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DEFENSE HEALTH CARE

**Challenges Facing DOD in
Implementing Nationwide
Managed Care**

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Mr. Chairman and Members of the Subcommittee:

We appreciate the opportunity to discuss (1) the Department of Defense's (DOD) efforts to implement its nationwide managed health care program called TRICARE and (2) our ongoing evaluation of the Department's efforts to secure regional health care contracts with civilian firms to support TRICARE.

For the past 7 years, in response to requests from this Subcommittee and others, we have reviewed various aspects of the Department's many health care delivery programs, which has culminated in DOD's decision to implement TRICARE for military beneficiaries.¹ Our testimony today is based on the results of those review efforts as well as on several ongoing evaluations of TRICARE implementation issues.

The Department has made substantial progress in implementing TRICARE, and we commend DOD officials for tackling this ambitious but necessary undertaking. TRICARE embodies many of the lessons learned from DOD's managed health care demonstration projects over the last several years. We believe that it offers the potential for improving beneficiary access to care, maintaining high-quality care, and gaining control of health care costs.

Yet, analyses that have been conducted to date show that it is uncertain whether TRICARE will be more cost effective than other health care options available to DOD. Much will depend on TRICARE's benefit and cost-sharing packages, which DOD still needs to finalize.

Also, given the complexity of TRICARE, several implementation and contracting issues remain to be addressed, including

- a controversy over how much authority the lead agents will have or need to bring about the operational changes necessary to achieve efficiencies,
- the need to obtain better information from offerors and reexamine the criteria and methodology to be used for evaluating offeror proposals,
- the time allotted to contractors to begin service delivery after the award of new contracts, and
- the speed with which DOD is implementing its system nationwide.

¹A list of our reports and testimonies on this issue appears in appendix I.

BACKGROUND

Before DOD's transition to managed care, the military health services system, consisting of both military hospitals and clinics as well as a traditional fee-for-service insurance program known as CHAMPUS,² lacked sufficient incentives and tools to control expenditures and provide beneficiaries accessible care on an equitable basis. DOD's frequently large CHAMPUS cost overruns prompted the Congress to authorize experiments with a variety of initiatives such as the CHAMPUS Reform Initiative and Catchment Area Management projects. DOD's experience with these initiatives culminated in its decision to implement TRICARE for military beneficiaries.

TRICARE's goals are to improve access to care and ensure a high-quality, consistent health care benefit for DOD's 1.9 million active-duty members and some 6.7 million nonactive-duty beneficiaries. It also seeks to preserve choice for nonactive-duty participants while containing health care costs, which now amount to about \$15.1 billion each year. TRICARE has four major components:

- Twelve health service regions have been established for the U.S.-based military health services system. Each region is headed by a medical center commander, designated as lead agent, with responsibilities for managing the care delivered to beneficiaries both in military facilities and by civilian providers.
- Beneficiaries will be free to choose from a health maintenance organization (HMO) option, a preferred provider organization option, or an indemnity fee-for-service option that is similar to the current standard CHAMPUS program.
- Health care resources are being allocated to military facilities using a capitation-based methodology with financial incentives for effective health care management.
- Contracts are being established with civilian health companies to complement each region's military health facilities' capabilities. These contracts are to be implemented nationwide by September 30, 1996.

DOD officials believe that TRICARE is compatible with the President's national health care proposal. DOD plans, moreover, to proceed with implementation of TRICARE as national health care reform is being debated and developed.

²Civilian Health and Medical Program of the Uniformed Services--a DOD program to finance private sector care for dependents of active duty members; and retirees, survivors, and their dependents.

DOD HAS MADE PROGRESS
IN IMPLEMENTING TRICARE

We testified previously that the Department's implementation of managed care holds promise for gaining additional control of its health care costs and improving beneficiary access to high-quality medical care. This is, at least in part, because of its unique role as both a provider and a financier of care for its beneficiary population--a role that puts it in a position to truly manage that population's care.

As a result of its many demonstration programs, DOD has made substantial progress in implementing its managed care plans. For example, it has adopted a budgeting system that allocates resources on the basis of the demographics of its beneficiary population, replacing a system of allocating resources on the basis of the workload that a military hospital can generate. This new system decreases hospital officials' incentives to admit patients inappropriately and retain them longer than medically necessary to justify additional resources. DOD has also strengthened its quality assurance and utilization management programs to provide more consistency in the quality of care provided in military and civilian facilities and to help reduce unnecessary care. These tools should help hospital officials better manage their operations.

DOD's demonstration programs have also provided very valuable lessons, both about the effects of changes in the health benefits and cost sharing structure on beneficiary behavior and about how to implement such an ambitious undertaking. These matters are discussed below.

POTENTIAL COST EFFECTIVENESS
OF TRICARE

We believe the military health services system is at a crossroads. As you have just heard from Department officials, while debate continues over precise numbers, it is becoming increasingly clear that the capacity of today's military medical system exceeds both current and future expected wartime requirements. Therefore, whether or to what extent such excess capacity should be maintained is a key question facing congressional and administration policymakers. The answer may lie largely in the extent to which DOD's direct care system can be operated more cost effectively than nonmilitary alternative sources of care such as CHAMPUS.

Analyses that the Congressional Budget Office (CBO), DOD, and we have conducted to date show that it is uncertain whether TRICARE will be a more cost-effective delivery method when compared to the combination of the direct care system and the CHAMPUS program or to

the CHAMPUS Reform Initiative that the Department conducted between 1988 and 1993 in California and Hawaii.

As presently established, TRICARE's benefits package (the health care services covered) is uniform for all beneficiaries--an objective that the Department has sought to achieve for some time. On the beneficiary cost-sharing side, TRICARE's HMO option imposes, for the various categories of nonactive-duty beneficiaries,³ small enrollment fees and generally modest point-of-service cost-sharing requirements for care received from civilian providers. However, only nominal cost sharing is required for inpatient care, and no cost sharing is required for outpatient care that these beneficiaries receive from military facilities.⁴

The lack of such a medical care cost-sharing requirement--particularly for outpatient care--may be the key factor in determining whether TRICARE will be cost effective. This is because, as the research of RAND and others has shown, beneficiaries' use of health care services increases as their contributions to the cost of that care decrease. We have testified before, and continue to believe, that DOD should impose some cost sharing in military facilities for dependents and that the Congress should consider authorizing DOD to impose a medical care cost-sharing requirement on retirees for care received in those facilities. These steps would

³Dependents of active-duty members; and retirees, survivors, and their dependents.

⁴DOD charges certain beneficiaries nominal fees while they are being treated as inpatients in military facilities. For fiscal year 1994, all dependents pay a daily fee of \$9.30, active-duty members and former officers pay \$4.75, and retired enlisted members pay nothing.

DOD is required to prescribe "fair charges" for inpatient care provided to dependents in military facilities. It has not exercised its authority to charge dependents for outpatient care in military facilities.

DOD does not have the authority to impose fees in excess of the nominal inpatient subsistence charges for active-duty members or former officers or any inpatient fees for retired enlisted members. Also, DOD does not have the authority to charge outpatient fees for any of these people.

- permit the creation of a uniform and equitable⁵ set of cost-sharing requirements for each category of beneficiary regardless of whether care is received from military or civilian providers;
- help the Department to control utilization of services that it now provides directly to beneficiaries, helping to contain costs in the major portion of its medical care budget; and
- perhaps most importantly, allow care managers to refer beneficiaries to appropriate providers (whether military or civilian), without regard to the financial implications of the managers' referral decisions for beneficiaries.

The issue of cost sharing is controversial with military beneficiary groups. Many military members, retirees, and their families believe that they were promised free health care for life and that requiring cost sharing of any kind for dependents and retirees represents the government's renegeing on that promise. This belief is especially held about care received in military facilities. By imposing medical care cost sharing in military facilities, DOD would have the opportunity to simultaneously reduce the cost-sharing requirements for care received in the civilian sector. Thus, it could even out the cost-sharing requirement so that beneficiaries could be referred to the care setting that makes the most sense from a medical standpoint.

In response to congressional directives that the Department develop a uniform benefits and cost-sharing package that more closely resembles a civilian HMO but does not increase costs to either DOD or beneficiaries, DOD is again analyzing several alternatives to the TRICARE cost-sharing arrangements. DOD's imposition of medical care cost sharing in military facilities for its nonactive-duty beneficiaries would, in our view, assist the Department greatly as it attempts to respond to these directives.

IMPLEMENTATION ISSUES NEED TO BE ADDRESSED

While DOD has made substantial progress in implementing the TRICARE program, several important implementation issues remain to be addressed. Some of these issues relate to the relationships that are to be established between and among military health officials and with TRICARE support contractors. Others relate to

⁵Our May 1993 testimony before the Subcommittee discussed in detail the cost sharing inequities that exist for like categories of beneficiaries. Defense Health Care: Lessons Learned From DOD's Managed Health Care Initiatives (GAO/T-HRD-93-21, May 10, 1993), p. 3.

DOD's procurements of contractor services to help support the TRICARE effort.

The full Committee is concerned about several of these issues as evidenced by the Chairman's request that we evaluate DOD's efforts to solicit, evaluate, and award its TRICARE support contract for California and Hawaii.⁶ The Committee asked us to identify any systemic flaws so that DOD can apply the lessons learned and fix the problems at the outset. While our work is still ongoing, so far it is substantiating many of the Committee's areas of concern.

Authority Given to Lead Agents

Our discussions with lead agents and service headquarters officials raised several concerns about whether lead agents will have sufficient authority to bring about changes needed to improve the efficiency of health care delivery in their respective regions. More specifically, these officials believe that lead agents need to have more control over (1) contractor activities and functions as well as decisions on what will be contracted out and (2) the use of CHAMPUS money. On the other hand, some prospective offerors are expressing concern that DOD is seeking too much control over things that, in their view, should be contractor decisions. At this time, it is unclear exactly what role and authority lead agents will have in contractor operations.

In our view, another potential problem exists with the regional lead agents having no command and control authority over military treatment facilities in their regions. At this time, lead agents have only a coordinating role. Authority to make decisions about direct care funds, facility maintenance, and personnel actions in the military treatment facilities is retained by the parent service, not the regional lead agent. As we have previously reported, interservice rivalries have historically hampered efforts to establish efficient health care delivery systems. Although communication among the services appears to have improved, the challenge to the lead agents will be to convince other services' hospital officials and headquarters commands to participate in initiatives designed to improve the efficiency of medical care delivery in the entire region. This will be especially true in

⁶In July 1993, DOD awarded a managed care contract for California and Hawaii. However, the contract award was protested by two unsuccessful offerors, and, on December 20, 1993, GAO sustained the protest on the basis that DOD did not follow the evaluation scheme for technical and cost proposals as stated in the solicitation. As a result, DOD is now recompeting the procurement, and again it is being protested.

those situations where a particular command or hospital would have to relinquish control of resources.

Proposal Evaluations

With regard to evaluating offeror proposals, questions have arisen on the extent to which DOD has the technical expertise to make such evaluations, whether its criteria and methodology are sufficient, and whether it requires offerors to provide the information necessary for it to judge their capabilities. Some offerors believe that DOD is deficient in each of these areas. The primary reason GAO sustained the protest on the California and Hawaii procurement was because DOD did not evaluate the proposals as it announced it would. DOD is now recompeting that procurement, and one company has filed a protest with GAO challenging DOD's evaluation methodology. The protest is currently under review in our office.

Contractor Start-up Time

Another concern expressed by some DOD and contractor officials is that the 6-month time period thus far allotted by DOD to contractors from the award of the contracts to the start of health care delivery may be too short. DOD's experience with the original CHAMPUS Reform Initiative and to some extent with the Aetna transition recently in California and Hawaii indicates a need for DOD to reconsider whether 6 months is long enough. A 6-month transition may be workable if an incumbent or former incumbent contractor is awarded a contract, but, for any contractors who never have provided CHAMPUS health care services, the tasks required during start-up, such as establishing provider networks and claims processing systems, are difficult and time consuming.

Implementation Timetable

Finally, the speed with which DOD has been trying to move on its procurements, brought on in part by a congressional mandate⁷ to implement managed care contracts across the country by September 30, 1996, has created a situation in which the procurement process appears to have gotten ahead of some necessary planning tasks. For example, DOD has three large and complex regional procurement efforts under way at this time.⁸ In none of the three had the lead agents completed their regional plans before the requests for offeror proposals were issued, even though those plans were to

⁷The Department of Defense Appropriation Act, 1994 (P.L. 103-139 § 8025).

⁸TRICARE procurement efforts are under way for (1) California and Hawaii, (2) Washington and Oregon, and (3) Arkansas, Oklahoma, and portions of Texas and Louisiana.

identify unique contract requirements for the region. As a result, DOD has had to issue amendments to the requests for proposals to incorporate information and specifications developed during this planning process. For example, requests for proposals have been changed to incorporate requirements for contractor-provided utilization management services to be performed in military facilities. The number of contract requirement and specification changes being made is also causing several offerors to express frustration with the process--very recently one offeror withdrew from DOD's procurement in Washington and Oregon.

While DOD has developed a schedule for meeting the mandated completion date for a nationwide managed health care system, it faces significant difficulties with its initial procurement efforts. Because it will likely take DOD some time to completely overcome these difficulties, our work to date suggests that the Congress may have to revise the time frames given the Department to fully implement TRICARE.

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

RELATED GAO PRODUCTS

Defense Health Care: Expansion of CHAMPUS Reform Initiative Into DOD's Region 6 (GAO/HEHS-94-100, Feb. 9, 1994).

Decision Regarding Protests Filed by Foundation Health Federal Services, Inc. and QualMed, Inc. (Redacted Version) (B-254397.4 et al., Dec. 20, 1993).

Defense Health Care: Expansion of the CHAMPUS Reform Initiative Into Washington and Oregon (GAO/HRD-93-149, Sept. 20, 1993).

DOD Health Care: Further Testing and Evaluation of Case-Managed Home Care Is Needed (GAO/HRD-93-59, May 21, 1993).

Defense Health Care: Lessons Learned From DOD's Managed Health Care Initiatives (GAO/T-HRD-93-21, May 10, 1993).

Defense Health Care: Additional Improvements Needed In CHAMPUS's Mental Health Program (GAO/HRD-93-34, May 6, 1993).

Defense Health Care: CHAMPUS Mental Health Demonstration Project in Virginia (GAO/HRD-93-53, Dec. 30, 1992).

Defense Health Care: Efforts to Manage Mental Health Care Benefits to CHAMPUS Beneficiaries (GAO/T-HRD-92-27, Apr. 28, 1992).

Defense Health Care: Obstacles in Implementing Coordinated Care (GAO/T-HRD-92-24, Apr. 7, 1992).

Defense Health Care: Implementing Coordinated Care--A Status Report (GAO/HRD-92-10, Oct. 3, 1991).

The Military Health Services System--Prospects for the Future (GAO/T-HRD-91-11, Mar. 14, 1991).

Defense Health Care: Potential for Savings by Treating CHAMPUS Patients in Military Hospitals (GAO/HRD-90-131, Sept. 7, 1990).

Potential Expansion of the CHAMPUS Reform Initiative (GAO/T-HRD-90-17, Mar. 15, 1990).

Implementation of the CHAMPUS Reform Initiative (GAO/T-HRD-89-25, June 5, 1989).

Defense Health Care: CHAMPUS Reform Initiative: Unresolved Issues (GAO/HRD-87-65BR, Mar. 4, 1987).

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