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DEFENSE HEALTH CARE

Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE

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

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the status of the Department of Defense's (DOD) implementation of its managed care program called TRICARE. Following years of demonstration programs that tested alternative health care delivery mechanisms, DOD began completely restructuring its system into TRICARE in 1993. TRICARE represents a redesign of DOD's $15.5 billion health care system and is being implemented to improve beneficiaries' access to health care while maintaining quality and controlling costs in a time of military downsizing and budgetary concerns. Under TRICARE, health care for over 8.2 million eligible beneficiaries is coordinated and managed on a regional basis using military hospitals and clinics, supplemented by contracted civilian services.

My statement today will focus on (1) DOD's progress in implementing TRICARE; (2) whether DOD is adequately assessing TRICARE's effects on military health care access, quality, and cost; and (3) the implications of ongoing and proposed changes in the military health care system itself for TRICARE's future. The information presented is based on completed and ongoing GAO studies as well as discussions with DOD and contractor officials. (See Related GAO Products at the end of this statement for a list of products related to TRICARE and its predecessor programs.)

In summary, TRICARE was established in an era of military downsizing and rapidly escalating DOD health costs. It was envisioned as a way to maintain beneficiary access to high-quality care while containing costs. Designing and implementing TRICARE to achieve these objectives, however, has proven to be a complex and difficult undertaking involving many stakeholders, including the Congress, the individual services and their many facilities and contractors, and the more than 8 million beneficiaries of the military health care system. DOD has taken steps to improve the program as it has evolved, but much remains to be done before TRICARE becomes the smooth-running and beneficiary-friendly endeavor envisioned by its developers. Moreover, many questions concerning its cost-effectiveness and ability to meet beneficiary access and quality-of-care concerns are still to be answered.

In addition to operational difficulties, TRICARE is likely to continue to be implemented amid many changes that could profoundly affect not only the program but the entire military health care system. The result of the

continuing evolution of TRICARE and the collective effects of these individual changes on it remain to be seen.

Background

DOD's primary military medical mission is to maintain the health of 1.6 million active duty service personnel[1] and be prepared to deliver health care during wartime. Also, as an employer, DOD offers health care services to 6.6 million non-active duty beneficiaries, including active duty members' dependents and military retirees and their dependents. Most care is provided in 115 hospitals and 471 clinics—called military treatment facilities (MTF)—operated by the Army, Navy, and Air Force worldwide. This direct delivery system is supplemented by DOD-funded care provided in civilian facilities. In fiscal year 1997, DOD spent about $12 billion for direct care and about $3.5 billion for civilian care.

In response to such challenges as increasing health care costs and uneven beneficiary access to care, in the late 1980s DOD initiated a series of congressionally directed demonstration programs to evaluate alternatives to its existing health care delivery approaches. Drawing from its experience with the demonstration projects, DOD then designed TRICARE as its managed care health program. The Office of the Assistant Secretary of Defense for Health Affairs sets TRICARE policy and has overall responsibility for the program. The Army, Navy, and Air Force Surgeons General have authority over the MTFs in their respective services.

TRICARE is designed to give beneficiaries a choice of three benefit options. These are TRICARE Prime, the health maintenance organization (HMO) option; TRICARE Standard, a fee-for-service benefit replacing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program;[2] and TRICARE Extra, a preferred provider option.

TRICARE Prime, the option in which care is most actively managed, is designed to provide comprehensive medical care to beneficiaries through a network of military and contracted civilian providers. Beneficiaries who select TRICARE Prime must enroll annually to receive care under this option; once enrolled, they must go through an assigned military or civilian primary care manager for all care. Active duty members and their families

[1]This number includes members of the Coast Guard and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration, who are also eligible for military health care.

[2]CHAMPUS is a DOD program to finance private sector care for dependents of active duty members, retirees and their dependents, and survivors under age 65.

do not pay an enrollment fee; retirees under age 65 and their dependents and survivors pay an annual enrollment fee of $230 for an individual and $460 for a family.[3] Copayments under Prime are lower than under the other options. TRICARE Standard provides beneficiaries with the greatest freedom in selecting civilian physicians but requires the highest beneficiary cost share. Under TRICARE Extra, beneficiaries do not enroll or pay annual premiums but, by using physicians in the TRICARE network, are charged copayments that are 5 percent less than under TRICARE Standard.

TRICARE Implementation Falling Short of DOD's Expectations

In restructuring its health care program, DOD designed a program that has proven difficult to implement. More than 4 years after initiating TRICARE, DOD is now 1 year behind its schedule for fully implementing the nationwide program, and that schedule may slip further. As DOD implements TRICARE, it is also continuing to make significant changes to the program's design. While these changes are aimed at improving TRICARE and addressing problems we and others have identified, they also create new implementation challenges. Moreover, DOD's progress in implementing TRICARE has been hampered by enrollment shortfalls and administrative problems.

Recurring Contract Award Problems

As part of its implementation of TRICARE, DOD has awarded large, complex, competitively bid contracts to supplement and support the health care provided in MTFs. These 5-year contracts are estimated to cost a total of about $15 billion. DOD had planned to award a total of seven contracts for the 11 TRICARE regions nationwide by September 30, 1996, and health care delivery under TRICARE was expected to have begun in all regions by May 1997. (The appendix contains a map of the 11 TRICARE regions.)

DOD's efforts to award contracts have been hindered by some problems. All seven contract awards have been protested at substantial cost to both DOD and the offerors. Three of the bid protests have been sustained, as shown in table 1. The two most recently sustained protests occurred earlier this month. DOD and the contract awardees have asked for reconsideration of the decisions sustaining these protests. Resolving the reconsideration requests, and implementing the corrective action recommended in the

[3]When retirees become eligible for Medicare at age 65, they are no longer eligible for TRICARE. They may, however, still seek care on a space-available basis in MTFs.

sustained protests if the reconsideration requests are denied, could further delay implementation of TRICARE in three regions.

Table 1: TRICARE Contract Implementation Status

TRICARE contractor	Region covered	5-year contract award amount	Bid protest sustained	Expected implementation date	Actual implementation date
Foundation Health Federal Services	Northwest	$475 million	No	March 1995	March 1995
Foundation Health Federal Services	Southwest	1.8 billion	No	November 1995	November 1995
Foundation Health Federal Services	Southern California, Golden Gate, and Hawaii-Pacific	2.5 billion	Yes	October 1995	April 1996
Humana Military Healthcare Services	Southeast and Gulf South	3.8 billion	No	May 1996	July 1996
Triwest Healthcare Alliance	Central	2.3 billion	No	November 1996	April 1997
Sierra Military Health Services	Northeast	1.2 billion	Yes	May 1997	Scheduled for May 1998
Anthem Alliance for Health	Mid-Atlantic and Heartland	3.1 billion	Yes	May 1997	Scheduled for May 1998

In 1995, we reported that such problems as DOD's failure to evaluate offerors' bids according to solicitation criteria led to the sustained protest of a pre-TRICARE contract award covering California and Hawaii.[4] In response, DOD put in place such improvements as a revised methodology for evaluating bids, which it believed would reduce the chance of protests being sustained. The recent sustained protests indicate, however, that problems with bid evaluations continue.

We also concluded in 1995 that DOD's managed care procurement process is extremely costly, complex, and cumbersome for all affected. We noted, for example, that DOD's solicitation requirements are so prescriptive that offerors cannot fully propose innovative and cost-saving managed care techniques or best practices now available in the private sector. DOD acknowledged the need to simplify its procurement requirements to be less prescriptive and more focused on outcomes. In response to recommendations from DOD health care managers, current contractors,

[4]This contract was awarded in July 1993 to Aetna Government Health Plans under the CHAMPUS Reform Initiative (DOD's pre-TRICARE program). The award was subsequently protested, and the protest was sustained in December 1993. The contract was recompeted, although Aetna's contract was allowed to proceed until a new award was made to Foundation Health Federal Services. As shown in table 1, this award was also protested, and the protest was sustained.

industry experts, and us, DOD is developing a more simplified procurement approach, which it will begin to use this summer as the first of the existing TRICARE contracts is recompeted. This new approach is designed to incorporate performance-based requirements and best commercial practices.

Prime Enrollment—A Key Cost-Saving Feature—Is Below DOD's Targets

DOD expected that, to take full advantage of cost-effective managed care principles and practices, significant numbers of beneficiaries would enroll in TRICARE Prime—especially those who rely on the military system for their health care. However, as of October 1997, only about half of the eligible beneficiaries using the military health care system had enrolled in TRICARE Prime.

DOD set targets to help ensure high enrollment in Prime. It expected, for example, that 100 percent of active duty members would enroll in Prime by the end of 1996. However, as of October 1997, only about 70 percent of active duty members had enrolled.[5] Moreover, DOD expected that at least 90 percent of non-active duty beneficiaries targeted for enrollment[6] would enroll in Prime within 1 year of TRICARE's implementation in each region. However, as of October 1997, in those regions where TRICARE had been implemented for at least a year, only about 57 percent of those targeted, or about 1.1 million beneficiaries, had enrolled.[7]

This less-than-optimal enrollment has several important implications. For example, DOD is less able to manage the utilization of health care for beneficiaries not enrolled in Prime. Under managed care, costs are contained in part through the use of primary care managers who ensure that beneficiaries receive necessary and appropriate care in the most cost-effective manner. Moreover, beneficiaries may sustain higher out-of-pocket health care costs if they choose not to enroll.

[5]Although all active duty members are considered "automatically" enrolled in TRICARE Prime, the enrollment figures represent only those who have had their enrollment paperwork processed. While all active duty members are not yet administratively enrolled, they do receive health care—but not in a managed care environment.

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

[7]TRICARE contractors are measured against the number of people they estimated in their bid that they would enroll in TRICARE Prime during each of the contract option periods. Overall, enrollment has exceeded these estimates.

Also, DOD is beginning to implement a new funding system—enrollment-based capitation—that is designed to motivate and reward MTF commanders for maximizing their enrolled population. Under this approach, DOD will fund MTFs on the basis of the number of beneficiaries enrolled in Prime at the MTF. Previously, DOD had set per capita rates according to past levels of military spending. This new capitation method is designed to better mirror private sector managed care funding methods. Under enrollment-based capitation, MTFs will continue to receive funding for the care they provide to nonenrollees, but at a lower rate than for those enrolled.

We have identified a number of reasons why beneficiaries may not be enrolling in Prime. Beneficiaries who are accustomed to receiving care in MTFs may not see the need to enroll. Retirees under 65 years of age and their dependents, who must pay an annual enrollment fee, may opt not to enroll for that reason. In addition, Prime is not available in all areas of the country—for example, in areas where there is no MTF and no civilian provider network. Also, some beneficiaries may choose to continue receiving care under TRICARE's traditional fee-for-service option.

DOD asserts that it can provide care more cost-effectively in its MTFs than through civilian providers, and for that reason, TRICARE was designed to maximize the use of the MTFs before relying on civilian care. However, although enrollment capacity still exists in MTFs, beneficiaries are being allowed to enroll in civilian facilities that are near MTFs.[8]

As of late last year, about 74 percent of MTFs' primary care capacity had been assigned to Prime enrollees. Thus, it appears that DOD could more fully and cost-effectively use its facilities before enrolling beneficiaries in civilian-provided care.

Physicians Complain About Administrative Difficulties

An important component of TRICARE is to attract and retain civilian physicians to supplement the care provided in MTFs. In a report we are issuing today, we have identified administrative problems physicians have encountered under TRICARE, which, if not resolved, could affect DOD's ability to attract the number of physicians needed to ensure adequate

[8]MTFs estimate their capacity for Prime enrollment by the number of primary care managers in the MTF and the specified enrollee workload. About 1,200 enrollees are assigned to each primary care manager.

access to quality care.[9] Physicians raised concerns about untimely claims reimbursement, a slow preauthorization process to approve medical treatment, and unreliable customer telephone service, among other things. Some physicians also complained about the lower, "discounted" rates paid to TRICARE network physicians under its Prime and Extra options. Because of these administrative and cost issues, some physicians are becoming disillusioned with TRICARE.

DOD Not Adequately Assessing Progress in Achieving Program Goals

As we have noted, DOD's goals in establishing TRICARE were to improve access while maintaining quality and controlling costs. DOD efforts to set goals and to measure access and quality are incomplete, however, and do not enable DOD or others to fully assess whether TRICARE has improved beneficiaries' access to and quality of health care. Moreover, DOD's failure to achieve expected cost savings under TRICARE raises questions about DOD's cost-savings claims.

DOD Access and Quality Goals and Measures Are Incomplete

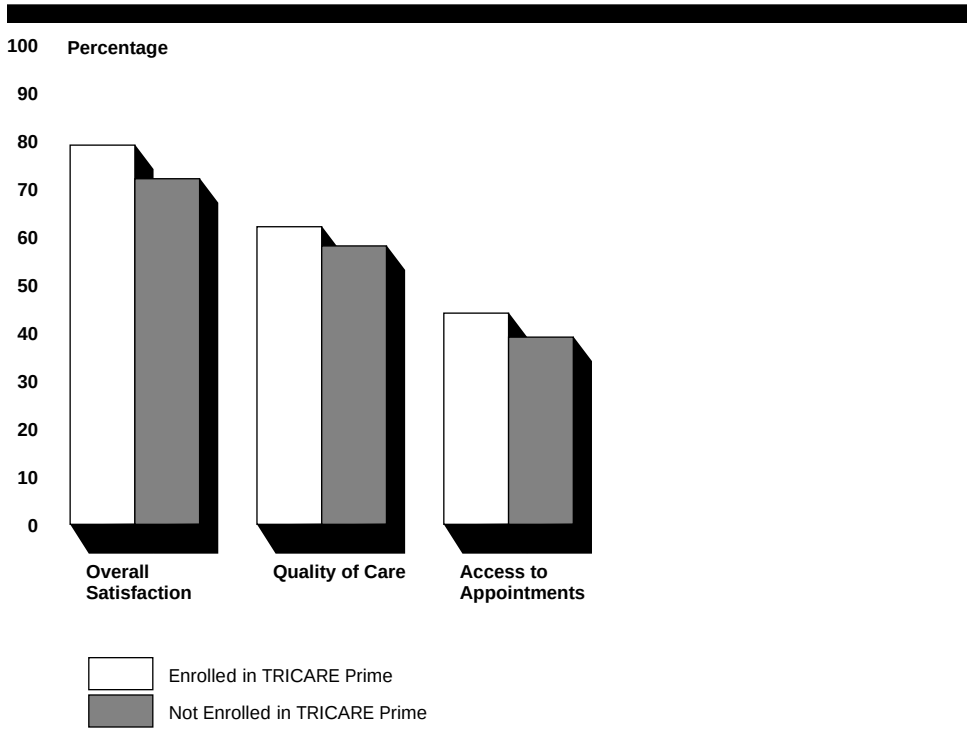
DOD has not set programwide goals and performance measures to track its progress in meeting TRICARE access and quality program goals for care provided in MTFs and by contractors. DOD has developed a military health system performance report card that includes goals and measures for some aspects of access and quality, such as 95-percent beneficiary satisfaction with access to appointments and system resources. However, this report card applies only to MTFs and does not include care provided through civilian contractors—an estimated one-third of DOD's peacetime health care delivery efforts. Under its managed care support contracts, DOD does set performance-related requirements, and contractors report to DOD their performance in meeting these requirements. However, this information is not yet compiled or consolidated with military facility data to provide a programwide picture.

Through its annual beneficiary survey, DOD does have some programwide data on beneficiaries' satisfaction with military health care. DOD has conducted this survey since 1994 to provide a comprehensive look at how beneficiaries view their health care. As shown in figure 1, the most recent survey results show that, despite their overall satisfaction with military health care, beneficiaries are somewhat less satisfied with quality and even less satisfied with access. DOD also conducts a monthly survey of beneficiary satisfaction with outpatient care in MTFs. As figure 2 shows, the

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

beneficiary satisfaction levels, on average, exceed those in civilian HMOs. However, DOD survey officials told us it is too soon to use the surveys' results to assess TRICARE because the program is new and not yet implemented nationwide. Also, they said the results from surveys conducted to date constitute an insufficient basis from which to identify trends.

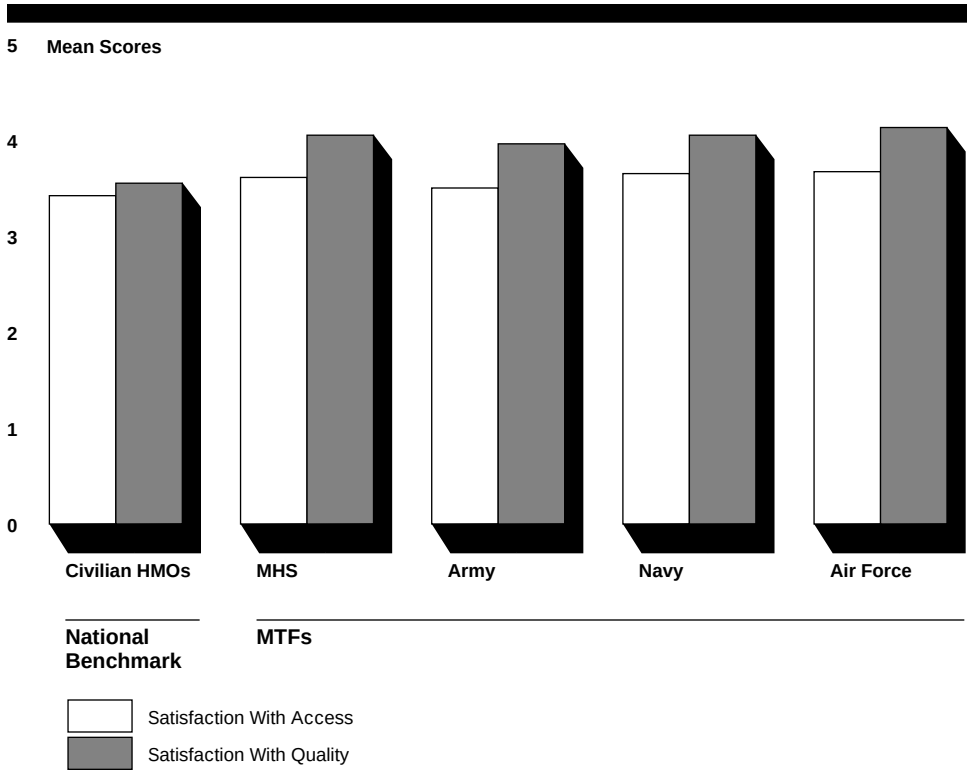
Figure 1: Comparison of Beneficiaries' Satisfaction With Specific Aspects of TRICARE, 1996 Annual Survey



Notes: Results for beneficiaries not enrolled in TRICARE Prime are for only those who had the option of enrolling and therefore do not include regions without TRICARE or any beneficiaries aged 65 and over.

"Quality of care" focuses on individuals' satisfaction with skill, thoroughness, and outcomes on health care. "Access to appointments" addresses convenience of arranging appointments.

Figure 2: Beneficiary Satisfaction With MTF Outpatient Care Visits—April/May/June 1997



Note: Satisfaction is measured on a 5-point scale, with 1 equaling "poor" and 5 equaling "excellent."

Although important, beneficiaries' perceptions do not totally measure DOD's actual performance. To supplement beneficiary satisfaction information on access to care, we recommended in 1996 that DOD collect data on the timeliness of appointments. While DOD agreed with our recommendation, it has yet to fully implement this data collection effort. Moreover, the beneficiary satisfaction information DOD uses in its report card to measure access is based on monthly surveys of patients receiving outpatient care. Relying on the outpatient survey provides limited information on access and may mask the extent of difficulty beneficiaries face since it only collects information from those patients who were able to obtain care at a military facility.

As required by the Congress, DOD has contracted for independent evaluations of TRICARE's progress in improving access, maintaining quality, and controlling costs. These studies are currently under way but are not expected to be completed until June 1999. Given the importance of TRICARE, and concerns about access and quality raised by beneficiary groups and recent media reports, we are also planning to examine DOD health care access and quality issues.

TRICARE Initiatives Are Not Achieving Expected Savings

When TRICARE was designed, the Congress required that the program be cost neutral—that is, that TRICARE costs not exceed the health care costs DOD would have incurred without the program. To control TRICARE costs, DOD planned to achieve cost savings from managed care efforts and initiatives. However, there are reasons now to question how current and analytically complete DOD's savings claims are.

An important cost-saving feature of DOD's partnership between military and civilian health care entities under TRICARE is resource sharing. To share resources, the contractor supplements the capacity of a military hospital or clinic by providing civilian personnel, equipment, or supplies. DOD had estimated that resource sharing could save about $700 million over 5 years.[10] We reported last summer, however, that DOD and the contractors had made agreements likely to save about 5 percent of DOD's overall resource sharing goal.[11] At that rate, after 9 to 24 months of operation, DOD could have expected to realize only about $36 million.

DOD officials acknowledged that resource sharing has not achieved the expected savings but told us that lower-than-expected contract award amounts have led to more than $2 billion in other savings. However, we found that as of May 1997, the existing five contracts had been modified as many as 350 times, with the resulting potential for substantial contract cost increases in TRICARE. These potential cost increases, just like the potential losses from lack of resource sharing, would also offset DOD's projected savings. Furthermore, last year we questioned DOD's utilization management savings estimate, which is set at a cumulative 5 to 7 percent, in its health care budget totals for fiscal years 1998 through 2003. We reported that DOD lacked a formal methodology for developing the estimates, and we concluded that, overall, future health care costs likely would be greater. Given these questions about TRICARE costs, we support

[10]This amount does not include expected savings from the three most recently awarded contracts.

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

DOD's plans to undertake a more current and complete cost analysis of MTF direct and contractor-provided care to determine TRICARE's cost-effectiveness. Until this analysis is completed, questions will remain regarding the extent to which the legislative objective for TRICARE's cost-effectiveness is being achieved.

Ongoing and Planned Military Health System Changes Likely to Affect TRICARE

DOD's efforts to fully implement TRICARE are occurring at a time when not only are changes being made in the organization to manage the program but other, perhaps more significant, changes are being contemplated for the military health care system itself. Planning for these changes and incorporating them into TRICARE is making an already complex task even more difficult.

Organizational Changes

On February 10, 1998, as part of a DOD-wide reform initiative to consolidate headquarters functions, DOD established within the Office of the Assistant Secretary of Defense for Health Affairs what it called the TRICARE Management Activity. This activity unifies several Health Affairs operational elements with two field activities, including the TRICARE Support Office, which is responsible for TRICARE procurement activities. The activity is expected to strengthen program oversight and performance by developing and using specific performance measures for the program's costs, quality, and health care access. We have found such measures to be needed.

A second significant organizational change that may affect the future of TRICARE relates to the imminent retirement of the now Acting Assistant Secretary of Defense, who has served in Health Affairs for the past 9 years and has been a key force in the design and development of TRICARE. Strong leadership will be needed in the future as implementation of TRICARE proceeds, and filling this void will be a major challenge.

Legislative Initiatives

The military health care system has changed continually over the years as a result of legislative initiatives designed to enhance coverage for military beneficiaries. For example, within the last 2 weeks, DOD and the Department of Health and Human Services announced that six demonstration sites have been selected for a 3-year test of the concept of enrolling Medicare-eligible military retirees and their (Medicare-eligible) dependents in TRICARE Prime.[12] Medicare will reimburse DOD for the care

[12]This demonstration was authorized by the Balanced Budget Act of 1997.

provided to enrollees above the amount DOD currently spends for them. Under this concept—known as Medicare subvention—DOD believes it can provide care to older retirees in MTFs at a lower cost than Medicare HMOs can. Medicare subvention will improve enrollees' access to care in MTFs and will allow Medicare HMOs to contract with DOD to provide specialty and inpatient care. While this program adds to the health care options available to certain military beneficiaries, it also introduces additional administrative complexities to the already complex TRICARE program, such as the need for new contracts with Medicare HMOs.

Many legislative proposals have been introduced in the 105th Congress that would authorize, either for all Medicare-eligible military beneficiaries or for Medicare eligibles and certain other non-active duty beneficiaries, enrollment in one of the many Federal Employees Health Benefits Program (FEHBP) plans. Enactment of an FEHBP option for these beneficiaries could dramatically alter TRICARE by reducing beneficiaries' demand for military health care.

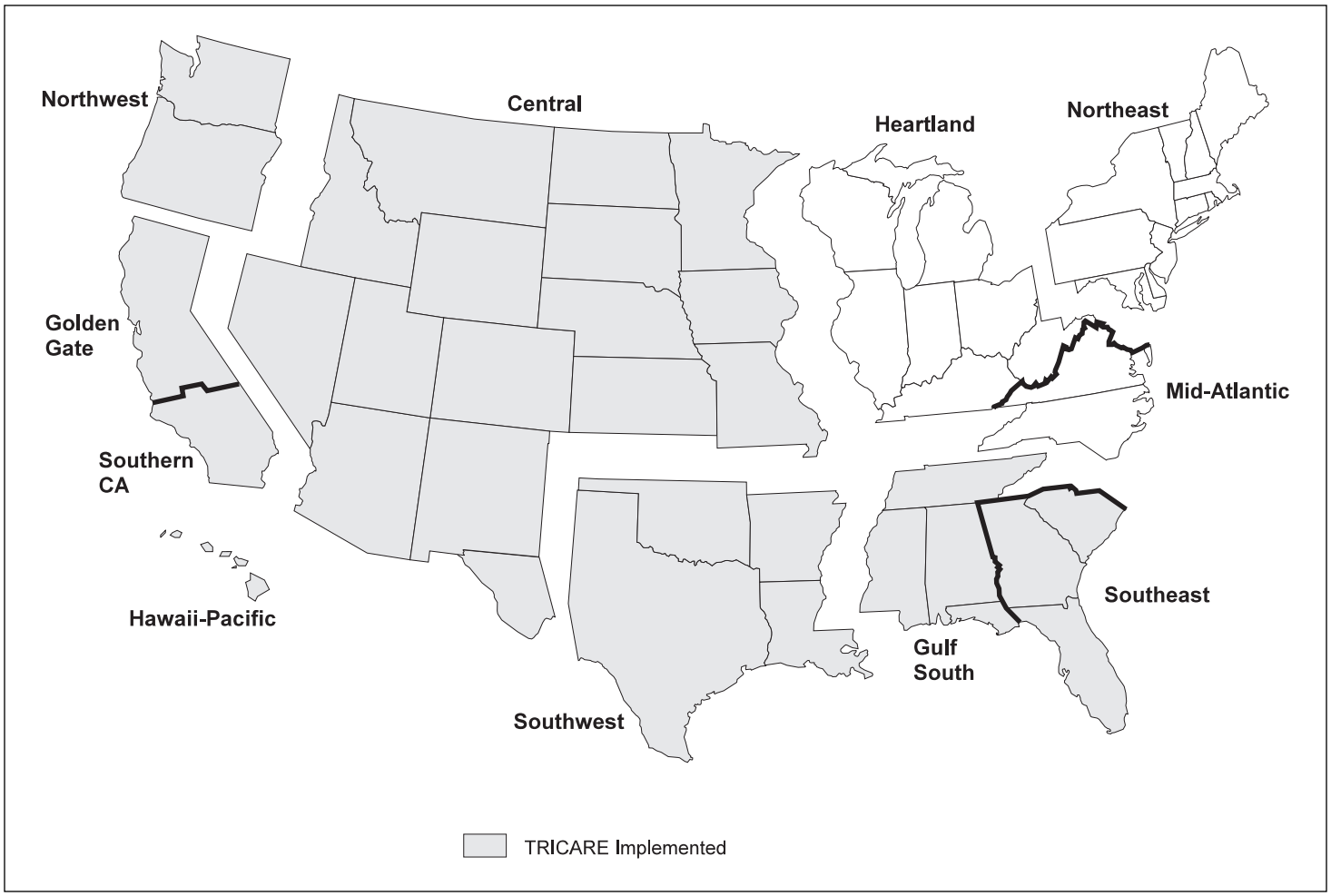
Downsizing of the Military Medical Force

The most significant change in the system may occur if and when DOD completes its now overdue update of what is known as its "733 study," which was completed in April 1994. In this study, conducted pursuant to section 733 of the National Defense Authorization Act for fiscal years 1992 and 1993, DOD's Office of Program Analysis and Evaluation (PA&E) challenged the Cold War assumption that all military medical personnel employed during peacetime are needed for wartime. The study concluded that DOD's wartime medical requirements are far lower—by as much as half—than the medical system then programmed for fiscal year 1999.

Although no action was taken by DOD as a result of that study, the Deputy Secretary of Defense, in August 1995, directed that the study be updated and improved. We understand that PA&E has nearly completed the study and that DOD top management will likely review it before its release. If the updated review results in conclusions similar to those in the 733 study, and if DOD acts on those conclusions, the potential reductions in military medical personnel and facilities could be significant. TRICARE's primary cost-saving advantages are rooted in the delivery of managed care at military facilities, and any significant reduction in such capacity would necessitate that beneficiaries be provided care in the contractors' networks. This would alter the potential cost-effectiveness of the program.

Mr. Chairman, this concludes my prepared statement. I will be glad to respond to any questions you or other Subcommittee members may have. We look forward to continuing to work with the Subcommittee as it exercises its oversight of this important program.

Regions Served by the Seven Managed Care Support Contracts



Related GAO Products

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

Defense Health Care: DOD Could Improve Its Beneficiary Feedback Approaches (GAO/HEHS-98-51, Feb. 6, 1998).

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

Defense Health Care: Actions Under Way to Address Many TRICARE Contract Change Order Problems (GAO/HEHS-97-141, July 14, 1997).

Military Retirees' Health Care: Costs and Other Implications of Options to Enhance Older Retirees' Benefits (GAO/HEHS-97-134, June 20, 1997).

Defense Health Care: Dental Contractor Overcame Obstacles, but More Proactive Oversight Needed (GAO/HEHS-97-58, Feb. 28, 1997).

Defense Health Care: Limits to Older Retirees' Access to Care and Proposals for Change (GAO/T-HEHS-97-84, Feb. 27, 1997).

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

Defense Health Care: Medicare Costs and Other Issues May Affect Uniformed Services Treatment Facilities' Future (GAO/HEHS-96-124, May 17, 1996).

Defense Health Care: Effects of Mandated Cost Sharing on Uniformed Services Treatment Facilities Likely to Be Minor (GAO/HEHS-96-141, May 13, 1996).

Defense Health Care: TRICARE Progressing, but Some Cost and Performance Issues Remain (GAO/T-HEHS-96-100, Mar. 7, 1996).

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

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

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