls have not been fully implemented, which renders federal programs, such as Medicare, Medicaid, and CHAMPUS, vulnerable to fraudulent and abusive psychiatric hospital practices.

Defense Health Care: Additional Improvements Needed in CHAMPUS's Mental Health Program (Report, GAO/HRD-93-34, May 6, 1993). Mental health cost control efforts are working; however, several problems remain: reviews of medical records show high rates of potentially inappropriate hospital admissions, inspections of residential treatment centers continue to reveal problems, and CHAMPUS payment rates to psychiatric facilities are higher than other government program rates.

DOD Mental Health Review Efforts (Letter, GAO/HRD-93-19R, Mar. 31, 1993). DOD has made a commitment to act against providers who deliver unnecessary or inappropriate care. The provision of mental health services to DOD beneficiaries is scrutinized more thoroughly than other federally financed insurance programs.

Defense Health Care: CHAMPUS Mental Health Demonstration Project in Virginia (Report, GAO/HRD-93-53, Dec. 30, 1992). The demonstration project has saved money under two measures of cost savings. However, improvements are needed in DOD oversight.

Defense Health Care: Efforts to Manage Mental Health Care Benefits to CHAMPUS Beneficiaries (Testimony, GAO/T-HRD-92-27, Apr. 28, 1992). Although DOD's management of mental health care has improved since the 1980s,

GAO has substantial concerns about the quality and appropriateness of mental health care provided to DOD beneficiaries and believes that DOD needs to act more aggressively in dealing with problem providers.

DOD's Management of Beneficiaries' Mental Health Care (Testimony, GAO/T-HRD-91-18, Apr. 24, 1991). Legislative changes and DOD's management initiatives enhance the prospects for gaining control over mental health care costs. However, DOD needs to improve its quality assurance program for mental health services.

Information Technology

Medical ADP Systems: Composite Health Care System Is Not Ready to be Deployed (Report, GAO/IMTEC-92-54, May 20, 1992). Two critical system-development and operational issues remain unresolved—multiple patient records and archiving patient records. The limited progress made by DOD on an efficient method of entering physicians' inpatient orders could have a significant impact on the Composite Health Care System (CHCS) deployment.

Composite Health Care System: Outpatient Capability Is Nearly Ready for Worldwide Deployment (Report, GAO/IMTEC-93-11, Dec. 15, 1992). The deployment plan lacks specificity and the cost/benefit analysis is still unclear and unsubstantiated.

Medical ADP Systems: Changes in Composite Health Care System's Deployment Strategy Are Unwise (Report, GAO/IMTEC-91-47, Sept. 30, 1991). DOD planned a March 1992 decision to deploy a version of CHCS that did not include the capability to archive and retrieve patient records and an efficient method for entry of physicians' orders.

Operation Desert Storm

Operation Desert Storm: Problems With Air Force Medical Readiness (Report, GAO/NSIAD-94-58, Dec. 30, 1993). The medical and evacuation units provided by the Air Force would have had difficulty handling the predicted number of casualties, and the system for regulating patient movement to available medical facilities was inadequate. However, initiatives to implement lessons learned may improve the Air Force's response to future contingencies.

Operation Desert Storm: Improvements Required in the Navy's Wartime Medical Care Program (Report, GAO/NSIAD-93-189, July 28, 1993). Navy medical units were assigned wartime missions they were not prepared to

fulfill. Deployment and assignment of medical personnel were not efficiently managed, personnel arrived in theater without adequate training, and lack of inventory controls hampered the flow of equipment and supplies.

Operation Desert Storm: Full Army Medical Capability Not Achieved (Report, GAO/NSIAD-92-175, Aug. 18, 1992). Testimony on same topic (GAO/T-NSIAD-92-8, Feb. 5, 1992). The Army's ability to provide adequate care had the predicted number of casualties occurred would have been questionable because of problems with nondeployable medical personnel, incomplete personnel information systems, medical personnel not trained for wartime missions, and hospitals that were never fully equipped or supplied.

Other

Decision Regarding Protest Filed by QualMed, Inc. (Redacted Version, B-257184.2, Jan. 7, 1995). The offeror protested the award on the grounds that the technical and business proposals were improperly evaluated. GAO found that the processes involved in evaluating health care costs were reasonable and in accordance with the request for proposal (RFP). In addition, no evidence existed to show that DOD acted with the intent of hurting the protester. The protest was denied in part and dismissed in part.

VA/DOD Health Care: More Guidance Needed to Implement CHAMPUS-Funded Sharing Agreements (Report, GAO/HEHS-95-15, Oct. 28, 1994). Potential sharing opportunities have been missed because neither DOD nor VA has conducted a systemwide search to identify opportunities for sharing agreements.

Defense Health Care: Uniformed Services Treatment Facility Health Care Program (Report, GAO/HEHS-94-174, June 2, 1994). USTF health care services equal TRICARE Prime and surpass other components of the military health care system. Beneficiary cost sharing in USTFs is less than in other DOD health programs except the direct care system. The cost and other implications of terminating the USTF agreements before they expire vary among the parties affected.

Decision Regarding Protests Filed by Foundation Health Federal Services, Inc. and QualMed, Inc. (Redacted Version, B-254397.4 et al., Dec. 20, 1993). This decision sustained the protests on the basis that DOD failed to evaluate offerors' proposals in accordance with the RFP evaluation criteria.

Defense Health Care: Health Promotion in DOD and the Challenges Ahead (Report, GAO/HRD-91-75, June 4, 1991). The health promotion programs reviewed appeared comparable to those of private-sector firms; however, the comprehensiveness of these programs varies. How cost beneficial health promotion efforts are unknown.

Defense Health Care: Potential for Savings by Treating CHAMPUS Patients in Military Hospitals (Report, GAO/HRD-90-131, Sept. 7, 1990). DOD can potentially save money by adding staff and equipment at military hospitals to treat more patients, rather than paying for their care under CHAMPUS.

Defense Health Care: Military Physicians' Views on Military Medicine (Report, GAO/HRD-90-1, Mar. 22, 1990). Physicians reported dissatisfaction with many aspects of military medicine, and physicians' intentions to leave the service over the next several years parallel DOD's historical attrition rates. Active-duty physicians' intentions to leave are influenced by the time spent on nonphysician tasks, the gap between military and civilian compensation, and the lack of opportunity to practice in their primary specialties.

Defense Health Care: Effects of AIDS in the Military (Report, GAO/HRD-90-39, Feb. 26, 1990). Thus far, AIDS has had a minimal impact on overall DOD operations. However, AIDS has had a significant impact on military hospitals primarily because of the strain placed on resources during mass testing. It is unclear how DOD plans to provide the resources needed to deal with the expected increase in demand for AIDS-related health care services.

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Acknowledgments

In addition to those named above, the following individuals made important contributions to this report. Paul Francis and Dade Grimes provided the information on DOD's wartime health care mission and performance. Helen Lew, Tonia Johnson, and John Riley provided the input on management information systems. Don Hahn and Cheryl Brand provided the data on the contracting process. Elkins Cox, Sylvia Diaz, Allan Richardson, and Nancy Toolan provided information on DOD's peacetime health care and TRICARE.

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