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DEFENSE HEALTH CARE

Offering Federal Employees Health Benefits Program to DOD Beneficiaries

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Health, Education, and
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The Honorable Dan Burton
Chairman
Committee on Government Reform and Oversight
House of Representatives

Dear Mr. Chairman:

The military health care system has changed significantly during the past decade. Along with substantial active duty force and infrastructure reductions, medical personnel strength has decreased by 15 percent, and one-third of all military hospitals have been closed. Further, the 1980s doubling of military health costs and increasing beneficiary concerns about care access in military hospitals led the Department of Defense (DOD) to establish its nationwide managed care program, called TRICARE. But further facility downsizing and access priority changes under TRICARE have continued to fuel beneficiary concern, especially among persons living far from military facilities and senior retirees who are ineligible for TRICARE and have the lowest priority for military facility care. And TRICARE's cost effectiveness, not yet proven, has increasingly come into question.

We have reported and testified frequently on TRICARE's implementation, including TRICARE contracting and resource sharing program problems and retirees' health benefit shortfalls and the pros and cons of proposed alternatives (see list of related GAO products at the end of this report).[1] We have recently reported on providers' participation in TRICARE and their concerns about existing payment mechanisms as well as TRICARE's beneficiary feedback systems.

In response to many concerns about TRICARE, members of the Congress, beneficiary groups, and others have proposed such measures as authorizing Medicare payments to expand TRICARE eligibility for senior retirees and extending to certain beneficiaries coverage under the Federal Employees Health Benefits Program (FEHBP), a health insurance program that offers a wide array of health plans to federal employees. At your request, we reviewed nine bills introduced in the 105th Congress to authorize FEHBP for military beneficiaries. Six of the bills would authorize immediate nationwide access to FEHBP for either all Medicare-eligible

[1]Resource sharing is a TRICARE cost-saving feature in which the TRICARE managed care support contractor supplements a military hospital's or clinic's capacity by providing civilian personnel, equipment, or supplies.

military beneficiaries (H.R. 76, H.R. 1456, H.R. 2128, and S. 224) or Medicare-eligible military beneficiaries and certain other nonactive duty beneficiaries (H.R. 1356 and H.R. 1631). Three other bills (H.R. 1766, H.R. 2100, and S. 1334) propose testing the approach to better determine government costs and beneficiary interest before deciding whether to implement the option nationwide.

Specifically, you asked us to (1) review issues that cut across the various bills, such as potential effects on beneficiary costs, eligibility, and the military health system (MHS) generally, and (2) profile and comment on the bills' key features, highlighting their similarities and differences (see app. I). In doing our work, we interviewed representatives of DOD; the Office of Personnel Management (OPM), FEHBP's administrator; and military beneficiary organizations. We also worked closely with Congressional Budget Office (CBO) staff on our estimates of the bills' effects on beneficiaries and the MHS, as well as on their estimates of certain bills' overall costs and related enrollment figures, which CBO has reported on separately. We conducted our work from October 1997 through January 1998 in accordance with generally accepted government auditing standards.

Results in Brief

Our analysis of the nine bills shows that their different features could affect the numbers of beneficiaries who would be attracted to participate in FEHBP, total government and beneficiary costs, and MHS operations. The bills vary, for example, with respect to which military beneficiaries would be eligible, how premiums would be calculated, to what extent they would be shared between DOD and enrollees, whether MHS participation would be concurrently allowed, and whether the approach should be tested prior to nationwide implementation. Tables 1 and 2 profile the bills' key features.

Table 1: Legislation Introduced in the 105th Congress to Extend FEHBP Coverage to Military Beneficiaries

Bill number and sponsor	Summary	Eligibility	Cost sharing	Concurrent FEHBP and DOD use	Separate risk pool?[a]
H.R. 76, Rep. Moran	Authorizes FEHBP for all Medicare-eligibles.	DOD determines which Medicare-eligible beneficiaries may enroll (1.3 million are Medicare-eligible). OPM may limit enrollment if needed for management purposes.	Enrollees pay same amount as federal enrollees. DOD pays remainder up to total premium.	FEHBP users may continue to use MHS. FEHBP cancellation is irrevocable.	Yes
H.R. 1356, Rep. Watts	Authorizes FEHBP for Medicare-eligibles and those who are not able to reach or are not guaranteed access to TRICARE. Adds TRICARE improvement provisions.	All beneficiaries without access under TRICARE equal to highest FEHBP option (eligibles unknown); those ineligible for TRICARE because of locality or limits (eligibles unknown) and Medicare- eligibles (1.3 million).	Enrollees pay same amount as federal enrollees. DOD pays remainder up to total premium.	Not addressed.	Yes
H.R. 1456, Rep. Thornberry	Authorizes FEHBP for all Medicare-eligibles. Approves Medicare subvention,[b] pays part B penalties,[c] approves Medigap enrollment period.[d]	Medicare-eligible beneficiaries (1.3 million).	Enrollees pay same amount as federal enrollees. DOD pays remainder up to total premium.	FEHBP users may continue to use MHS, DOD can collect third-party payments from FEHBP plans.[e] FEHBP cancellation is irrevocable.	Yes
H.R. 1631, Rep. Mica	Authorizes FEHBP for active duty dependents, retirees and their dependents, and survivors.	All qualified dependents, retirees, survivors, and former spouses (total eligible, 6.3 million). Enrollment limits: 100,000 in year 1; 200,000 in year 2; 400,000 in year 3.	Total premium amount is the same as for federal enrollees. DOD determines its contribution amount.	Enrollees in FEHBP may not use MHS. FEHBP choice is for 3 years. If FEHBP is elected, DOD coverage cannot be restored until 3-year period passes.	Not addressed.
H.R. 2128, Rep. Stearns	Authorizes FEHBP for Medicare-eligibles.	Medicare-eligible beneficiaries only (1.3 million). OPM may limit enrollment if needed for management purposes.	Enrollees pay same amount as federal enrollees. DOD pays remainder up to total premium.	Enrollees in FEHBP may not use MHS. FEHBP cancellation is irrevocable.	Yes
S. 224, Sen. Warner	Authorizes FEHBP for Medicare-eligibles.	Medicare-eligible beneficiaries (1.3 million). OPM may limit enrollment if needed for management purposes.	Enrollees pay same amount as federal enrollees. DOD pays remainder up to total premium.	Enrollees in FEHBP may not use MHS. FEHBP cancellation is irrevocable.	Yes

(Table notes on next page)

[a]Creating separate risk pools means that OPM would calculate the military group's premiums separately from the federal group's to prevent the military group's risk characteristics such as age, gender, and care use from altering the federal group's premiums.

[b]Medicare subvention would allow Medicare to reimburse DOD for care provided to Medicare-eligible beneficiaries in military facilities.

[c]If an eligible beneficiary does not enroll in Medicare part B (a voluntary program that covers outpatient care, laboratory tests, and medical equipment) when first eligible, a 10-percent surcharge per year is assigned to the premium if the beneficiary chooses to enroll later.

[d]This provision would allow military beneficiaries who did not enroll in a medigap supplementary insurance plan at age 65 to enroll in such a plan without consideration of age or medical condition in the setting of the plan's premium.

[e]DOD can collect from health insurance plans, known as third-party payers, the health care costs incurred on behalf of insured military dependents and military retirees to the extent that the insurer would pay if the services were provided at a civilian hospital.

Table 2: Legislation Introduced in the 105th Congress to Authorize a Demonstration of Extending FEHBP Coverage to Military Beneficiaries

Bill number and sponsor	Summary	Eligibility and enrollment	Cost sharing	Concurrent FEHBP and DOD use	Separate risk pool?[a]
H.R. 1766, Rep. Moran	Authorizes FEHBP demonstration for Medicare-eligibles.	Medicare-eligible beneficiaries; must keep Medicare part B. Limited to two sites: (1) catchment area with up to 25,000 eligibles and (2) noncatchment area with up to 25,000 eligibles.	DOD contribution may not be more than that paid for a federal employee. Enrollee contribution not addressed.	Concurrent use not addressed. FEHBP cancellation is irrevocable.	Yes
S. 1334, Sen. Bond	Authorizes FEHBP demonstration for Medicare-eligibles.	Medicare-eligible beneficiaries; must keep Medicare part B. Limited to two sites: (1) catchment area with up to 25,000 eligibles and (2) noncatchment area with up to 25,000 eligibles.	DOD contribution may not be more than that paid for a federal employee. Enrollee contribution not addressed.	Concurrent use not addressed. FEHBP cancellation is irrevocable.	Yes
H.R. 2100, Rep. Stearns	Authorizes FEHBP demonstration for Medicare-eligibles and those unable to enroll in TRICARE.	Active duty dependents and retirees who live outside a TRICARE Prime enrollment area and Medicare-eligible beneficiaries who live in the demonstration region (total eligibles unknown).	Not addressed.	Not addressed.	Not addressed.

[a]Creating separate risk pools means that OPM would calculate the military group's premiums separately from the federal group's to prevent the military group's risk characteristics such as age, gender, and care use from affecting the federal group's premiums.

FEHBP coverage would likely vary in attractiveness, depending on beneficiaries' current health care costs and military care eligibility and access and their other health care coverage, if any. For example, Medicare-eligible beneficiaries—ineligible for TRICARE and with the lowest priority for military facility care access—would likely find an FEHBP option advantageous. In contrast, active duty families and retirees younger than 65, eligible for TRICARE, would find FEHBP plans' annual premiums to be higher than the annual fee for TRICARE's Prime health maintenance organization (HMO) option and thus potentially less attractive.[2] Adding a benefit such as FEHBP is likely to result in the enrollement in FEHBP of some beneficiaries who are not now using any DOD health care source. Increased DOD costs would occur unless military medical facilities were downsized or closed to free up funding for DOD's share of the FEHBP premiums. This may be possible, in light of recent studies that have indicated that the system is now larger than required for wartime needs.[3]

The various bills' premium-setting and cost-sharing features would affect not only whether beneficiaries' chose to participate but also DOD's potential added costs. Most proposals would set military enrollees' premiums separately from the federal FEHBP group's to shield the federal group's premiums should the military group have higher care usage and costs and thus a higher total premium.[4] In some bills, the military FEHBP enrollees' premium amount would be the same as civilian enrollees' and DOD would pay the remainder.[5] Should the total military premium be higher than the civilian premium, the government would bear a higher portion for military than for civilian enrollees. Bills requiring that DOD's premium share not exceed that paid for a civilian enrollee would put any additional cost burden on military enrollees.[6] One bill would allow DOD to determine its premium share and thereby potentially provide greater

[2]TRICARE also offers preferred provider organization and fee-for-service options. Active duty families pay no annual fee for these options, but retirees and their families must pay an annual fee to enroll in Prime. That fee, $230 for an individual enrollee or $460 for a family, is approximately half the cost of most FEHBP plans. For example, in 1998, the Blue Cross and Blue Shield national plan costs $1,471 per family, and across the country the Kaiser Permanente plan averages about $1,400.

[3]DOD, Office of Program Analysis and Evaluation, "The Economics of Sizing the Military Medical Establishment," Executive Report of the Comprehensive Study of the Military Medical Care System, Washington, D.C., Apr. 1994.

[4]OPM officials told us they believe the military premiums would likely not be significantly different from the civilian FEHBP pool, despite past studies showing higher health care use by military beneficiaries.

[5]H.R. 76, H.R. 1356, H.R. 1456, H.R. 2128, and S. 224

[6]H.R. 1766 and S. 1334.

subsidies to enlisted families than to officers or greater subsidies to active duty families than to retirees and their families.[7]

Whether military FEHBP enrollees should be allowed concurrent use of the MHS is both a cost issue and a military readiness issue. Allowing concurrent use of FEHBP and DOD care would create a system of overlapping coverage for younger beneficiaries who already have priority access to DOD-funded care through military facilities and civilian providers. But for those aged 65 and older, who have lower priority access to military health care, FEHBP would be far less duplicative. Prohibiting concurrent DOD and FEHBP care use might enable DOD to more appropriately size its system, facilitate downsizing of unneeded capacity, and thus have savings for use in helping fund FEHBP enrollment.

The size and patient mix of the DOD medical system, however, are also affected by readiness needs. DOD officials have stated that retaining sufficient numbers and an appropriate mix of patients in the DOD system is critical to recruiting, retaining, and training military physicians and support staff for wartime readiness. Yet some experts believe that military facilities' current patient mix is not sufficient to ensure physicians' wartime readiness.[8] Thus, retaining enough patients for such purposes in its facilities would be a central issue for DOD should FEHBP be offered. Shortly, we will be reporting on DOD's efforts to provide trauma care training for its physicians in civilian facilities.

Finally, to better assess an FEHBP option's attractiveness and potential effects on government costs and the MHS's operation, some bills would authorize a test of the program in a few areas of the country. Such sites would include areas with military medical facilities and those far from such facilities and areas where a variety of FEHBP plans and such other health care options as Medicare HMOs are alternatively available. However, military facility sites' variability, beneficiaries' current care alternatives, the local health care markets, and other factors would greatly complicate the task of choosing sites representative of the overall MHS. To limit the test's cost, a maximum number of enrollees, or funding limit, could be set, as is done in H.R. 1766 and S. 1334, by limiting the test to a total of 50,000 enrollees, or 25,000 at each of two sites.

[7]H.R. 1631.

[8]Congressional Budget Office, "Restructuring Military Medical Care," Washington, D.C., July 1995.

Background

The Military Health System

The MHS has a dual mission—providing medical services and support to the armed forces in peacetime and war and caring for the families of active duty personnel, military retirees and their dependents, and survivors. In carrying out its mission, the MHS offers health care coverage to about 8.2 million people, more than half of whom are retirees and their dependents and survivors, at a cost of $15.6 billion in fiscal year 1997. Health care for eligible beneficiaries is provided through military medical treatment facilities (MTF), called the direct care system, and through an insurance-like benefit that covers much of the cost of civilian care. DOD also uses the direct care system to recruit and train military physicians and support personnel needed to meet its wartime mission and such related peacekeeping roles as the Somalia, Haiti, and Bosnia deployments.

All DOD beneficiaries are eligible for military facility care at little or no cost if space and resources are available. Active duty personnel are given first-priority access to military facilities, followed by their family members and then retirees and their families. However, such space-available care varies from comprehensive inpatient and outpatient care at medical centers and larger hospitals to only outpatient services at very small facilities. Moreover, as we testified in 1997, recent downsizing and facility closings and changes in the access priorities under TRICARE have resulted in reductions in space-available care across the MHS.[9]

The TRICARE program was introduced in 1993 in response to soaring 1980s and early 1990s cost increases and increasing beneficiary complaints about military facility care access. Its goals were to improve beneficiary access and quality while containing MHS costs. TRICARE encompasses both military facility care and civilian care and offers beneficiaries three options: Prime, an HMO; Extra, a preferred provider network; and Standard, a fee-for-service benefit. All three TRICARE options, like FEHBP, provide comprehensive coverage, including inpatient and outpatient care, mental health, and prescription drugs but not dental care.[10] And like many FEHBP

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

[10]DOD beneficiaries can purchase dental coverage separately under the TRICARE Active Duty Family Member Dental Plan or the Retiree Dental Plan.

plans, TRICARE also limits catastrophic out-of-pocket costs from expensive medical conditions.[11]

To participate in TRICARE Prime, beneficiaries must enroll in the program, choose a primary care physician, and limit their care to the Prime network of civilian and DOD providers. Active duty dependents pay no fee to enroll in TRICARE Prime, but eligible retirees and their dependents pay $230 for a single enrollee or $460 for a family per year—less than half of most FEHBP plan premiums. Prime enrollees receive priority-care access in military facilities and pay only nominal copayments if civilian care is needed. Under TRICARE, DOD changed the access priorities by ranking all Prime enrollees first in priority after active duty members but before all other beneficiaries, regardless of beneficiary class. In the regions where TRICARE has been implemented, approximately 2 million, or 46 percent, of eligible beneficiaries have enrolled in Prime.

Eligible beneficiaries pay no enrollment fee to participate in TRICARE Standard or Extra. TRICARE Standard is available nationwide and beneficiaries can choose any authorized TRICARE provider. Like most FEHBP fee-for-service plans, beneficiaries must first meet an annual deductible, after which DOD shares the cost of care with the beneficiary. Active duty dependent beneficiaries generally pay 20 percent of the allowed charge, and retirees pay 25 percent. Under TRICARE Extra, beneficiaries can choose providers from the TRICARE civilian network and have their copayments reduced by 5 percent. See appendix II for a comparison of beneficiary costs under TRICARE's three options and selected FEHBP plans.

TRICARE 's implementation over the past 4 years has met with a variety of problems. We have reported, for example, that DOD has struggled with awarding and managing its multibillion dollar contracts with private health plans to supplement military facility care and provide administrative services and that it has failed to achieve expected savings under one part of the TRICARE program.[12] Also, beneficiaries have complained that

[11]The catastrophic limits are $1,000 for active duty families under all TRICARE options and for retirees are $3,000 under Prime and $7,500 under Standard and Extra (see app. II).

[12]All seven TRICARE contract awards were protested and the protests were sustained for three—the most recent sustained protests occurred in February 1998. DOD and the awardees have requested reconsideration of these protests. Defense Health Care: Despite TRICARE Procurement Improvements, Problems Remain (GAO/HEHS-95-142, Aug. 3, 1995); Defense Health Care: New Managed Care Plan Progressing, but Cost and Performance Issues Remain (GAO/HEHS-96-128, June 14, 1996); Defense Health Care: Actions Under Way to Address Many TRICARE Contract Change Order Problems (GAO/HEHS-97-141, July 14, 1997), Defense Health care: TRICARE Resource Sharing Program Failing to Achieve Expected Savings (GAO/HEHS-97-130, Aug. 22, 1997).

TRICARE Prime is not available in many areas that are far from military medical facilities. Further, provider complaints have arisen about discounted payment rates, delayed payments to beneficiaries and providers, and the reluctance of physicians to care for beneficiaries under TRICARE Standard.[13] We plan to report on these matters during the next few months.

DOD has begun addressing such concerns by attempting to simplify its contracting process, for example, and making the Prime benefit available in more areas of the country. DOD estimates that Prime will be available within the next year to 90 percent of active duty beneficiaries and the majority of TRICARE-eligible retirees as well. Questions nonetheless remain about the MHS's optimal size and about the combination of military facility and private contractor support that might provide the cost- and quality-optimal system. Further, while TRICARE's overall cost-effectiveness and ability to improve care access and quality remain unproven, a formal congressionally mandated TRICARE evaluation is just beginning.[14]

Only active duty family members and retirees under age 65 are eligible for TRICARE. Because Medicare-eligible retirees aged 65 and older are ineligible for TRICARE, they can obtain military facility care only if space is available after TRICARE enrollees and other active duty members and their dependents receive their care. We have reported that the older retiree population is increasing more rapidly than other beneficiary groups and, as TRICARE enrollment increases, military facility space-available care will continue to decline such that many senior retirees may find it unavailable to them in the future.[15]

In addition to care provided by DOD through TRICARE or the direct care system, military beneficiaries may have private health care insurance through current or former employers, coverage under the Medicare program or the Veterans' health care program, eligibility for FEHBP through employment with the federal government, or coverage supplementing TRICARE or Medicare purchased privately. According to a recent DOD beneficiary survey, nearly half of military retirees have private insurance,

[13]According to DOD, private providers accept the allowable charge on 86 percent of all TRICARE Standard claims.

[14]This evaluation was mandated by the National Defense Authorization Act for fiscal year 1996, section 717, and is being conducted for DOD under contract with the Institute for Defense Analyses and the Center for Naval Analyses.

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

and one-third have purchased private supplemental insurance coverage. Also, about 5 percent of military retirees, approximately 80,000 people, are active federal employees and are eligible for FEHBP.[16]

The Federal Employees Health Benefits Program

FEHBP is available to federal employees, retirees, annuitants, and their dependents. In 1997, approximately 9 million beneficiaries participated in 374 FEHBP plans nationwide at a cost of approximately $16.3 billion—$12.1 billion paid by the government and $4.2 billion by enrollees. In comparison, DOD provided care to about 6.3 million beneficiaries in fiscal year 1997 at a total cost of approximately $15.6 billion, which also includes its costs for medical readiness and training, military deployments, veterinary services, and occupational health. See appendix III for a historical comparison of DOD and FEHBP beneficiary numbers and program costs.

The federal share of the FEHBP premium is about 72 percent, not to exceed 75 percent of any plan's premium.[17] The types of FEHBP plans—HMOs, managed fee-for-service plans, and plans offering a point of service product—are similar to TRICARE's three options. And although not all plans are available in all localities, each type is. FEHBP enrollees, depending on where they live, can choose from between 10 and 30 plans, including such fee-for-service plans as Blue Cross and Blue Shield and such health maintenance organizations as Kaiser Permanente. More than 85 percent of federal employees participate in FEHBP. To differing degrees, all FEHBP plans cover inpatient and outpatient care, prescription drugs, and mental health services, and many cover some dental care expenses. They also have limits on catastrophic out-of-pocket costs in the case of expensive health care problems. For Medicare-eligible beneficiaries, many FEHBP plans operate as a "wraparound" policy to Medicare, giving retirees comprehensive coverage with no or small copayments and deductibles.

Crosscutting FEHBP Bill Issues

Along with the bills' individual price-tags, several other key issues cut across them to extend FEHBP coverage to military beneficiaries. The issues include (1) who would be eligible and, among those, how many might be attracted to FEHBP and might choose to enroll; (2) how premiums would be set and what the cost-sharing arrangement would be; (3) whether FEHBP

[16]OPM officials told us they do not have information on how many federal retirees are also military retirees or how many federal employees have spouses who are military members or retirees and thus dually eligible for both DOD care and FEHBP.

[17]In 1998, according to OPM, the government will pay up to $1,715 annually for each self-only enrollment and $3,699 for each family enrollment.

enrollees would be prohibited from also using military health care; and (4) whether the FEHBP option should be tested before deciding on nationwide implementation.

Defining Eligibility and Projecting Enrollment

Each FEHBP option's first consideration, tempered by overall cost considerations, is who would receive the benefit. Many of the bills would provide eligibility only for Medicare-eligible beneficiaries aged 65 and older—approximately 1.3 million retirees, dependents, and survivors.[18] The Military Coalition, an alliance of beneficiary associations including The Retired Officers' Association and the National Military Family Association, favors this approach as responding to the immediate needs of persons with declining direct care system access and as a way to reduce the option's price tag.[19] Other bills would extend FEHBP eligibility beyond Medicare-eligibles to certain other military beneficiaries.[20] The maximum number of eligible beneficiaries under the bills studied would range from an estimated 50,000, under the most limited demonstration bills, to almost 3 million, under the bill with the broadest eligibility definition.[21]

Projecting FEHBP enrollment under the various options requires making assumptions about beneficiaries' behavior, including their coverage choices, cost consciousness, and risk aversion. Many TRICARE-eligible beneficiaries have care alternatives that they may find more attractive than FEHBP. For those who are most concerned with cost and are eligible for TRICARE Prime, Prime would likely be more attractive, because most FEHBP plans would cost more than TRICARE Prime's enrollment fee. For example, FEHBP's lowest-cost HMO is Foundation Health, available in South Florida, at $279 per year for a single enrollee and $787 per year for a family. This compares with Prime, which has no annual fee for active duty singles or families and a fee of $230 for single retirees or $460 for retiree families. And Prime's guarantee of priority access to free care in military facilities may be more attractive to many who live near facilities than FEHBP's plan choices. Alternatively, a beneficiary could participate in TRICARE Standard or Extra for no annual fee and make use of available free care and prescriptions at a nearby military facility. In contrast, FEHBP's

[18]H.R. 76, H.R. 1456, H.R. 1766, H.R. 2128, S. 224, and S. 1334.

[19]Some organizations represented by the Military Coalition also support other bills. For example, the National Military Family Association also supports offering FEHBP to all active duty family members and retirees and their families.

[20]H.R. 1356, H.R. 1631, and H.R. 2100.

[21]H.R. 1766 and S. 1334 are the most limited; H.R. 1631 has the broadest eligibility definition.

lowest-cost nationwide fee-for-service plan, Mail Handlers Standard, costs $1,030 for family coverage, and the lowest-cost point-of-service plan, United HealthCare Puerto Rico, is $1,019 per year. These plans, like TRICARE Standard and Extra, may require beneficiaries to meet an annual deductible and may charge copayments typically ranging from 20 to 30 percent of care costs.

Also, persons with private insurance coverage may find their costs lower than those under FEHBP—many large employers pay a greater plan premium share than the government's 72 percent of FEHBP premiums. However, the benefits covered under some private plans may not be as generous as FEHBP, and some studies have indicated a decline in employer coverage of retiree health benefits.[22] Finally, for beneficiaries generally dissatisfied with their access to care or choices under TRICARE or private plans, FEHBP's wide array of choices would likely be more attractive.

FEHBP would likely be more attractive and beneficial to Medicare-eligible beneficiaries, who also may have alternative health care choices but find them less comprehensive and more costly than FEHBP. FEHBP's advantages for senior beneficiaries include prescription drug coverage and catastrophic limits on out-of-pocket costs: Medicare covers neither. And on the basis of FEHBP's current federal employee cost-sharing provisions, senior retirees could pay lower premiums for more coverage than they would under private Medigap policies that they purchase to supplement Medicare's coverage. For example, in 1997 an enrollee's share of the premium for the five largest plans in FEHBP with comprehensive coverage, including prescriptions and some dental coverage, ranged from about $370 to $1,750, compared with Medigap plans, which have premiums ranging from $750 to almost $3,000 but offer no dental benefits and limit prescription coverage to 50 percent of drug costs, after payment of a $250 deductible. Medigap plans also have maximum benefit limits on prescriptions ranging from $1,250 to $3,000.

Further, for retirees with both Medicare part A (hospital) and part B (physician and laboratory services and outpatient care) coverage, most FEHBP fee-for-service plans operate as a "wraparound" policy to Medicare, providing comprehensive coverage and waiving most copayments and deductibles.[23] For those who have Medicare part A but who have not

[22]See Retiree Health Insurance: Erosion in Employer-Based Health Benefits for Early Retirees (GAO/HEHS-97-150, July 11, 1997).

[23]The beneficiary is responsible for the Medicare part B premium—about $526 per year in 1998.

purchased part B, FEHBP plans generally do not waive the copayments and deductibles but provide the same coverage as for non-Medicare enrollees.

Alternatively, many Medicare-eligible beneficiaries can now join an HMO or other health care plan under the expanded Medicare+Choice program. Approximately 50 percent of Medicare-eligible military retirees live in a county in which 10 percent or more Medicare beneficiaries are enrolled in Medicare HMOs, indicating that they have access to at least one Medicare HMO. Many such plans offer coverage comparable to FEHBP HMOs, including prescription drugs, vision care, and even dental care at low or zero premiums.[24] A significant unknown is the extent to which these plans' growing availability might affect beneficiaries' decisions to enroll in FEHBP. Further, those who already have health care insurance paid in full or in part by their current employer—about 17 percent of older retirees—might not elect FEHBP if it cost more than their current coverage. Also, some number of senior retirees will have guaranteed access to DOD health care by enrolling in the recently authorized Medicare subvention demonstration.[25] Finally, those with high risk tolerance, in good health, and living near large military facilities may forgo FEHBP and continue taking their chances in gaining access to free space-available care.

Bill Cost-Sharing and Premium Provisions

Premium-setting and cost-sharing provisions also differ under the bills and would likely affect beneficiaries' decisions about participating in FEHBP. OPM, which administers FEHBP, would set the premiums for plans that participate in the military FEHBP option separately from the federal groups' premiums. According to OPM, if a sizable group were added to FEHBP, it would be appropriate to keep those enrollees separate from the federal participants, called a risk pool. A separate risk pool—required under all but two of the bills (H.R. 1631 and H.R. 2100)—would protect federal participants from large changes in premiums because of a military population that may have different health care usage and cost patterns.

Most of the bills stipulate separate risk pools until a cost and health care use pattern similar to that of civilian FEHBP enrollees has been established and until merging with the federal civilian pool can be safely done. Thus, military beneficiaries' premiums could be different from those under the federal civilian program. OPM officials told us that they could not prospectively estimate military enrollees' potential premiums without a final plan and detailed data on military beneficiaries' historical health care

[24]The beneficiary is responsible for the Medicare part B premium.

[25]Balanced Budget Act of 1997, P.L. 105-33, section 4015.

use patterns. However, because not all military beneficiaries get their care from DOD, this historical use data may not be available. Despite past studies showing higher health care use by military beneficiaries than the civilian population, OPM believes that the initial military premiums would not be markedly different from the federal pool and that future use by military FEHBP enrollees, because of the premium and copayment effects on usage patterns, would approximate that of the federal pool.

The bills' provisions for sharing premium costs between DOD and enrollees also differ. Under some bills, the enrollee premium amount for military beneficiaries would be the same as for federal civilians enrolled in the same FEHBP plans, with DOD contributing the remainder, up to the total premium.[26] Under this arrangement, DOD's—and thus the government's—share of the premium could be greater than the 72 percent the government now pays on average toward civilian FEHBP premiums and more in total dollars if, under separate risk pools, the military premiums are higher than civilian premiums.

Other bills could move the cost burden to beneficiaries by limiting DOD's share to what is now paid on civilian FEHBP enrollees' behalf.[27] Thus, should the military program's premiums be higher than in the federal civilian plan, beneficiaries would likely pay more than civilian enrollees. Another bill's premium-sharing arrangement would have the total premium set at civilian FEHBP levels and allow DOD to determine its premium share.[28] Under this arrangement, DOD could set different shares for different beneficiary groups such as families of enlisted personnel and officers or active duty families and retirees and their families.

Potential Concurrent Use of FEHBP and Military Health Care

Another key issue is whether military FEHBP participants would also be allowed to continue using military facilities on a space-available basis or enroll in TRICARE or both.[29] In commenting on past proposals similar to the bills, OPM has stated that military enrollees should be clearly committed to FEHBP and that it should be their exclusive vehicle for health care coverage. Also, OPM officials told us that military beneficiaries who

[26]H.R. 76, H.R. 1356, H.R. 1456, H.R. 2128, and S. 224.

[27]H.R. 1766 and S. 1334.

[28]H.R. 1631

[29]Because TRICARE Prime has no enrollment fee for active duty dependents, those who are attracted to FEHBP for its choice of plans and coverage but who still want priority for virtually free care in military facilities might pay for a very low cost FEHBP plan and also enroll in TRICARE.

enroll in FEHBP should, if they disenroll, be prevented from reenrolling in FEHBP. Disenrollment is allowed under each of the bills, and most bills propose that FEHBP cancellation be irrevocable. Nonetheless, all but three would allow concurrent DOD and FEHBP care use.[30]

Current law allows eligible military beneficiaries access to space-available military facility care and TRICARE civilian care, regardless of other insurance coverage. Also, military retirees who are now active or retired federal employees and are FEHBP enrollees have both benefits—although neither OPM nor DOD has analyzed how much they use either care source. Such dual use and the lack of a total enrolled population have exacerbated the MHS's recurring problems with respect to estimating and budgeting for care use and containing costs. DOD estimates that about two-thirds of eligible beneficiaries who are not active duty members rely on the DOD system, although the numbers of those who partially use the system along with other benefits is likely much larger.

Should concurrent DOD and FEHBP use be allowed, the government would in effect be providing affected beneficiaries with coverage that is duplicative and unnecessarily costly. If beneficiaries were required to elect either FEHBP or DOD care, such benefit redundancy and associated costs could be guarded against. Precedent for such a requirement already exists in DOD's Uniformed Services Treatment Facilities (USTF) managed care program, under which enrollees agree to receive all their care from that program and forgo DOD care and Medicare.[31]

Allowing concurrent FEHBP and DOD care use also has DOD sizing and readiness implications.[32] Should many current DOD care users switch to FEHBP, prohibiting concurrent use would allow DOD to downsize or close additional military facilities to help fund FEHBP costs. As it is, DOD's $15.6 billion annual MHS appropriation is not sufficient to fund care for all DOD-eligible beneficiaries; it will fund only those now using the system. Therefore, should FEHBP attract beneficiaries not now using DOD, then system downsizing may not be feasible and the added costs could be significant.

[30]H.R. 1631, H.R. 2128, and S. 224 would prohibit concurrent use of DOD and FEHBP.

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

[32]In June 1997, we reported that the MHS's current size and structure relative to its wartime mission are being evaluated and that further downsizing in line with reduced wartime needs is predicted. The training needs of DOD physicians and the "medical readiness" tenet that military facilities have a mix of patients of all ages to keep physicians ready for wartime may be difficult to meet if large numbers of beneficiaries receive care outside MHS. See GAO/HEHS-97-134, June 20, 1997.

Should concurrent use be allowed, however, some revenue could be generated by DOD's collecting third-party payments from FEHBP plans. FEHBP plans are now permitted to reimburse MTFs that provide care to dually eligible beneficiaries. In such cases, the FEHBP plan is the primary insurer. In contrast, when a Medicare-eligible beneficiary is also enrolled in FEHBP, Medicare is usually the primary payer and the FEHBP plan is the secondary payer. Because MTFs are currently prohibited by law from billing Medicare (except under the Medicare subvention demonstration), revenue from Medicare-eligibles enrolled in FEHBP plans would be less than that from younger beneficiaries. Also, DOD facilities are usually not part of FEHBP HMOs' provider networks and thus would likely receive reimbursement only for providing emergency care to DOD eligibles enrolled in those plans. Moreover, should large numbers of DOD beneficiaries enroll in FEHBP and reduce their DOD care use without consequent direct care downsizing, DOD might need to seek out FEHBP enrollees who are also DOD beneficiaries in order to maintain facility use levels and might need to continue to aggressively seek FEHBP plan reimbursement to help offset its overall costs.

Benefit Equity

In creating the TRICARE Prime benefit, members of the Congress and DOD sought reduced out-of-pocket costs for all beneficiaries, including an enrollment fee of zero for active duty members and their families and low fees for retirees and their dependents. The resulting TRICARE Prime fees are two-tiered. Active duty members and their families pay no annual fees or deductibles, while retirees annually pay $230 per individual or $460 per family.

Most of the bills we reviewed would structure the FEHBP option such that military enrollees would pay the same dollar amount as similarly situated federal enrollees—that is, no payment differential would be made based on grade or position.[33] Currently, civilian enrollees in FEHBP plans pay the same amount per plan regardless of their grade or position. Other bills would authorize DOD to determine the premium share that it would pay, thus enabling it, should it choose, to structure premiums so that they account for enrollees' beneficiary category, such as is done in TRICARE.[34] The premium amounts charged to military beneficiaries would likely have significant effects on how many chose to enroll in FEHBP. Moreover, beneficiary groups have expressed concern that FEHBP plans may be less

[33]H.R. 76, H.R. 1356, H.R. 1456, H.R. 2128, and S. 224.

[34]H.R. 1631, H.R. 1766, and S. 1334.

affordable for enlisted members than for officers.[35] Nonetheless, such groups believe that many beneficiaries would be willing to pay the added FEHBP costs for its choice and care availability.

Testing an FEHBP Option

Some of the bills authorize a demonstration program before deciding on full implementation.[36] In our view, this would be prudent, particularly with respect to determining the extent of beneficiaries' interest in the program and, thus, providing a better basis for estimating program costs. But enough carefully chosen sites will be needed so that the results might be generally representative of a program implemented nationwide. Health care use and choices tend to be relatively local and, thus, a test with too few localities and types of health care options could have results that would not be replicated across the country. However, limiting enrollment and sites would allow the test to be appropriately isolated, would allow its results to be compared with control sites, and would otherwise allow it to be properly studied.

The demonstration's evaluation would be critical to determining whether to authorize more widespread use of the program. Such an evaluation, however, would need to have open access to all enrollment, use, and cost records of DOD, OPM, and the participating FEHBP plans.

Agency Comments

Officials from DOD and OPM provided oral comments on a draft of this report. DOD and OPM generally agreed with our representation of the facts and related issues. They provided technical comments that we have incorporated where appropriate.

[35]Approximately 84 percent of active duty members are enlisted, and 70 percent of retirees are former enlisted members.

[36]H.R. 1766, H.R. 2100, and S. 1334.

Major contributors to this report were Catherine O'Hara, Evaluator-in-Charge, and Mary Reich, Office of the General Counsel. If you have any questions or would like to discuss the matters further, please call me at (202) 512-7101 or Dan Brier, Assistant Director, at (202) 512-6803.

Sincerely yours,

Stephen P. Backhus
Director, Veterans' Affairs
and Military Health Care Issues

Contents

Abbreviations

CBO	Congressional Budget Office
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
HMO	health maintenance organization
OPM	Office of Personnel Management
MHS	military health system
MTF	medical treatment facility
PPO	preferred provider organization
USTF	Uniformed Services Treatment Facilities

The Bills in the 105th Congress

We reviewed nine bills introduced in the 105th Congress that would authorize enrollment in FEHBP plans for selected military beneficiary groups. In this appendix, we provide our detailed analysis of each bill, including eligibility and premium-sharing provisions, whether concurrent use of DOD health care is allowed, and the implications for MHS operations and beneficiary costs.

Bills Authorizing Nationwide Implementation

H.R. 76: Rep. James P. Moran

This bill allows nationwide FEHBP participation by certain Medicare-eligible military beneficiaries. There are approximately 1.3 million such beneficiaries; however, the bill allows OPM to limit enrollment if it deems this necessary for managing the program. The bill also allows enrollees to continue receiving services from military medical facilities, DOD's civilian TRICARE network, and TRICARE Standard providers—while permitting DOD to bill FEHBP plans for care from any such sources. Military enrollees would be a separate risk pool with separately calculated premiums. Beneficiaries would pay the same dollar amount toward plan premiums as similarly situated federal employees, and DOD would pay the amount remaining in the total premium after the enrollees' contribution. A beneficiary's decision to disenroll from FEHBP would mean that he or she could not return to FEHBP. With disenrollees barred from reenrolling, the system's stability would be maintained. Finally, the bill requires an extensive evaluation to measure participation, out-of-pocket costs, and overall government costs, as well as an analysis of the program's effects on the military health care system's cost and access and use rates.

While military beneficiary groups in the Military Coalition extensively support the enactment of legislation authorizing nationwide FEHBP participation immediately, they believe that the approach's high potential cost would likely doom any bill's passage. Thus, they have chosen to support Representative Moran's more limited demonstration legislation, H.R. 1766, to gather evidence that the program is cost-effective.

H.R. 1356: Rep. J. C. Watts, Jr.

This bill approves nationwide FEHBP participation for Medicare-eligible military beneficiaries, other beneficiaries who cannot enroll in TRICARE

because of capacity or geographic limits, and those who are not guaranteed care access under TRICARE Standard comparable to the FEHBP plan with the most generous benefit, such as the Blue Cross and Blue Shield high-option plan. Premium-setting and sharing provisions are the same as for H.R. 76. Also, the bill contains reporting requirements identical to those in H.R. 76. In addition, the bill mandates that TRICARE Standard benefits be comparable to the highest benefits offered under FEHBP and that provider reimbursement rates be the same as the highest FEHBP plan.

Provisions requiring that TRICARE Standard benefits and reimbursements be equal to those of the highest FEHBP plan's level would be difficult and costly to implement. While the benefit package offered under a plan such as FEHBP's Blue Cross and Blue Shield high option may be more generous than TRICARE in terms of covered services and copayments, the option's total premium cost—at $7,250 annually for a family (enrollee pays $3,551, government pays $3,699)—is one of FEHBP's highest. And participation in TRICARE Standard and Extra requires no premiums. Thus, improving the TRICARE Standard benefit without a comparable increase in beneficiary contributions would be likely to increase DOD's total cost.

Further, requiring that provider reimbursements be equal to the highest option under FEHBP would entail determining actual provider reimbursements under FEHBP. This would be extremely difficult because of the wide range of reimbursement methods across plans, because plans guard this information as proprietary, and because OPM does not maintain records on this type of information. Further, if current rates are bringing about desired care access and quality outcomes, then increasing them to coincide with the highest FEHBP rates becomes cost-ineffective.

Eligibility under this bill's provisions would also be likely to extend to few active duty dependents or younger retirees, because the required benefit change would mean that no TRICARE-eligible beneficiary would have a benefit level less than Blue Cross and Blue Shield high option. Further, where TRICARE Prime is available, according to DOD, no eligible beneficiary has been refused enrollment. Also, TRICARE Prime availability is expanding and is now available in 90 percent of the zip codes in many regions, and new contracts require coverage wherever active duty members live. Thus, only Medicare-eligible beneficiaries would be likely to be eligible for FEHBP under the bill's terms.

Beneficiary associations affiliated with the Veterans' Alliance, such as the National Association of the Uniformed Services, favor Representative

Watts's bill because it would restore the TRICARE Standard benefit level to that in the legislation authorizing the civilian health insurance benefit for military beneficiaries—the Dependents' Medical Care Act of 1956. Further, they support immediate enactment and nationwide FEHBP implementation instead of an initial demonstration because many senior beneficiaries would benefit immediately rather than in a phased-in way through a demonstration.

H.R. 1456: Rep. William M. Thornberry

This bill authorizes nationwide FEHBP participation for about 1.3 million Medicare-eligible military retirees, dependents, and survivors at the same contribution amount as federal employees and retirees. There would be a separate risk pool, and DOD would pay the difference between enrollees' contributions and the total premiums. FEHBP enrollees would continue to be eligible for military facilities' space-available care, and DOD would be permitted to bill FEHBP plans for care that its facilities provided to those enrollees. Also, the bill authorizes Medicare reimbursement for Medicare-eligible beneficiaries cared for in the military medical care system—known as Medicare subvention. Further, the bill requires DOD to pay the late-enrollment penalties for beneficiaries who fail to enroll in Medicare part B, the Medicare portion covering physicians' visits, outpatient care, laboratory tests, and home medical equipment. This bill requires that DOD and OPM conduct an annual study of the FEHBP provisions and that improvements be made to the TRICARE program similar to those under H.R. 1356. If those changes are not made, the bill requires that beneficiaries other than Medicare-eligibles be allowed to participate in FEHBP as well.

The 1997 Balanced Budget Act authorized a 3-year demonstration of Medicare subvention at six sites beginning in 1998. The passage of H.R. 1456, therefore, would likely supersede the demonstration before its viability and cost-effectiveness data could be studied. We are now evaluating this demonstration and are required to provide annual reports to the Congress during its 3-year duration. Our June 1997 report on alternatives for military retirees' health care analyzed the Medicare subvention approach to providing senior retirees' care at military facilities and compared that approach with the FEHBP option, among others.[37]

Enrollment in Medicare part B is voluntary. However, if beneficiaries do not enroll at age 65, when they are first eligible, they must pay a penalty should they later do so. That penalty is substantial, calculated at

[37]GAO/HEHS-97-134, June 20, 1997.

10 percent of the monthly premium for each year past the first year of eligibility. Thus, a 65-year-old beneficiary who does not enroll and chooses to do so at age 70 faces a monthly premium 50-percent higher than the normal premium. According to a recent DOD survey, approximately 10 percent of military retirees aged 65 and older do not have Medicare part B. FEHBP participation does not require that Medicare-eligible beneficiaries be enrolled in part B, and neither does this bill. However, because each fee-for-service FEHBP plan waives its hospital and medical deductibles and copayment for members enrolled in part A and part B, if beneficiaries do have part B and choose such a plan as Blue Cross and Blue Shield, they would have nearly 100-percent coverage. Because part B is not required but adds to the benefit for enrollees, having DOD pay the part B penalties would seem to be an unnecessary expense for DOD.

H.R. 1631: Rep. John L. Mica

This bill authorizes FEHBP participation for all active duty dependents, retirees and their dependents, and survivors. It also extends the FEHBP option to certain former spouses of military members and retirees and to persons eligible for continued DOD health care system coverage. We estimate that about 6.5 million beneficiaries would be eligible for participation. The bill, however, temporarily limits the total number of program participants to 100,000 the first year, 200,000 the second year, and 400,000 the third year, with participants to be selected randomly from all those who are eligible and seeking to enroll.

The FEHBP enrollees are ineligible for military facility care or TRICARE and must stay in FEHBP for a minimum of 3 years. However, the bill does permit DOD to contract with plans to provide certain services to military beneficiaries enrolled in FEHBP plans. If FEHBP coverage is dropped, beneficiaries could not reenroll in FEHBP until the 3-year period passes. Further, eligibility for DOD care cannot be restored until the 3-year period passes. Thus, beneficiaries who disenrolled from FEHBP before the end of the 3-year enrollment term would be without DOD or FEHBP health care coverage until the end of that period. The total FEHBP premium charges are the same as in the civilian federal program. Beneficiaries' premium charges are based on the contribution made by DOD. The bill does not require DOD to contribute a particular amount toward the FEHBP plan but allows the Secretary of Defense to determine the amount of DOD's contribution.

Comparatively, this bill offers the least restrictive eligibility, and it would be phased in over 3 years. The phase-in period would allow for testing and

needed program refinements before full implementation. Further, requiring beneficiaries to elect either the military care system or FEHBP would help stabilize both programs' beneficiary population and aid in forecasting costs and care use.

H.R. 2128: Rep. Clifford Stearns

This bill authorizes FEHBP participation for the 1.3 million Medicare-eligible DOD beneficiaries and prohibits concurrent eligibility for military facility care, but FEHBP disenrollment is irrevocable. Beneficiaries' FEHBP premium share is the same amount as for similarly situated federal employees, and a separate military enrollee risk pool would be established. DOD would contribute the remaining amount up to the total premium. Like all the bills but H.R. 1631 and H.R. 2100, it requires DOD and OPM to extensively study the program each year of its operation. Representative Stearns has also introduced a bill, H.R. 2100, that authorizes an FEHBP demonstration.

S. 224: Sen. John W. Warner

This bill authorizes FEHBP participation by Medicare-eligible beneficiaries in lieu of DOD facility care. The bill allows OPM to limit enrollment if necessary for management purposes. Enrollees' FEHBP premiums are the same amount as for similarly situated federal employees, and a separate military enrollee risk pool would be established. DOD would contribute the remaining amount up to the total premium. Beneficiaries who disenrolled from FEHBP and returned to the DOD system would not be permitted to reenroll in FEHBP. Annual DOD and OPM reports, similar to those of H.R. 2128, would also be required.

Bills Authorizing FEHBP Demonstration Project

H.R. 1766: Rep. James P. Moran and S. 1334: Sen. Kit Bond

These two bills are identical and authorize a 2- to 3-year demonstration program for Medicare-eligible beneficiaries at two sites. The bills set forth that the sites should be (1) an area that includes one or more military medical facilities and contains fewer than 25,000 eligible beneficiaries and (2) an area that does not include any military medical facility but contains fewer than 25,000 who are eligible. Enrollees do not need Medicare part B

coverage, but the bills require that enrollees with such coverage retain it throughout the demonstration. A separate risk pool would be established, and DOD's premium share could not exceed that paid for a civilian FEHBP enrollee in the same plan. Therefore, if their total premiums were higher, military enrollees might pay more for FEHBP plans than civilians. Those who disenrolled from FEHBP could not reenroll during the demonstration. These bills also require annual DOD and OPM studies to address participation rates, beneficiary and government costs, and a cost comparison with other care alternatives.

Limiting enrollment under these demonstration bills limits the government's cost and provides some evidence of military beneficiaries' interest in the program. But using only two test sites might limit the usefulness for predicting the effects of nationwide implementation. Because Medicare and FEHBP choices vary widely in different areas of the country and because military facilities also differ markedly, it would be difficult to select sites from among those meeting the bills' proposed criteria where results would be representative of the country as a whole. Only the San Diego Naval Hospital, California, and MacDill Air Force Base, Florida, catchment areas and six noncatchment areas—northern and southern California, eastern Florida, eastern Texas, and the states of Georgia and Pennsylvania—have more than 25,000 Medicare-eligible beneficiaries. Thus, all other areas in the continental United States would be possible test sites.

H.R. 2100: Rep. Clifford Stearns

This bill authorizes a 2-year FEHBP test in at least one DOD health care region for all Medicare-eligible beneficiaries in the test area and active duty dependents and retirees under age 65 who live in the test region but outside the TRICARE Prime option's availability range. The bill does not address cost-sharing requirements, whether concurrent eligibility for military facility care would be allowed, or whether separate risk pools would be established. Unlike the other bills, demonstration participants could also use medical savings accounts. Participants are allowed up to a 25-percent tax credit for payments made annually to their medical savings accounts. The bill requires DOD, in consultation with the Treasury Department, to prepare a demonstration implementation plan within 6 months of enactment.

Testing the program in one or more DOD health care regions might provide a better basis for determining participation rates and program costs than would the more limited H.R. 1766 and S. 1334 tests, but it might not be

possible to choose regions that typify all DOD's regions. Which regions are selected would also determine how many younger beneficiaries would be eligible for the demonstration, because TRICARE Prime availability still varies markedly from region to region. In regions that saw early implementation of TRICARE, offering the Prime benefit was generally not required outside military facility catchment areas.

Comparison of TRICARE Coverage and Costs

Table II.1: Comparison of Tricare Prime Coverage and Costs to Selected FEHBP HMO Plans

	TRICARE Prime			FEHBP		
	Junior enlisted active duty families	**Officer and senior enlisted active duty families**	**Retirees and family**	**Foundation Health HMO, Florida**	**Kaiser Foundation HMO, California**	**Prudential HealthCare HMO (Mid-Atlantic)**
Annual fee or premium (single/family)	$0/$0	$0/$0	$230/$460	$279/$787	$465/$1,111	$671/ $1,552
Catastrophic limit on out-of-pocket costs	$1,000	$1,000	$3,000	Limited to stated copayments	$1,500 self $3,000 family	$3,308 self; $8,593 family
Outpatient visits	$6	$12	$12	$3	$5	$5 primary; $10 specialty
Emergency room visits	$10	$30	$30	$25 copayment and charges not covered	$25 copayment and charges not covered	$50 copayment and charges not covered
Mental health visits	$12	$25	$25	$20 40-visit limit	$10/individual or $5/group therapy; 40-visit limit	20% visit 1-5; 35% visit 6-30; 50% visit 31+
Ambulatory surgery	$25	$25	$25	$0	$5	$0
Prescriptions (free in military facilities to all beneficiaries)	$5 (30-day supply retail); $4 (90-day supply, mail-order)	$5 (30-day supply retail); $4 (90-day supply, mail-order)	$9 (30-day supply retail); $8 (90-day supply, mail-order)	$5	$5	$5 generic drugs; $10 brand name drugs
Inpatient per diem, general	$11 ($25 minimum)	$11 ($25 minimum)	$11 ($25 minimum)	$0	$0	$0

Table II.2: Comparison of TRICARE Extra and Standard Coverage and Costs to FEHBP's Blue Cross and Blue Shield Standard Option Plan

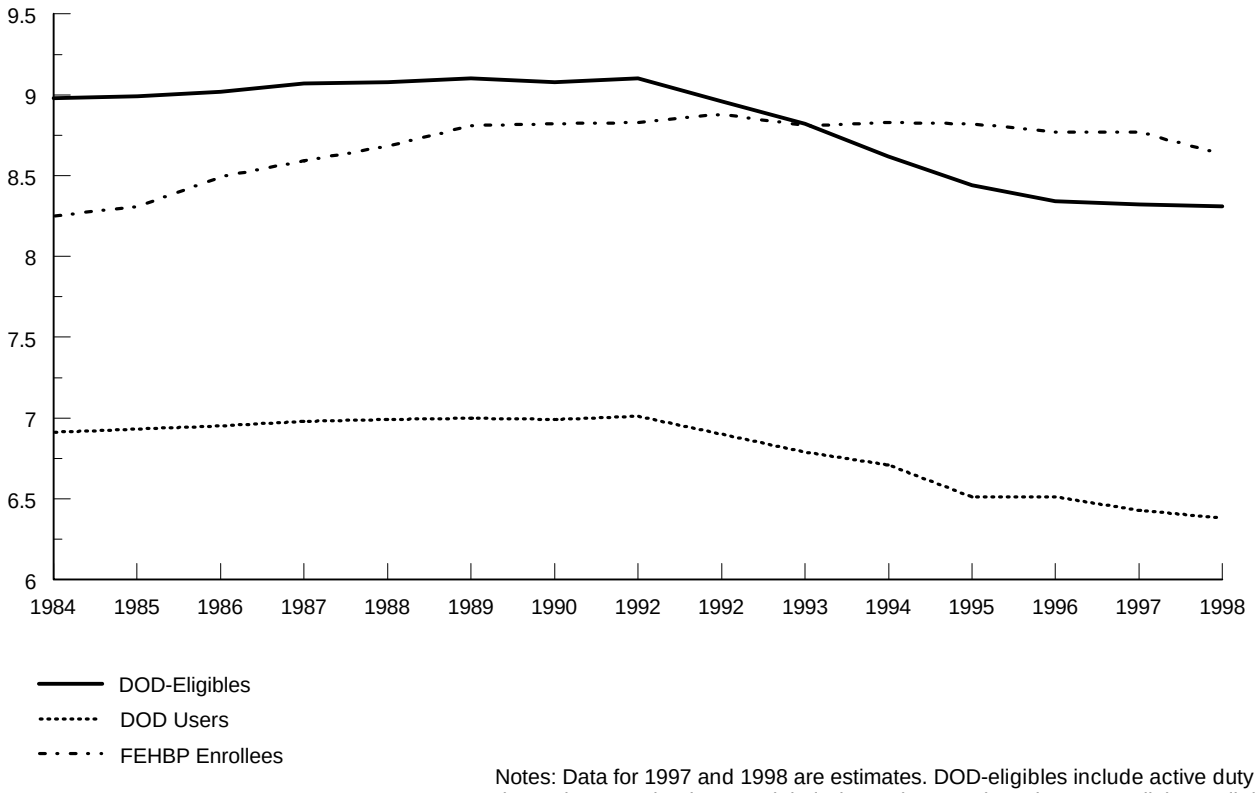
	TRICARE			FEHBP
	Junior enlisted active duty families	**Officer and senior enlisted active duty families**	**Retirees and family**	**Blue Cross and Blue Shield Standard Option Plan (Non-PPO/PPO)**
Annual enrollment fee or premium	$0	$0	$0	Non-PPO and PPO: $604 single, $1,471 family
Deductible	$50 single; $100 family	$150 single; $300 family	$150 single; $300 family	Non-PPO and PPO: $200 single, $400 family
Catastrophic limit	$1,000 family	$1,000 family	$7,500 family	Non-PPO: $3,750 single or family. PPO: $2,000
Outpatient care	Standard: 20% of allowable charge. Extra: 15% of negotiated fee	Standard: 20% of allowable charge. Extra: 15% of negotiated fee	Standard: 25% of allowable charge. Extra: 20% of negotiated fee	Non-PPO: 25%. PPO: $10 per visit
Prescription drugs (free in military facilities to all beneficiaries)	Standard retail (30-day supply): pay 20% after paying deductible. Extra network retail (30-day supply): 15% cost share after paying deductible. Mail order (90-day supply): $4	Standard retail (30-day supply): pay 20% after paying deductible. Extra network retail (30-day supply): 15% cost share after paying deductible. Mail order (90-day supply): $4	Standard retail (30-day supply): pay 25% after paying deductible. Extra network retail (30-day supply): 20% cost share after paying deductible. Mail order (90-day supply): $8	Non-PPO and PPO: 20% after $50 single or $100 family annual deductible at preferred pharmacies. Mail order: $12 for 90-day supply, no deductible
Inpatient care	Greater of $25 or $9.90 per day, Standard or Extra	Greater of $25 or $9.90 per day, Standard or Extra	Standard: lesser of $360/day or 25% of billed charges plus 25% of professional fees. Extra: lesser of $250/day or 25% of billed charges plus 20% of professional fees	Non-PPO: 25% of professional fees, 0% copayment after $250/admission deductible. PPO: 5% of professional fees, no copayment or deductible

Historical Comparison of the Defense Health Program and FEHBP

DOD and FEHBP Populations Have Declined Recently

From a high in 1992, both DOD and FEHBP have experienced recent declines in beneficiary numbers (see fig. III.1). Not all persons eligible for DOD care actually use it, because they live too far from military facilities, have other sources of health insurance and health care, or face resource limits in gaining access to military facilities. DOD has estimated that about 75 percent of eligible beneficiaries use the DOD system. More than 85 percent of federal employees participate in FEHBP.

Figure III.1: DOD and FEHBP Beneficiaries, Fiscal Years 1984-98

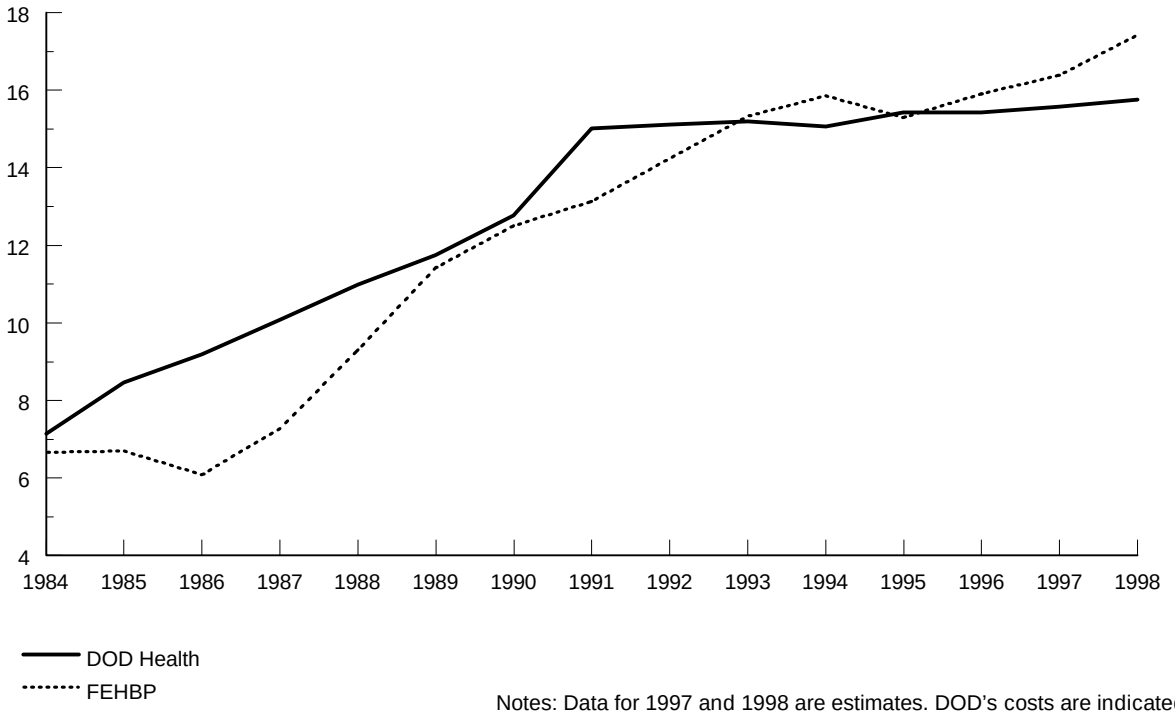


Notes: Data for 1997 and 1998 are estimates. DOD-eligibles include active duty personnel, their dependents, and retirees and their dependents and survivors. Not all those eligible for care from DOD use it, because they live too far from a DOD facility, have other sources of health insurance and care, or face limited access because of a lack of DOD resources. The term "DOD users" represents a DOD estimate of the number of eligible beneficiaries who rely on DOD for their care. FEHBP enrollees represent the federal employees and retirees who are enrolled in an FEHBP plan and their dependents.

Defense Health and FEHBP Costs Have More Than Doubled Since 1984

Like the private health care industry, both DOD and FEHBP have experienced increases in their costs since 1984 (see fig. III.2). In the past 5 years, however, DOD's costs have increased almost 4 percent, while FEHBP's have grown by almost 14 percent.

Figure III.2: DOD Health and FEHBP Costs, Fiscal Years 1984-98

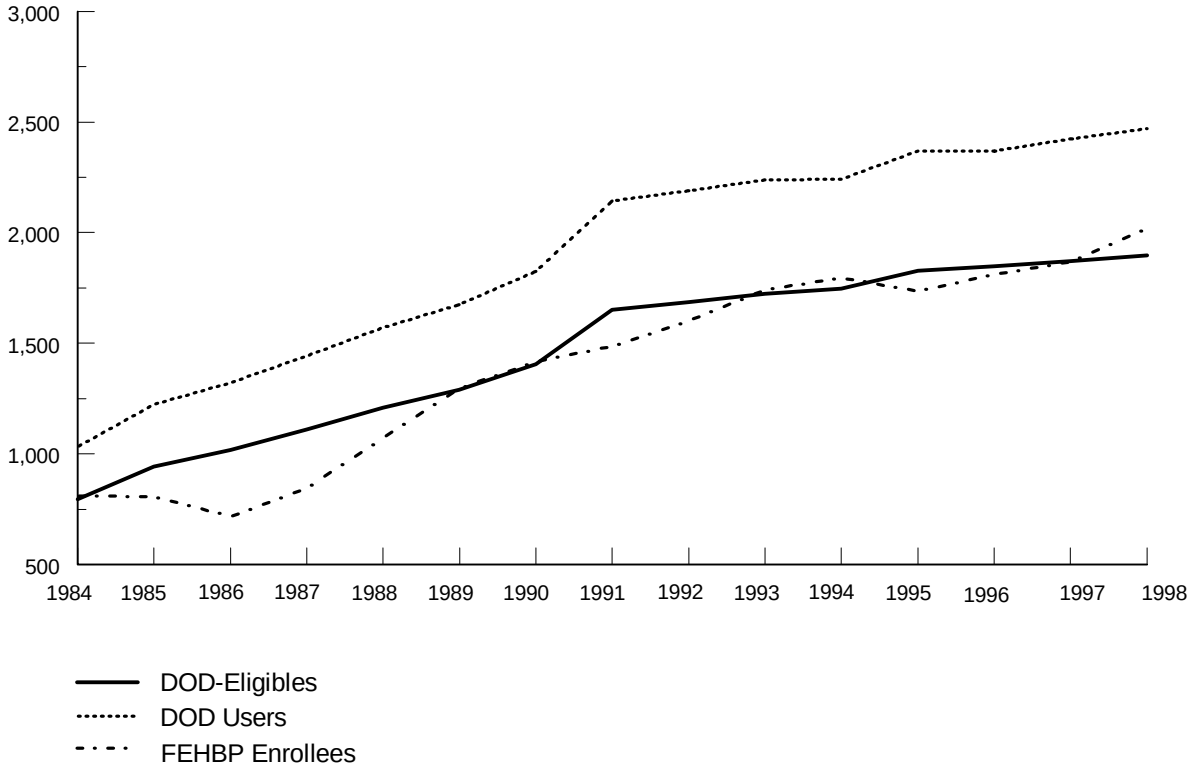


Notes: Data for 1997 and 1998 are estimates. DOD's costs are indicated by its health budget, which includes all DOD medical activities, including readiness, veterinary, training, occupational health, construction, procurement, and peacetime health care services to beneficiaries. Recent DOD budget studies have found that approximately 22 percent of DOD's health care budget pays for activities uniquely related to wartime and is not used for providing peacetime health care. The budget shown has not subtracted out those unique military costs. FEHBP's costs are in the sum of premiums paid by the government and enrollees plus the administrative costs incurred by OPM. It does not include the costs to federal agencies of administering FEHBP nor does it include beneficiary out-of-pocket costs after premium payments.

DOD and FEHBP per Capita Costs Are Also More Than Double Those of 1984

On a per person basis, DOD and FEHBP have both experienced increases of more than 100 percent since 1984 (see fig. III.3). In the past 5 years, DOD's cost per user has risen by about 10 percent, while FEHBP's has grown almost 16 percent.

Figure III.3: DOD Health and FEHBP per Capita Costs, Fiscal Years 1984-98



Notes: Data for 1997 and 1998 are estimates. The per capita costs for DOD have not subtracted out the unique military costs that are not comparable to FEHBP's costs. Therefore, the per capita costs for DOD may be overstated. Further, DOD beneficiaries pay very low or no premiums for DOD care, thus raising the cost to DOD of providing the peacetime benefit.

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: 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: 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).

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