United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Military Personnel, Committee on National Security, House of Representatives

For Release on Delivery
Expected at 2:00 p.m.
Thursday, March 7, 1996

DEFENSE HEALTH CARE

TRICARE Progressing, but Some Cost and Performance Issues Remain

Statement of Stephen P. Backhus, Associate Director,
Health Care Delivery and Quality Issues
Health, Education, and Human Services Division

G A O
75 years
1921 - 1996

GAO/T-HEHS-96-100

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to discuss the Department of Defense's (DOD) implementation of its nationwide managed health care program—TRICARE. The changes embodied in the TRICARE program represent a sweeping reform of the $15 billion per year military health care system.

Among TRICARE's goals are to improve access to care and ensure high-quality, consistent health care benefits for the 1.7 million active-duty Service personnel[1] and some 6.6 million nonactive-duty beneficiaries. It also seeks to preserve choice for nonactive-duty beneficiaries by giving them the option of enrolling in TRICARE Prime, which is like a health maintenance organization; using a preferred provider organization called TRICARE Extra; or using civilian health care providers under a fee-for-service arrangement like the current CHAMPUS program.[2] Another system goal is to contain DOD's health care costs.

We have reported several times over the past 9 years on DOD's efforts to reform the military health care system and on the evolving development of TRICARE.[3] Now that TRICARE is well into implementation in some areas of the country and beginning to be implemented in others, we appreciate this chance to discuss what is occurring as the program moves from the drawing board toward becoming a real part of the lives of the people served by military health care.

You asked that we talk about DOD's experience in enrolling people and delivering health care to them under the program. In this regard, we would like to focus on four issues:

- First, whether DOD's experiences with initial implementation of TRICARE have produced the outcomes DOD expected;
- second, how early outcomes may affect costs;
- third, whether DOD has defined and is capturing the information needed to manage and assess TRICARE's performance; and
- fourth, concerns about the health care needs of retirees.

[1]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.

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

[3]See app. I for a listing of related GAO products.

My comments today are based on an extensive body of work we have completed and have under way covering various aspects of TRICARE.

In summary, our TRICARE work to date has shown that despite initial beneficiary confusion caused by education and marketing problems, early implementation of the program is progressing consistent with congressional and DOD goals. Steps may be necessary now, however, such as gathering certain cost and access-to-care data to help improve DOD's and the Congress' ability to assess the program's success in the future. In addition, retirees, who represent about one-half of the population eligible for military health care, remain concerned about the implications of TRICARE on their access to medical services.

TRICARE's Origins and Development

Before DOD's transition to managed care, the military health services system consisted of military hospitals and clinics supplemented by a fee-for-service insurance program known as CHAMPUS. This system lacked sufficient incentives and tools to control expenditures and provide beneficiaries accessible care on an equitable basis. DOD's frequently large CHAMPUS cost overruns and other system shortcomings prompted the Congress to authorize demonstrations of alternative health care delivery approaches. DOD's experience with these initiatives culminated in its decision to implement TRICARE for military beneficiaries.

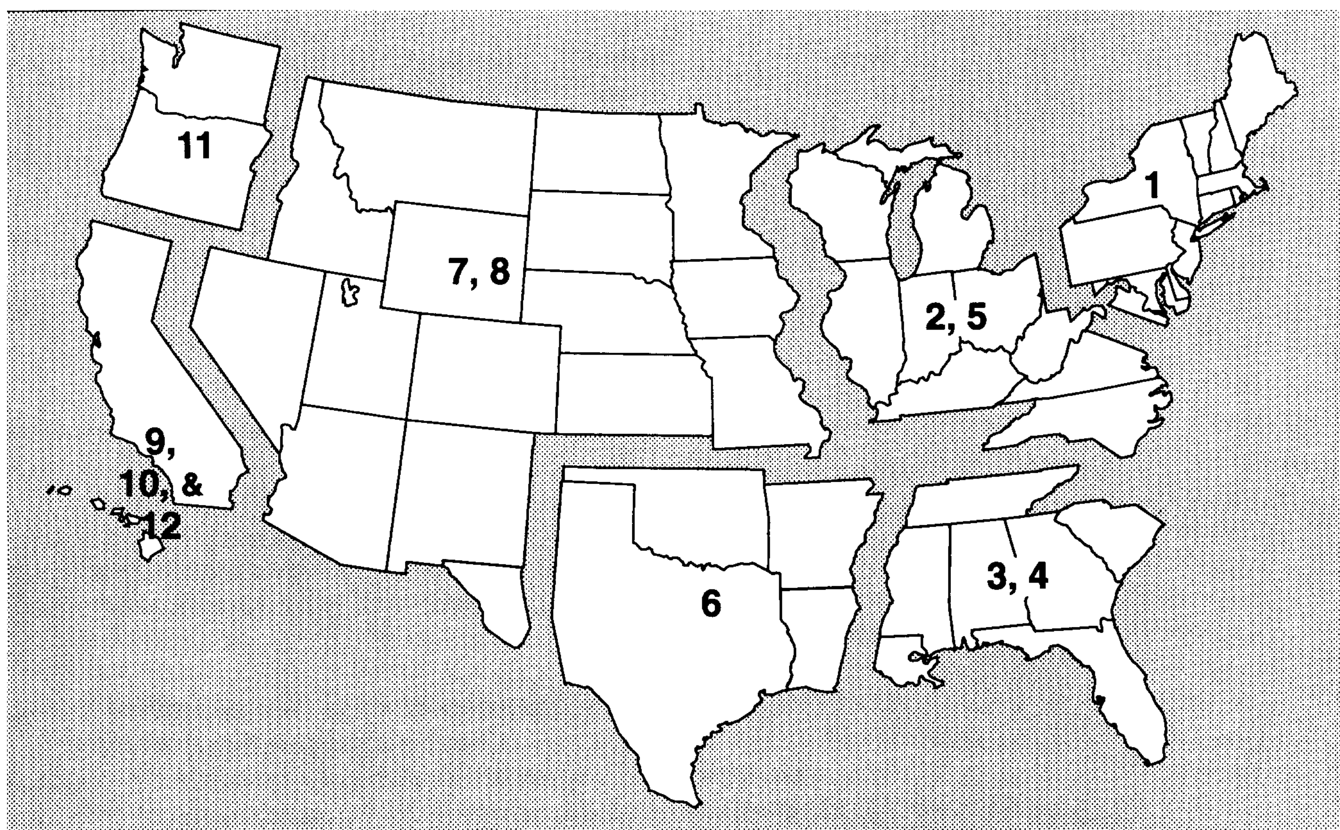
TRICARE's implementation is occurring in a rapidly changing military environment. Post-cold war contingency planning scenarios, efforts to reduce the overall size of the nation's military forces, federal budget reduction initiatives, and base closures and realignments have heightened scrutiny of the size and makeup of DOD's health care system, how it operates, whom it serves, and whether its missions can be satisfactorily carried out in a more cost-effective way.

TRICARE incorporates cost-control features of private sector managed care programs, such as primary care managers, capitation budgeting, and utilization management.[4] One significant feature retained from the earlier demonstration programs is the use of contracted civilian health care providers to supplement care provided in military hospitals. DOD estimates that these contracts will cost about $17 billion over the 5-year contract period. In all, DOD is awarding seven 5-year contracts covering its 12 health

[4]Utilization management involves the use of such techniques as preadmission hospital certification, concurrent and retrospective reviews, and case management to determine the appropriateness, timeliness, and medical necessity of an individual's care.

care regions, as shown in figure 1. Thus far, DOD has awarded four of the seven contracts. DOD's goal is to have all contracts awarded and the TRICARE program fully operational by August 1997.

Figure 1: DOD Regions Served by the Seven Managed Care Support Contracts



Note: Managed care support for Alaska will be addressed separately from these regions.

Last year, after reviewing early TRICARE procurement problems, we reported that while DOD had taken steps to improve future contract awards, several areas of concern remained.[5] Among our

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

recommendations—which DOD agreed to adopt—were that DOD consider the potential effects on competition of such large TRICARE contracts and weigh alternative award approaches to help ensure competition during the next procurement round. We also urged, and DOD agreed, that DOD try to simplify the next round's solicitation requirements and seek to incorporate best-practice, managed care techniques in the contracts. We plan to follow up on these issues and to begin a study of how well DOD's contractors are performing under the current contracts.

TRICARE Implementation Is Proceeding Despite Setbacks

Despite procurement and other unanticipated obstacles, DOD's early implementation of TRICARE appears to be moving forward toward meeting congressional and DOD expectations for the program. After some initial problems, DOD is enrolling large numbers of beneficiaries into TRICARE Prime. It has also succeeded in encouraging Prime enrollees to select military health care providers—the source of care that DOD believes is more cost effective than civilian-provided care. DOD is also addressing implementation problems that early on have caused confusion for beneficiaries and difficulties for military health care managers.

As of January 31—after fewer than 12 months of operation in one region and fewer than 4 months in four others—over 400,000 people have enrolled in TRICARE Prime.[6] As DOD intended through its marketing efforts, many active-duty dependents have chosen to enroll in TRICARE Prime.[7] For example, in the Northwest Region, about two-thirds of active-duty dependents have chosen this option. Also, in those regions under way, the bulk of those beneficiaries choosing Prime have enrolled with military, as opposed to civilian, health care providers.

DOD has encountered a number of unanticipated obstacles as it implements TRICARE. For example, in the Northwest Region, the first region to begin enrollment, DOD saw much higher, much faster rates of Prime enrollment than expected—58,000 people enrolled in just 4 months, compared with the 28,000 that were expected in the first year. This created a significant amount of confusion among beneficiaries because the contractor had to hire temporary employees who were not adequately trained and were not able to sufficiently address beneficiaries' questions. However, the Southwest Region's managers and contractor learned from the Northwest's experience and avoided these problems by anticipating an

[6]400,000 enrollees does not count active-duty military personnel, who are automatically enrolled in TRICARE Prime.

[7]Active-duty dependents tend to have a high level of reliance on the DOD health system.

early surge in enrollment and making sure sufficient numbers of adequately trained staff were ready to handle it.

DOD also has learned that marketing and beneficiary education efforts must be a continuously coordinated process. Even in the Southwest Region, where marketing and education efforts have, for the most part, gone smoothly, beneficiaries continue to express confusion about such program details as cost sharing and how to make appointments. As a result, DOD has reemphasized marketing and education as an ongoing priority, as well as the need to further focus education programs on its own health care providers—staff who have daily face-to-face contact with beneficiaries.

Cost Issues Have Emerged During Early Implementation

As DOD implements TRICARE, it faces uncertainties regarding the program's potential costs. The intent of the Congress is that TRICARE must not increase DOD's health care costs. However, factors we see in TRICARE's early implementation, both within and outside DOD's and its managed care support contractors' control, may stand in the way of achieving this goal.

DOD's ability to control its health care costs depends to a large degree on the extent to which beneficiaries who currently do not use military health care enter the system for care, generating higher costs. If large numbers of people stop using other sources of care and begin to use military care, the overall cost of the system will increase. It will be important for DOD to know the extent to which this phenomenon has occurred as it analyzes the cost-effectiveness of the TRICARE reforms. DOD does not now appear to be taking the steps needed to gather the demographic and other data to do this. We are continuing to explore this question with DOD as part of our ongoing work.

Also, TRICARE depends on managed care cost-reduction techniques to achieve maximum efficiency of its military facilities and control rising health care costs. Strategies such as sharing resources with the support contractor and managing beneficiaries' utilization of health care services are key to TRICARE's success. However, implementation continues to be a problem, and the actual effect of these measures on overall TRICARE costs remains to be seen. Early indications are that confusion exists among military health care managers and DOD's contractors about resource sharing under TRICARE.[8] The details of how agreements should be

[8]Resource sharing allows the contractor, through agreements with DOD, to provide personnel, equipment, or supplies to a military facility to improve its capability to provide care.

developed appear to be not well understood. Similarly, DOD and its contractors have not fully incorporated utilization management at the hospital level, despite intentions to do so at the start of health care delivery under TRICARE. DOD officials told us that they plan to provide additional training for resource sharing and to work with the contractors to improve utilization management.

Unresolved Performance Data Issues

Because of TRICARE's newness, size, and complexity, appropriate and effective information management has become increasingly important. We see some gaps in DOD's efforts to obtain and analyze the information it will need to evaluate whether TRICARE is meeting its goals of providing beneficiaries increased access to high-quality care while controlling system costs.

For example, in addition to the information DOD needs to analyze the program's potential costs, military health care managers are not currently measuring whether TRICARE is meeting DOD's standards for beneficiary access to primary care services—a long-standing area of beneficiary dissatisfaction. While DOD expects to have the capability to gather this information in the future, in the interim, without this information it will be difficult to determine whether DOD has accomplished a pivotal TRICARE goal of improving beneficiaries' ability to obtain the services they need.

Care for Military Retirees

Care for military retirees and their dependents and survivors is an important issue for both beneficiaries and DOD. Concerns about their access to military health care services, as well as Medicare-eligible beneficiaries' ineligibility for CHAMPUS, existed before TRICARE and would still exist regardless of whether TRICARE had been instituted. At issue is whether, and if so, how, DOD can help provide care for retirees without impeding access for other beneficiaries or greatly increasing costs.

Currently, military retirees, survivors, and their dependents make up over half of all those eligible for care and almost a third of those, about 1.2 million people, are age 65 and over. This Medicare-eligible population is expected to grow by 25 percent through the year 2002, while the number of the rest of the military population is expected to decline. DOD has traditionally treated many retired beneficiaries in military hospitals on a space-available basis. DOD officials contend that some care of this population is important for training and practice needed to maintain wartime readiness of their physicians because it adds to the physicians'

range of experiences. However, DOD's health care eligibility legislation and funding considerations in TRICARE constrain DOD's ability to include Medicare-eligible beneficiaries in the TRICARE program.

For some of these members of the military community, Medicare and space-available care in military hospitals are their only health care options. These beneficiaries are greatly concerned that TRICARE, combined with the effects of base closures and downsizing, will push them entirely out of the military health care system. This issue was raised repeatedly in focus groups assembled by DOD in the Northwest and Southwest Regions.

Several potential solutions have been offered by DOD, beneficiary groups, and the Congress, including (1) reimbursement to DOD by the Health Care Financing Administration for care provided to Medicare-eligible beneficiaries (known as Medicare subvention), (2) extending CHAMPUS coverage to beneficiaries aged 65 and over as a second payer to Medicare, and (3) offering coverage under the Federal Employees Health Benefits Program. The cost and effectiveness of these and other proposals remain uncertain but are obviously very important.

As discussed with your staff, in the coming months we will explore the pros and cons of proposed alternative solutions to address this issue.

Conclusion

TRICARE represents a major change in the way the military provides for the health care needs of its people. We would not expect an undertaking of this size to proceed without some problems, and DOD has done well in overcoming early difficulties. However, we believe that unless DOD takes steps now to track certain cost and performance information, it will be difficult to measure the overall success of the program. Also, an important unanswered question is how DOD can help provide care for retirees without impeding access for other beneficiaries or greatly increasing costs.

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. We look forward to continuing to work with this Subcommittee as it exercises its oversight responsibility for this important program.

Contributors

For more information on this testimony, please call Daniel M. Brier at (202) 512-6803. Other major contributors include Bonnie Anderson, Sylvia Jones, David Lewis, Allan Richardson, and Catherine Shields.

Related GAO Products

VA Health Care: Efforts to Increase Sharing With DOD and the Private Sector (GAO/T-HEHS-96-41, Oct. 18, 1995).

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

Defense Health Care: Problems With Medical Care Overseas Are Being Addressed (GAO/HEHS-95-156, July 12, 1995).

Defense Health Care: DOD's Managed Care Program Continues to Face Challenges (GAO/T-HEHS-95-117, Mar. 28, 1995).

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

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

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, and others, 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).

Ordering Information

The first copy of each GAO report and testimony is free. Additional copies are $2 each. Orders should be sent to the following address, accompanied by a check or money order made out to the Superintendent of Documents, when necessary. VISA and MasterCard credit cards are accepted, also. Orders for 100 or more copies to be mailed to a single address are discounted 25 percent.

Orders by mail:

U.S. General Accounting Office
P.O. Box 6015
Gaithersburg, MD 20884-6015

or visit:

Room 1100
700 4th St. NW (corner of 4th and G Sts. NW)
U.S. General Accounting Office
Washington, DC

Orders may also be placed by calling (202) 512-6000
or by using fax number (301) 258-4066, or TDD (301) 413-0006.

Each day, GAO issues a list of newly available reports and testimony. To receive facsimile copies of the daily list or any list from the past 30 days, please call (202) 512-6000 using a touchtone phone. A recorded menu will provide information on how to obtain these lists.

For information on how to access GAO reports on the INTERNET, send an e-mail message with "info" in the body to:

info@www.gao.gov

PRINTED ON RECYCLED PAPER

United States
General Accounting Office
Washington, D.C. 20548-0001

Official Business
Penalty for Private Use $300

Address Correction Requested

Bulk Rate
Postage & Fees Paid
GAO
Permit No. G100