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DEFENSE HEALTH CARE

DOD's Managed Care Program Continues to Face Challenges

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Mr. Chairman and Members of the Subcommittee:

We appreciate the opportunity to be here today to discuss the Department of Defense's (DOD) implementation of its nationwide managed health care program called TRICARE. This hearing is timely because the military health care system is in a period of significant challenge and change. Efforts to reduce the overall size of the nation's military, federal budget reductions, and base closures and realignments have combined to heighten scrutiny of the size and make-up of DOD's health care system, how it operates, and whether its missions can be satisfactorily conducted in a more cost-effective way.

For several years now, we have reported on military health care issues such as DOD's efforts to implement managed care.[1] We testified last year that managed care offers DOD the potential for improving beneficiary access to care, maintaining high-quality care, and containing health care costs.[2] We believe this is still the case today.

During the past year, we visited five of DOD's regional managed care administrators and four hospitals within those regions, met with several prospective managed care contractors and reviewed private-sector managed care practices. On March 22, 1995, we issued a report that describes the progress that DOD has made in implementing TRICARE.[3] TRICARE incorporates features from several DOD managed care demonstration programs as well as from private-sector managed care models. The experiences of DOD's demonstration programs provided many valuable lessons and has enabled DOD to become one of the nation's leaders in the managed care arena.

The report also highlights the challenges now facing military health care and, in particular, TRICARE. It is these issues that I would like to focus on today, which are summarized as follows:

-- Regional TRICARE officials continue to be concerned that the administrative structure established for TRICARE does not provide them with sufficient authority and control over funds and personnel because these resources remain under the control of the Services.

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[1]A list of GAO testimonies and reports on these issues appears in appendix I.

[2]Defense Health Care: Challenges Facing DOD in Implementing Nationwide Managed Care (GAO/T-HEHS-94-145, Apr. 19, 1994).

[3]Defense Health Care: Issues and Challenges Confronting Military Medicine (GAO/HEHS-95-104, Mar. 22, 1995).

-- DOD has had many problems in obtaining civilian health care services because of a cumbersome and contentious procurement process.

-- Officials in military hospitals are also concerned that important managed care information systems, such as those needed to support patient scheduling and referrals, may not be available by the time TRICARE is implemented in their regions.

-- TRICARE may not fully address beneficiaries' concerns about equitable access to care and cost-sharing because lower cost health care options will not be available in all areas, enrollment in the lowest cost-sharing option may be limited, and outpatient care from civilian providers requires cost sharing, but care received from military providers does not.

In addition to the above operational issues, questions remain about TRICARE's potential cost-effectiveness. Past studies of military health care do not provide sufficiently relevant and precise analyses to predict the cost-effectiveness of TRICARE.

BACKGROUND

DOD's health care system is one of the nation's largest, 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[4] and to be prepared to deliver health care during times of war. DOD also offers health care services to 6.6 million nonactive-duty beneficiaries through a system of 127 hospitals and about 500 clinics worldwide. DOD also operates a fee-for-service, insurance-like program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which pays for a portion of the care military families and retirees under the age of 65 receive from private-sector health care providers.[5] 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.

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[4]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.

[5]At age 65, beneficiaries are no longer eligible for CHAMPUS because they become eligible for Medicare.

TRICARE was developed in 1993, the outgrowth of several DOD demonstration programs in the late 1980s and early 1990s designed to test managed health care principles. TRICARE is significantly changing the military health care system. It gives beneficiaries opportunities to reduce their health care costs by offering alternatives to the current CHAMPUS program, including a health maintenance organization (HMO) option (called TRICARE Prime) and a network of preferred health care providers (called TRICARE Extra).

To implement and administer TRICARE, DOD has reorganized its medical delivery system into 12 joint-Service regions. A new administrative organization has also been created in each region, with a medical center commander designated as the regional administrator, called lead agent, to monitor and coordinate the delivery of health care. (Table 1 presents information on the 12 TRICARE regions, including the designated lead agents, the states included in the 12 regions and the dates that TRICARE will be implemented in each region).

Table 1: Information on the 12 TRICARE Regions

Region	Lead agent	States in region	Implementation date
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	May 1997
2	Portsmouth Naval Hospital	North Carolina, Southern Virginia	May 1997
3	Eisenhower Army Medical Center	Georgia, South Carolina, parts of Florida	May 1996
4	Keesler Air Force Medical Center	Alabama, Tennessee, parts of Florida and Louisiana	May 1996
5	Wright-Patterson Air Force Medical Center	Illinois, Indiana, Kentucky, Michigan, Ohio, West Virginia, Wisconsin	May 1997
6	Wilford Hall Air Force Medical Center	Arkansas, Oklahoma, parts of Louisiana and Texas	November 1995
7	William Beaumont Army Medical Center	Arizona, Nevada, New Mexico, parts of Texas	November 1996
8	Fitzsimons Army Medical Center[a]	Colorado, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming, parts of Idaho	November 1996
9	San Diego Naval Hospital	Southern California	October 1995
10	David Grant Air Force Medical Center	Northern California	October 1995
11	Madigan Army Medical Center	Oregon, Washington, parts of Idaho	March 1995
12	Tripler Army Medical Center	Hawaii	October 1995

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

TRICARE incorporates cost control features of private-sector managed care programs, such as primary care managers, capitation budgeting, and utilization management. One significant feature maintained from the demonstration programs is the use of contracted civilian health care providers to supplement care provided in military medical facilities. DOD estimates that these contracts will cost about $17 billion over the 5-year contract period. DOD's goal is to have all contracts awarded and the TRICARE program implemented by May 1997.

As DOD implements its TRICARE program, several operational issues have emerged that must be addressed if the program is to achieve its goals of containing costs, improving beneficiary access to care, and maintaining high-quality care. I would now like to discuss several of these issues.

LEAD AGENT AUTHORITY AND CONTROL ISSUES

The reorganization of medical facilities into joint-Service regions and establishment of the lead agent structure is a significant change to the administrative structure of the military health care system. Officials from the lead agent offices and medical facilities have expressed concern about the new structure, however, suggesting that their limited control and authority over health care resources and civilian contractors might negatively impact their ability to effectively manage service delivery in the regions.

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 contractor-provided care. For example, the Air Force lead agent in one region will oversee and manage health care delivery by 19 Army, Navy, and Air Force military treatment facilities and the civilian contractor. However, the individual military Services retain command and control over their medical facilities and personnel, with each facility accountable to its parent Service. Additionally, lead agents do not control the funds that flow from the Services to their respective facilities or CHAMPUS funds, which DOD controls. Officials in lead agent offices and medical facilities, particularly those with experience in managed care demonstration programs, also told us that lead agents and medical facility commanders need more control over what is to be contracted out and over contractor activities and functions.

DOD recognizes that TRICARE's success relies to a great extent on inter-Service cooperation and lead agents' administrative skills. It believes it has developed the necessary guidelines for the regional structure to work well. Hospital commanders, lead agents, and Service officials stated that they are committed to making TRICARE and its regional

structure work and are satisfied with the amount of inter-Service cooperation in the regions thus far.

While TRICARE provides a framework to foster teamwork and regional health care delivery, it remains to be seen whether lead agents will be able to overcome the effects of inter-Service rivalries that have historically hampered efforts to promote joint-Service cooperation in health care delivery. Moreover, many of the most difficult decisions must still be made in the regions, including those on closing or consolidating medical services in specific facilities.

HEALTH CARE CONTRACTING ISSUES

So far, DOD's experience with contracting for private-sector health care services is proving to be cumbersome, complex, and costly, resulting in protests, schedule delays, and an overall lengthy procurement process. For example, the one contract awarded to date for the region encompassing Washington and Oregon took almost 2 years to award--more than twice as long as DOD had originally planned.

Prospective contractors are frustrated with the process, telling us that the level of detail in DOD's requests for proposals and the number of changes to the requests contribute to contract delays and increase their costs of preparing responsive proposals. For example, prospective contractors estimate that it costs them between $1 and $2 million to prepare a proposal. Also, several protests have been filed with our Office. One of the protests was sustained, resulting in a contract award being found improper and the procurement being re-competed. DOD has changed several of its procurement procedures to address the protested issues. The other protests, filed after the changes were made, were denied.

DOD officials recognize that prospective contractors are frustrated with the process but consider the detailed procurement specifications, contracting process, and associated costs to be reasonable because of the size of the contracts and the need to establish a uniform program nationwide. DOD officials also think that the problems stemming from changing the request for proposals will diminish as they continue to gain experience with TRICARE contracts.

At the request of this Committee, we are examining DOD's procurement process to determine whether additional changes are needed and plan to report on these matters in June 1995.

MANAGEMENT INFORMATION SYSTEMS ISSUES

The lack of adequate and timely information on health care has, over the years, impeded several DOD initiatives to provide

health care more cost effectively. Military hospital commanders told us that inadequate information systems continue to hamper their effectiveness in performing their job and implementing change. These concerns about DOD health care management information systems become even more critical with the implementation of TRICARE.

DOD is developing a state-of-the-art integrated, automated medical information system called the Composite Health Care System (CHCS). This system comprises various modules that support a wide range of hospital functions, such as pharmacy, laboratory, patient administration, medical test results, and physician orders. A managed care program module has been designed specifically to support TRICARE. This module is designed to track the enrollment of beneficiaries in the Prime option, patient appointment bookings, and patient referrals--functions that are needed at the outset of TRICARE implementation. DOD is installing the module (into CHCS) in military medical facilities nationwide. Given CHCS' long development history and deployment schedule delays, however, lead agents and medical facility officials are concerned that the managed care module will not be available in their regions when needed to begin TRICARE.

COST-SHARING AND ACCESS INEQUITY ISSUES

We have previously reported on the need for uniform benefits and cost sharing for each category of beneficiary, regardless of where they live or receive their care.[6] As you know, in 1994 the Congress required DOD to develop, to the extent practical, health benefit options, including a uniform health benefit modeled after private-sector HMOs.[7] We believe DOD has progressed significantly on this issue. TRICARE offers beneficiaries three health benefit options, and, in December 1994, DOD announced a health benefit and fee structure for beneficiaries who 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 remain. For example, in some areas of the country, beneficiaries

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[6]Defense Health Care: Challenges Facing DOD in Implementing Nationwide Managed Care (GAO/T-HEHS-94-145, Apr. 19, 1994).

[7]Section 731 of the National Defense Authorization Act for fiscal year 1994 (P.L. 103-160) also requires that the DOD costs be no greater than the costs that would otherwise be incurred to provide health care to the covered beneficiaries who enroll in the HMO option. Section 8025 of the Department of Defense Appropriations Act, 1994, (P.L. 103-139) requires DOD to establish a triple option health benefit.

may not have access to the TRICARE Prime and Extra options because sufficient medical resources may not exist to establish networks of physicians and hospitals needed for the Prime and Extra option. In those areas, beneficiaries may have access only to the TRICARE Standard option.

Secondly, in some places even where the TRICARE Prime option is established, DOD expects that availability will be limited and not all eligible beneficiaries will be permitted to enroll. DOD has established priorities for enrollment, which give family members of active-duty personnel priority over retirees, their dependents, and survivors. This has raised concerns about the extent to which retirees and others will be excluded from this option, which provides beneficiaries with the greatest cost advantage.

DOD's fee structure has reduced the disparity in beneficiary cost sharing for inpatient care but not for outpatient care. For inpatient care, primary care managers can now refer beneficiaries to appropriate providers (whether military or civilian), without regard to the effect on beneficiaries' cost shares.

For outpatient care, however, Prime enrollees using civilian providers must pay a greater cost share than enrollees assigned or referred to military physicians. Beneficiaries can receive outpatient care at a military facility at no cost but must pay a copayment ranging from $6 to $12 for outpatient care received from private-sector providers. Not all beneficiaries enrolled in Prime will receive their care in military facilities because there are not enough military providers to serve all enrollees. Rather, some beneficiaries will be assigned to a civilian primary care physician or referred to civilian specialists.

This cost-sharing inequity will likely affect retirees and their dependents more than other beneficiaries because families of active-duty dependents, even those not enrolled in Prime, have priority over enrolled retirees for receiving care from military providers. DOD is considering establishing fees for outpatient care provided by military medical facilities, and we have also recommended that such fees be established. Establishing fees for outpatient care would not only eliminate the inequity but could also help control the demand for health care and free up capacity within the military facilities.

Beneficiaries believe that TRICARE is flawed when addressing the needs of retirees age 65 and older. In response to these concerns, DOD and beneficiaries have proposed that the Health Care Financing Administration reimburse DOD for the care it provides beneficiaries who are also eligible for Medicare. Advocates of this proposal state that if DOD received such revenue, it would be able to enroll beneficiaries age 65 and over in TRICARE Prime, for which they are not now eligible.

Beneficiaries also suggest that CHAMPUS eligibility should continue beyond age 65, with CHAMPUS providing supplemental coverage to Medicare. They contend that DOD is virtually the only large employer that does not pay for part or all of their retired employees' medical expenses not covered by Medicare. In addition, they suggest that all beneficiaries should be permitted to choose from among TRICARE and the options offered in the Federal Employees Health Benefits Program.

The cost and budget implications of these proposals are obviously very important. We have not analyzed these implications but understand that the Commission on the Roles and Missions of the Armed Forces is currently studying and will report on the cost and feasibility of some of these proposals.[8] Additionally, the Congressional Budget Office is presenting information on some of these matters today.

DOD officials believe that legislative restrictions on TRICARE limit the benefit and cost-sharing design options available to them. Because TRICARE must be cost neutral and CHAMPUS eligibility is limited to those under age 65, DOD believes that several of the proposed alternatives are not feasible without legislative action.

WILL TRICARE BE COST-EFFECTIVE?

DOD has estimated that TRICARE, even with its improved benefits, will be no more expensive than the current military health care system. As we stated earlier, TRICARE contains several features, such as utilization management and primary care managers, that if implemented properly, should contain costs. While many studies have been conducted of the military health care system and, in particular, the cost-effectiveness of DOD's managed care demonstration programs, none provides a sufficient basis to predict whether TRICARE will indeed be cost-effective. The usefulness of these studies has been limited because of inadequate data and because the studied programs differ significantly from TRICARE.

The most recent example is DOD's "733 study," so named because it was mandated by Section 733 of the National Defense Authorization Act of Fiscal Years 1992 and 1993. The 733 study was intended (in part) to assess the cost-effectiveness of maintaining a military health care system larger than that

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[8]This Commission, established by the National Defense Authorization Act of 1994, is charged with providing an independent review and report on improving the effectiveness and efficiency of the Armed Forces.

required for wartime in order to serve peacetime needs.[9] The study concluded that, on a case-by-case basis, care in military facilities was less expensive than CHAMPUS-provided care. The study cautioned, however, that this cost advantage was more than offset by a resulting increase in the demand for care brought about by expanding the availability of virtually free care in military facilities. This suggests that an improved health care benefit option, such as that offered in TRICARE Prime, may attract more people than the system can accommodate without increasing total costs. The study's conclusion is useful because it demonstrates the importance of controlling utilization of health benefits and thus costs. However, the study was based largely on data from DOD's CHAMPUS Reform Initiative demonstration project, which was so different from TRICARE that the specific cost and demand projections have little direct applicability to the new program.

Additionally, study analysts had to adjust and augment DOD's data in many ways to make it more compatible with CHAMPUS data and therefore usable for the 733 analyses. However, the number and magnitude of these adjustments underlie our concerns about the completeness and accuracy of the study. Therefore, while we find the study results to be plausible, we believe data-related problems also limit the utility of the study as a predictor of the potential cost-effectiveness of TRICARE.

As it moves forward with TRICARE's implementation, DOD has recognized the need for a periodic evaluation of the program's cost-effectiveness. To date, however, DOD has not developed a plan for such an evaluation. Evaluation plans and performance measures are needed to provide timely information on TRICARE's cost-effectiveness and thus DOD's compliance with legislative requirements that it be cost neutral. Furthermore, to ensure the usefulness and accuracy of future evaluations, DOD also needs to alleviate the data problems highlighted by past studies.

CONCLUSION

In summary, Mr. Chairman, DOD is dealing with difficult and costly health care problems. The Department's ability to successfully address the operational challenges to TRICARE's implementation and to use TRICARE to adequately augment a downsized medical care system are key to its future utility. Ultimately, TRICARE's success depends on DOD's ability to fairly

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[9]The wartime portion of the 733 study concluded that DOD needed about one-half of the current level of medical personnel to meet wartime requirements. Our analysis of the wartime conclusions will be presented to this Subcommittee at a hearing on March 30, 1995.

accommodate affected beneficiaries, while achieving its goal of containing military health care costs.

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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.

For more information on this testimony, please call Stephen P. Backhus, Assistant Director, at (202)512-7111. Other major contributors include Elkins Cox, Sylvia Diaz, Allan Richardson, Catherine Shields, Scott Smith, and Nancy Toolan.

RELATED GAO PRODUCTS

Defense Health Care: Issues and Challenges Confronting Military Medicine (GAO/HEHS-95-104, Mar. 22, 1995).

Decision Regarding Protest Filed by QualMed, Inc. (Redacted Version, B-257184.2, Jan. 7, 1995).

VA/DOD Health Care: More Guidance Needed to Implement CHAMPUS-Funded Sharing Agreements (GAO/HEHS-95-15, Oct. 28, 1994).

Medical ADP Systems: Defense's Tools and Methodology for Managing CHCS Performance Need Strengthening (GAO/AIMD-94-61, July 15, 1994).

Defense Health Care: Challenges Facing DOD in Implementing Nationwide Managed Care (GAO/T-HEHS-94-145, Apr. 19, 1994).

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

Psychiatric Fraud and Abuse: Increased Scrutiny of Hospital Stays Is Needed for Federal Health Programs (GAO/HRD-93-92, Sept. 17, 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).

Composite Health Care System: Outpatient Capability Is Nearly Ready for Worldwide Deployment (GAO/IMTEC-93-11, Dec. 15, 1992).

Medical ADP Systems: Composite Health Care System Is Not ready To Be Deployed (GAO/IMTEC-92-54, May 20, 1992).

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

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