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DEFENSE HEALTH PROGRAM

Reporting of Funding Adjustments Would Assist Congressional Oversight

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The Honorable Jerry Lewis
Chairman, Subcommittee on Defense
Committee on Appropriations
House of Representatives

Dear Mr. Chairman:

As one of the largest health care providers in the nation, the Department of Defense (DOD) has experienced many of the same challenges as the private sector health care industry—including rising costs, problems with access to care, and lack of a uniform benefit. Between fiscal years 1994 and 1998, the Congress appropriated $48.9 billion for DOD's Defense Health Program (DHP) to provide medical and dental services to active duty personnel and their families and retired military personnel. These funds were appropriated for DHP operations and maintenance (O&M) expenses.[1] They were primarily used to deliver patient care in DOD's direct care system of service-operated military treatment facilities (MTF) or to purchase care through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and seven TRICARE managed care support (MCS) contracts.[2]

Each year, the Congress appropriates funds for DHP O&M expenses after reviewing and making adjustments to DOD's budget request. DOD's request estimates dollar requirements for the entire DHP and shows how proposed spending would be allocated among seven major health care subactivities (for example, direct care, purchased care, training) and the 34 specific program elements. After the Congress appropriates overall DHP funding, DOD allocates its appropriation among the seven DHP subactivities and the 34 program elements. These budget allocations generally align with the budget request estimates, and DOD reports the allocated amounts back to

[1]In addition to the DHP O&M appropriation, the Congress appropriates funds to cover other military health system costs. For example, in fiscal year 1999, the Congress appropriated a total of about $15.9 billion for the military health system. This included $9.9 billion for DHP O&M; $5.3 billion for military personnel; $401 million for DHP procurement; $228 million for military construction; and $19.4 million for research and development.

[2]DOD administered CHAMPUS as an insurance-like program to pay for a portion of the care military families and retirees under age 65 received from private sector providers. Under its TRICARE managed care reform effort, DOD phased out CHAMPUS between 1995 and 1998 and now purchases private health care and administrative services nationwide from major health care companies under its MCS contracts.

the Congress with the next fiscal year's budget request. Actual obligations,[3] however, are separately reported two years later to the Congress with that subsequent fiscal year's budget request.

The previous subcommittee chairman raised concerns about apparent discrepancies between DOD's budget allocations and the actual obligations for direct and purchased care. The chairman asked that we determine (1) the extent to which DHP obligations have differed from DOD's budget allocations, particularly for MCS contracts; (2) the reasons for any such differences; and (3) whether congressional oversight of DHP funding changes could be enhanced if DOD provided notification or budget execution data. In doing our work, we interviewed and obtained documentation from budget officials of the Office of the Secretary of Defense (Comptroller); the Office of the Assistant Secretary of Defense (Health Affairs); the TRICARE Management Activity (TMA); and the Army, Navy, and Air Force Surgeons General. Because MCS contracts became a DHP program element in fiscal year 1994, we analyzed fiscal years 1994 through 1998 budget data. DOD provided the data on DHP O&M requests, budget allocations, and obligations between 1994 and 1998 by subactivity and program element.[4] We reviewed these data for internal consistency, where possible, but did not independently review source data to validate its accuracy. We performed our work between August 1998 and March 1999 in conformance with generally accepted government auditing standards.

Results in Brief

Between fiscal years 1994 and 1998, the Congress appropriated $48.9 billion for DHP O&M expenses. During that period, DHP obligations at the subactivity level, particularly for direct and purchased care, differed in significant ways from DOD's budget allocations. In total, about $4.8 billion was obligated differently—as either increases to or decreases from the budget allocations DOD had developed for the seven DHP subactivities. Between 1994 and 1998 for example, DOD decreased its purchased care obligations by about $2 billion and adjusted direct patient care and information technology obligations by $1.4 billion. DOD also moved varying amounts into and out of such other subactivities as MTF base operations, medical education, and management activities.

[3]Amounts of orders placed, contracts awarded, services received, and similar transactions during a given period that will require payments during the same or future period.

[4]In compiling the 1994 through 1998 data, DOD used the program element structure for the fiscal year 2000 DHP budget request and made adjustments for prior years to ensure accurate comparisons.

These funding changes occurred because of internal DOD policy choices and other major program changes. According to DOD, its strategy was to fully fund purchased care activities within available funding levels. This strategy left less to budget for direct care and other DHP subactivities. TMA officials also told us that because the DHP has both direct and purchased care components, whereby many beneficiaries can access either system to obtain health care, it is difficult to reliably estimate annual demand and costs for each component. Between 1994 and 1996, purchased care obligations were $1.9 billion less than allocated because of faulty physician payment rate and actuarial assumptions. Between 1994 and 1998, direct patient care obligations amounted to $1 billion more than DOD had allocated—during a period of base closures and MTF downsizing—largely because DOD understated estimated direct care requirements. Also, between 1996 and 1998, DOD overestimated MCS contract costs, believing that contract award prices would be higher and implementation would begin sooner than what occurred. Thus, most of the unobligated MCS contract funds were used to defray higher than anticipated CHAMPUS obligations.

The movement of DHP funds from one subactivity to another does not require prior congressional notification or approval.[5] As a result, these sizeable funding changes have generally occurred without congressional awareness. Now that the MCS contracts are implemented nationwide, DOD officials expect future DHP obligations to track more closely with budget allocations. However, they also expect some level of changes to continue during budget execution, given the uncertainties in estimating the annual costs of the direct care and purchased care system components. Meanwhile, current law and regulations will continue to allow DOD the latitude to move funds between subactivities with little or no congressional oversight. Thus, congressional oversight could be enhanced if the Congress chooses to require DOD to (1) notify the congressional defense committees of its intent to shift funds among subactivities whenever the shifted amount exceeds a certain threshold amount and/or (2) provide quarterly budget execution data.

Background on the DHP O&M Budget

The DHP budget estimates submitted to the Congress consist of all the O&M and procurement resources needed to support DOD's consolidated medical

[5]As defined in DOD financial management regulation 7000.14-R (Vol. 3, Ch. 6), these actions are not considered reprogramming, which requires notification or prior approval of the Congress.

activities.[6] According to DOD, the budget estimates are based on the continued refinement and application of a managed care strategy and methodology used to produce DOD's health care services for eligible beneficiaries. Operating under the Assistant Secretary of Defense (Health Affairs), TMA is responsible for formulating the DHP budget request and for managing DOD's CHAMPUS and MCS contracts. The Surgeons General of the Army, Navy, and Air Force are responsible for the budget execution of decentralized medical activities such as direct MTF patient care.

The DHP O&M budget request consists of a single budget activity—administration and servicewide activities.[7] Each year, DOD provides detailed DHP budget information to the Congress in "justification materials" that show amounts requested for each of the 7 subactivities that encompass 34 program elements (see table 1).[8]

[6]This report addresses O&M resources, or about 96 percent of DOD's fiscal year 1999 DHP budget request. The remaining 4 percent of the DHP budget request ($401 million in fiscal year 1999) funds procurement of capital equipment in support of MTF and health care operations.

[7]In addition to the DHP O&M budget request that covers health care expenses, DOD submits O&M budget requests to finance other portions of DOD's readiness and quality-of-life priorities. O&M appropriations fund a diverse range of programs and activities that include salaries and benefits for most civilian DOD employees, depot maintenance activities, fuel purchases, flying hours, environmental restoration, base operations, and consumable supplies. Moreover, each service and DOD agency spends O&M funds.

[8]In general, non-DHP O&M budget requests are presented as four broad budget activities: operating forces, mobilization, training and recruiting, and administration and servicewide activities. These requests usually break down each budget activity into activity groups, which in turn are broken into subactivity groups, and finally into program elements. In contrast, the DHP O&M budget consists of a single budget activity—administration and servicewide activities. For comparison of the budget line items, the DHP subactivities and program elements correspond to the non-DHP O&M activity groups and subactivities line items.

Table 1: Defense Health Program Operations and Maintenance Subactivities and Program Elements

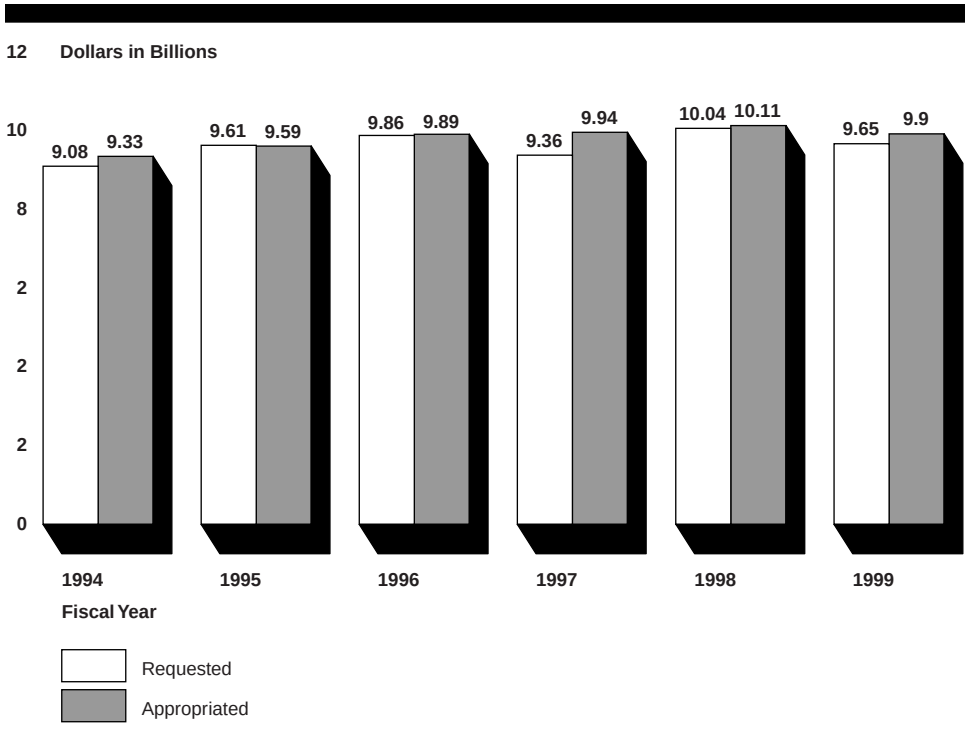
Subactivity	Pays for	Program element
In-house care (direct care)	Medical and dental care for patients in MTFs	Defense medical centers, hospitals, and medical clinics—CONUS; defense medical centers, hospitals, and medical clinics—OCONUS; dental care activities—CONUS; and dental care activities—OCONUS
Private sector care (purchased care)	Medical and dental care for patients in private sector settings	Managed care support contracts, CHAMPUS, and care in nondefense facilities
Consolidated health support	Supporting DOD's worldwide delivery of patient care	Other health activities, military public/occupational health, other unique military medical activities, aeromedical evacuation activities, Armed Forces Institute of Pathology, examining activities, and veterinary activities
Information management	Automated information systems to support military medical readiness and health care administration	Central information management
Management activities	Headquarters administration of direct care and private sector medical activities	Management headquarters and TRICARE Management Activity
Education and training	Achieving and maintaining general and specialized medical skills and abilities of military and civilian professionals	Armed Forces Health Professions Scholarship Program, Uniformed Services University of the Health Sciences, and other education and training
Base operations/ communications	Operating and maintaining DOD-owned medical and dental facilities	Minor construction—CONUS; minor construction—OCONUS; maintenance and repair—CONUS; maintenance and repair—OCONUS; real property services—CONUS; real property services—OCONUS; base operations—CONUS; base operations—OCONUS; base communication—CONUS; base communication—OCONUS; environmental conservation; environmental compliance; pollution prevention; and visual information activities

Note: CONUS means continental United States; OCONUS means outside the continental United States.

Source: Department of Defense Comptroller.

While the Congress appropriates DHP O&M funds as a single lump sum, its budget decision is based on the DHP budget request presented at the subactivity and program element levels. Since 1994, the Congress has generally appropriated more for DHP O&M expenses than DOD requested (see fig. 1).

Figure 1: Defense Health Program Operations and Maintenance Budget Status, Fiscal Years 1994–99



Source: TMA Office of Resource Management.

Committee reports may specify relatively small amounts of funding for such items as breast cancer and ovarian cancer research, which DOD then obligates through the appropriate account in accordance with congressional direction.[9] Other than the funds specifically earmarked by the Congress, DOD has the latitude to allocate its congressional appropriation as needed to meet estimated subactivity and program element requirements. Between 1994 and 1999, DOD allocated most appropriations to direct care (primarily MTF patient care) and to purchased care (primarily CHAMPUS and MCS contracts). Table 2 shows the allocation of DHP appropriations by subactivity (see tables I.1 and I.2 for detailed information on DHP budget requests, budget allocations, and actual or currently estimated obligations between fiscal years 1994 and 1999).

[9]Between fiscal years 1994 and 1999, of the total $58.7 billion DHP O&M appropriation, the Congress specified about $929 million in funding for designated activities.

Table 2: DOD's Allocation of Defense Health Program Operations and Maintenance Appropriations by Subactivity, Fiscal Years 1994-99

Dollars in billions

Subactivity	1994	1995	1996	1997	1998	1999
Direct care	$2.93	$3.06	$3.45	$3.46	$3.35	$3.15
Purchased care	4.38	4.51	4.27	3.94	4.05	4.07
Consolidated health support	0.68	0.66	0.71	0.83	0.98	0.88
Information management	0.22	0.21	0.22	0.31	0.22	0.30
Management activities	0.13	0.12	0.10	0.09	0.15	0.17
Education and training	0.25	0.26	0.22	0.29	0.32	0.31
Base operations	0.74	0.77	0.91	1.01	1.03	1.02
Total[a]	**$9.33**	**$9.59**	**$9.89**	**$9.94**	**$10.11**	**$9.90**

[a]Totals may not add because of rounding.

Source: TMA Office of Resource Management.

Significant Differences Between Budget Allocations and Obligations

The Congress appropriated $48.9 billion for DHP O&M expenses between fiscal years 1994 and 1998. During budget execution, DOD obligated about $4.8 billion differently—as either increases or decreases—from its budget allocations for the various subactivities (see table 3). Obligations differed particularly for the direct care and purchased care subactivities. However, the magnitude of the funding adjustments has diminished in recent years, dropping to about $283 million in fiscal year 1998 from a peak of almost $1.5 billion in fiscal year 1995. Because the Congress makes a lump-sum appropriation, under DOD regulations and informal arrangements with the Congress, these adjustments did not require congressional notification or approval.

Table 3: Funding Adjustments Made at the Subactivity Level During Budget Execution, Fiscal Years 1994-98

Dollars in thousands

Subactivity	1994	1995	1996	1997	1998	Magnitude of increase and decrease
Direct care	$519,842	$356,469	–$40,875	–$106,997	–$2,691	$1,026,874
Purchased care	–606,680	–727,119	–546,764	–66,069	–84,093	2,030,725
Consolidated health support	7,403	157,296	148,368	69,111	–78,332	460,510
Information management	23,393	45,458	220,467	–101,271	5,739	396,328
Management activities	–29,691	–2,938	44,715	68,118	33,628	179,090
Education and training	–23,696	16,927	59,147	4,527	13,458	117,755
Base operations	127,004	187,738	95,617	69,235	–64,904	544,498
Subtotal, increase	677,642	763,888	568,314	210,991	52,825	2,273,660
Subtotal, decrease	–660,067	–730,057	–587,639	–274,337	–230,020	–2,482,120
Magnitude of adjustment	1,337,709	1,493,945	1,155,953	485,328	282,845	4,755,780
Appropriation	**$9,326,635**	**$9,591,331**	**$9,886,961**	**$9,937,908**	**$10,108,007**	**$48,850,842**

Note: This table details funding adjustments at the subactivity level during budget execution. See table I.3 for information presented for each fiscal year on other DHP adjustments such as supplemental appropriations, rescissions, and reprogramming, as well as the amount of unobligated funds left over at the end of the fiscal year.

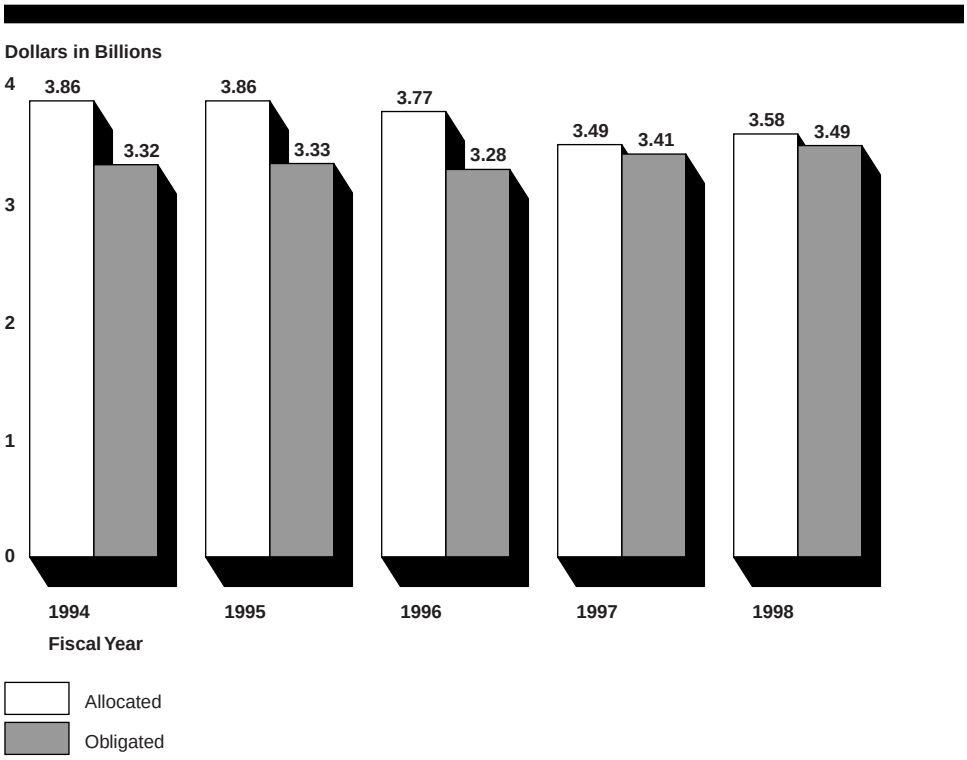
Source: TMA Office of Resource Management data.

The largest funding adjustments occurred in the direct care and purchased care subactivities. Between 1994 and 1998, DOD allocated $21.2 billion from the final DHP appropriation for purchased care but obligated only $19.1 billion, allowing DOD to reallocate $2.0 billion into such areas as direct patient care, information management, and base operations. For example, between 1994 and 1995, DOD increased obligations for direct care at MTFs by $876.3 million above the allocation. Between 1994 and 1996, DOD obligated about $289.5 million more than it had allocated for the information management subactivity. Also, funding for the base operations subactivity—which includes such items as repairs and maintenance on MTF facilities—received an increase of $479.6 million over the budget allocation between 1994 and 1997. (Table I.4 details the funding increases and decreases for each subactivity and program element between fiscal years 1994 and 1998.)

In each year between 1994 and 1998, DOD's budget allocation for purchased care—which provided funds for CHAMPUS, the now-terminated CHAMPUS

Reform Initiative contracts,[10] and MCS contracts—exceeded obligations, as shown in figure 2.

Figure 2: Comparison of CHAMPUS and MCS Contract Budget Allocations and Actual Obligations, Fiscal Years 1994-98



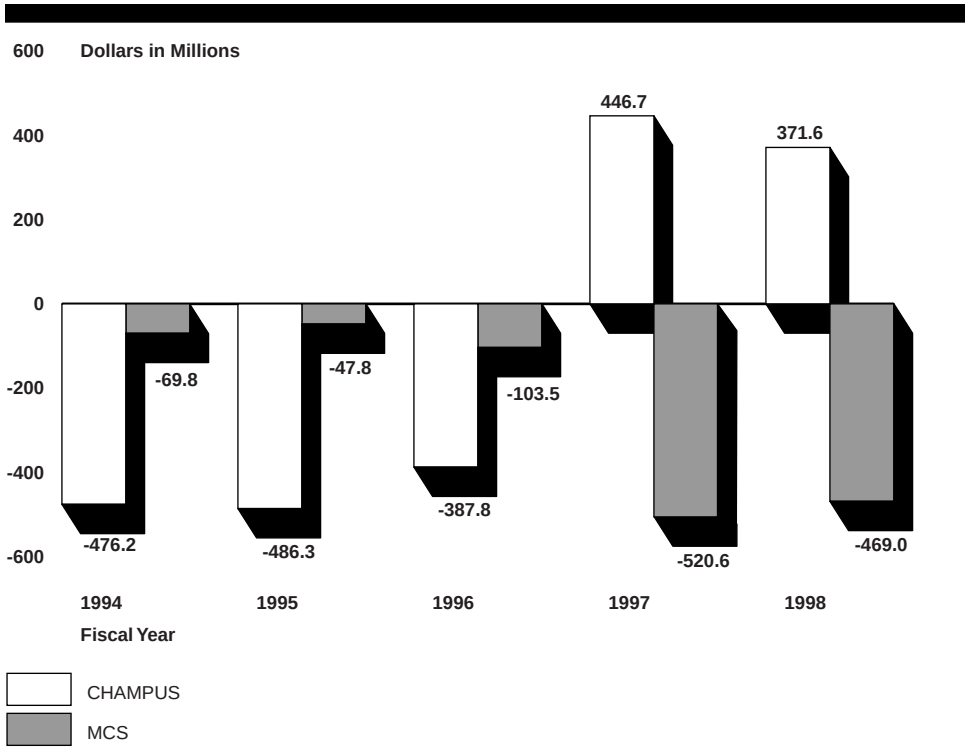
Source: TMA Office of Resource Management.

At the program element level, the largest adjustments within the purchased care subactivity occurred between 1994 and 1996, when DOD obligated $1.4 billion less than the budget allocation for the CHAMPUS program element (see table I.4 and fig. 3). In contrast, MCS contract budget allocations more closely matched obligations through 1996, when DOD implemented two of the then four awarded MCS contracts on time. In 1997 and 1998, however, when implementation of the last three contracts was delayed, MCS budget allocations exceeded obligations by $990 million. Because of the delays in starting up these contracts, most of the

[10]Between 1994 and 1996, most MCS contract obligations were used for two CHAMPUS Reform Initiative managed care contracts in Louisiana, California, and Hawaii. Budget obligations for these two contracts were $820.4 million (1994), $826.2 million (1995), and $838.2 million (1996).

unobligated MCS contract funds were used to defray higher than anticipated CHAMPUS program obligations.

Figure 3: Purchased Care Subactivity Funding Adjustments in CHAMPUS and MCS Contract Program Elements, Fiscal Years 1994-98



Source: TMA Office of Resource Management data.

DHP Obligations Differed From Budget Allocations for Several Reasons

According to DOD officials, between 1994 and 1998, DOD-wide budget pressures and major program changes—such as downsizing and the rollout of TRICARE managed care reforms—made it difficult to estimate and allocate resources between direct care and purchased care budgets. They emphasized that while they are directly responsible for appropriation amounts at the lump-sum level, they have flexibility to manage the health care delivery system. Therefore, in executing the DHP appropriation funds for patient care, such funds may flow from direct care to purchased care and vice versa. They believe this flexibility is critical to efficiently managing the military health care delivery system.[11]

DOD officials cited several interrelated reasons why DHP obligations differed from DOD's budget allocations between fiscal years 1994 and 1998. These reasons also suggest why "shortfalls" in recent DHP budget requests have prompted congressional concerns about the process DOD uses to estimate and allocate the DHP budget.

Decision to Fully Fund Purchased Care Left Less for Other Subactivities

TMA, Health Affairs, and service budget officials made various internal budget policy choices that included a DHP budget strategy to fully fund purchased care activities within available funding levels. This strategy, coupled with general budget pressures, left less money with which to budget direct care and other DHP subactivity requirements (such as information management and base operations). To keep within the DOD-wide spending caps, the officials intentionally understated requirements for direct care and other subactivities in the DHP budget requests submitted to the Congress. This pattern of policy choices, which led budget officials to underestimate direct care budget requirements, is underscored by the congressional testimonies by the Assistant Secretary of Defense (Health Affairs) and the service Surgeons General—all of whom identified shortfalls in the past 3 years of DHP budget requests, 1997 through 1999.[12] The shortfalls—that is, the difference between the Assistant Secretary's and the Surgeons General's views of their needs and the President's budget submission—have raised congressional concerns over DHP budget requests and prompted both DOD and the Congress to

[11]DOD officials commented that most of the adjustments moved between purchased care and direct care subactivities—both of which pay for the delivery of health care to beneficiaries—and that increased funding for information management also supported the implementation of managed care in the direct care system.

[12]For example, in testimony before appropriations committees on the fiscal year 1997 budget request, the Assistant Secretary of Defense (Health Affairs) and the service Surgeons General provided specific details of how a $475 million shortfall would severely reduce care and medical services to military families and retirees. One Surgeon General testified that the shortfall would force him to cut services equivalent to closing two large hospitals for an entire year.

offset the shortfalls in various ways (see table 4). In addition, TMA and service officials told us they have relied on DHP's flexibility during budget execution to fund direct patient care with funds available and not needed for CHAMPUS and MCS contracts.

Table 4: Offsets to Shortfalls in Defense Health Program Operations and Maintenance Budget Requests, Fiscal Years 1997-99

Dollars in millions

		Offset by		
Fiscal year	Budget request	DOD action	Appropriation increase	Supplemental appropriation
1997	$9,358.3	None	$475.0	None
1998	10,040.6	$274.0 (amended budget request)	None	$1.9[a]
1999	9,653.4	104.6[b] (reprogramming)	None	204.1[b]

[a]P. L. 105-174.

[b]P. L. 105-277. In addition to the almost $309 million in offsets from the supplemental appropriation and DOD reprogramming, DOD plans to take other actions in fiscal year 1999 to address the additional fiscal pressures. Planned actions include making cost-saving efficiencies within the direct care system, support activities, headquarters management, and MCS and information technology contracts.

Timing of the Budget Process Presents Challenges

TMA officials told us that forecasting health care costs for budgeting purposes is inherently challenging because the budget year starts about 18 months after DOD starts preparing DHP budget estimates and 8 months after the President submits the DHP budget request to the Congress. They commented that many conditions change, affecting their direct and purchased care estimates over these protracted periods. In our view, however, these comments do not explain the often large differences that have occurred between budget allocations—which are established after the congressional appropriation is actually received—and obligations, which follow almost immediately thereafter. DOD has the flexibility to allocate most of its congressional appropriations as needed among the various DHP subactivities. Despite this flexibility and even taking into account the minor impacts of other adjustments to DHP's allocated budget amounts such as supplemental appropriations or reprogrammings,[13] DHP

[13]Table I.3 identifies other adjustments following congressional approval of funds for DHP O&M expenses enacted through the annual appropriations act. Compared with the almost $4.8 billion in funding increases and decreases during budget execution, the impacts were minor from other adjustments: a net decrease of $139.4 million from foreign currency fluctuations, supplemental appropriations, program cancellations, rescissions, reprogrammings, transfers, and withholds; and $57.7 million in unobligated funds between 1994 and 1998.

obligations still varied significantly from the budget allocations reported to the Congress, calling into question DOD's methods for estimating DHP budget requirements.

Number of Nonenrolled Beneficiaries Causes Budget Uncertainty

TMA and Health Affairs budget officials told us that the DHP beneficiary population is largely undefined, leading to budget uncertainty. According to these officials, DOD has little control over where beneficiaries go to get their health care because MTFs and MCS contractors do not enroll most beneficiaries. TMA officials stated that, in formulating the DHP budget request, separate cost estimates for MTFs and MCS contracts are based on the best available information at the time. Although service officials told us they had developed higher direct care budget estimates—which TMA nonetheless chose to underfund in the final DHP budget requests—one official told us that the nonenrolled beneficiary population is a major impediment to submitting realistic DHP budget requests. Moreover, DOD's capitation method (allocating MTF budgets on the basis of the number of estimated users of the military health system) has not kept pace with MTF cost increases for space-available care to nonenrolled beneficiaries for medical services and outpatient prescription drugs.[14]

Others have noted similar concerns about the lack of a clearly defined beneficiary population and the effect on DHP budgeting uncertainties. For example, in a 1995 report,[15] the Congressional Budget Office (CBO) raised concerns that, even with TRICARE Prime's lower cost-sharing features providing incentives, not enough beneficiaries would enroll, and DOD would continue to have difficulties planning and budgeting. For DOD to effectively predict costs and efficiently manage the system, CBO concluded that DOD would need a universal beneficiary enrollment system to clearly identify the population for whom health care is to be provided. CBO concluded that even under TRICARE, beneficiaries can move in and out of the system as they please, relying on it for all, some, or none of their care. DOD would have to continue its reliance on surveys to estimate how many beneficiaries use direct care and purchased care and to what extent DOD is

[14]DOD has designed a new funding system—enrollment-based capitation—which is intended to motivate and reward MTF commanders for maximizing their enrolled population. Under this approach, DOD funds MTFs on the basis of the number of beneficiaries enrolled in Prime at the MTF. 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.

[15]CBO Papers: Restructuring Military Medical Care (July 1995).

their primary or secondary source of coverage. In previous reports,[16] we also raised concerns about the budgetary uncertainties caused by less-than-optimal enrollment. Moreover, at the end of fiscal year 1998, we estimate that less than half of the 8.2 million DOD-eligible beneficiaries were enrolled. Thus, DOD's budgeting uncertainties stem, in large measure, from its lack of a universal enrollment requirement.

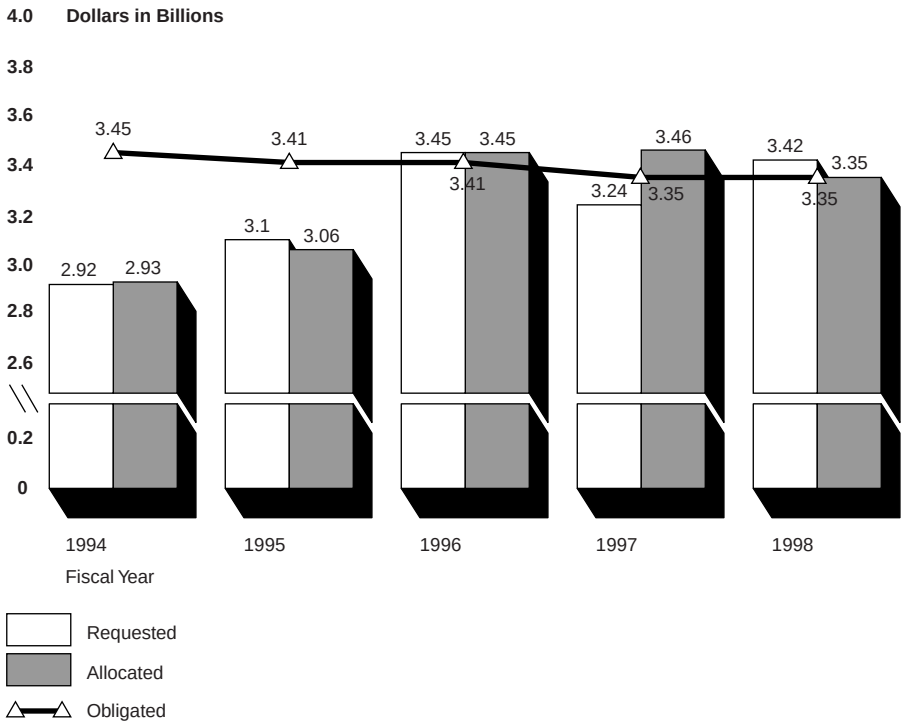
Base Closures Did Not Yield Expected Savings

Higher than expected MTF costs in fiscal years 1994 and 1995 were given as another reason that DHP obligations differed from budget allocations, according to TMA, Health Affairs, and service officials. The budget savings projected to result from base closures (and reflected in their requests) were not achieved. Therefore, although the number of MTFs decreased by 9.5 percent between 1994 and 1998, DOD wound up obligating $726 million more for direct care than the amount allocated (see fig. 4). One service official told us that despite MTF downsizing, the number of beneficiaries going to MTFs has not dropped, thus sustaining a high level of demand for MTF health care. But MTF inpatient and outpatient workload data reported to the Congress in DOD's annual justification materials indicate that MTF inpatient and outpatient workload declined by a respective 54.5 percent and 26 percent between 1994 and 1998. However, DOD and TMA officials cautioned us that the MTF workload data are not accurate. Yet, a May 1998 DOD Inspector General audit report (on the extent to which managed care utilization management savings met Health Affairs' expectations as reflected in its DHP budgets[17] found a significant reduction in inpatient and outpatient workload at 15 large MTFs from fiscal year 1994 through 1996, but no corresponding decrease in operating costs. DOD's Inspector General attributed the cause to MTFs generally increasing their military medical staffing and infrastructure costs (real property maintenance, minor construction, and housekeeping). And, according to the Inspector General, it is especially difficult to reduce operating costs when workload is reducing without decreasing military medical staffing.

[16]For more information on DOD enrollment and capitation features, see Defense Health Care: Issues and Challenges Confronting Military Medicine (GAO/HEHS-95-104, Mar. 22, 1995) and Defense Health Care: Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE (GAO/T-HEHS-98-100, Feb. 26, 1998).

[17]DOD, Office of the Inspector General, Joint Audit Report: Military Health System Utilization Management Program at Medical Centers, Report No. 98-136 (May 22, 1998).

Figure 4: Direct Care Budget Status, Fiscal Years 1994-98



Source: TMA Office of Resource Management.

Lower Purchased Care Obligations Were Not Anticipated

TMA, Health Affairs, and service officials also told us that several interrelated factors had made purchased care obligations significantly lower than the allocated amounts between 1994 and 1998. First, they did not fully account for savings from rate changes in the CHAMPUS maximum allowable charge (CMAC) for physician payments.[18] DOD officials told us that during this period, CHAMPUS budget requests and allocations did not account for $408 million to $656 million in estimated 3-year CMAC savings between 1994 and 1996. For fiscal years 1997 to 1998, DOD has estimated that CMAC saved $1.5 billion in CHAMPUS and TRICARE contract costs. Given that DHP purchased care budget requests and allocations track more closely with obligations in 1997 and 1998, it appears TMA better accounted for CMAC savings. Second, DOD officials cited a factor related to their

[18]Beginning in 1991, the Congress directed DOD to gradually lower reimbursement rates paid to civilian physicians under CHAMPUS. Physician payments had been based on charges that were 50 percent higher on average than those paid for identical treatment under the Medicare program. For more information, see Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians (GAO/HEHS-98-80, Feb. 26, 1998).

budget strategy of conservatively estimating purchased care costs. After an earlier history of CHAMPUS budget shortfalls, DOD changed its budget strategy from not fully funding CHAMPUS to ensuring CHAMPUS was fully funded.[19] However, they noted that an actuarial model for projecting CHAMPUS costs, which was used to formulate the budget requests for fiscal years 1994 through 1996, greatly overestimated CHAMPUS requirements.

Concerns About Antideficiency Act Violations Drove Decisions

Finally, with the CHAMPUS phase-out and the switch to MCS contracts, TMA and Health Affairs officials cited the need to fully fund these contracts in their budget request. According to these officials, their MCS budgeting strategy was essentially driven by the concern that if there were not enough funds allocated for the MCS contracts, an Antideficiency Act violation could occur. We do not see, however, how requesting the amount of funds DOD anticipates the contracts will actually cost could trigger an Antideficiency Act violation. Budget requests, even where they fail to fully fund an activity, do not cause such violations.

One of the ways an Antideficiency Act violation could occur is if DOD continued to pay additional amounts under the contract and overobligated or overexpended the appropriation or fund account related to the contract.[20] In such a case, the proper response would be to reprogram funds and/or seek additional appropriations in advance of any such potential deficiency. In other words, should funds allocated for the MCS contracts appear to be inadequate, DOD would find itself in essentially the same position as any agency that anticipates running short of funds. Only if DOD officials continued to make additional payments under the contract knowing that appropriations for them were not available would there be an Antideficiency Act violation.

Looking ahead, DOD officials pointed out that the amount of funds shifted between DHP subactivities had fallen in 1997 and 1998, and they anticipated that volatility within the purchased care subactivity would also decrease now that all seven MCS contracts have been implemented. Officials also stated that TMA has established new resource management controls. A quarterly workgroup process, for example, refines CHAMPUS and MCS

[19]Between 1985 and 1991, unanticipated growth in the CHAMPUS program was the main factor behind $2.8 billion budget shortfalls, much of which had to be financed through reprogramming and supplemental appropriations. For more information, see DOD Health Care: Funding Shortfalls in CHAMPUS, Fiscal Years 1985-91 (GAO/HRD-90-99BR, Mar. 19, 1990).

[20]Antideficiency Act violations can also occur when entering into a contract or making an obligation in advance of an appropriation unless authorized by law; or overobligating or overexpending an apportionment or reapportionment of amounts permitted by DOD's administrative control of funds regulations.

contract requirements and identifies associated DHP-wide adjustments that can be used to formulate future budget estimates. They stated that these procedures represent significant improvements in their ability to precisely project direct care and purchased care requirements. They acknowledged, however, that the next round of MCS contracts will be awarded and administered differently than the first round and that their integrated care system, with its largely nonenrolled beneficiary population, is inherently difficult to budget for. Thus, funding changes during budget execution are nearly inevitable.

Notification or Budget Execution Data Would Enhance Oversight of DHP Funding Changes

The movement of DHP funds between subactivities does not require prior congressional notification or approval. While the Congress must be notified in many cases when DOD transfers or reprograms appropriated funds, these reporting rules do not apply to the movement of funds among DHP subactivities. As a result, sizeable funding changes have occurred without specific notification. Refinements to the reporting process would put the Congress in a better position to be aware of funding changes.

Reprogramming Actions Have Varying Degrees of Congressional Oversight

Under procedures agreed upon between congressional committees and DOD, funds can be obligated for purposes other than originally proposed through transfers and reprogrammings. Reprogramming shifts funds from one program to another within the same budget account, while a transfer shifts funds from one account to another. According to the Congressional Research Service, DOD uses the term "reprogramming" for both kinds of transactions.[21] DOD budgetary regulations,[22] reflecting instructions from the appropriations committees, distinguish among three types of reprogramming actions:

1. Actions requiring congressional notification and approval, including (a) all transfers between accounts, (b) any change to a program that is a matter of special interest to the Congress, and (c) increases to congressionally approved procurement quantities;

2. Actions requiring only notification of the Congress, including reprogramming that exceeds certain threshold amounts; and

[21]In annual appropriations bills, the Congress grants DOD authority to transfer up to specified amounts between accounts. In recent years, DOD has been given general transfer authority of $2 billion per year, and additional amounts have been made available for transfer for specific purposes. See M. Tyszkiewicz and S. Daggett, CRS Report for Congress: A Defense Budget Primer (Washington, D.C.: Congressional Research Service, 1998).

[22]DOD Financial Management Regulation 7000.14-R (Vol. 3, Ch. 6).

3. Actions not requiring any congressional notification, including reprogramming below certain threshold amounts and actions that reclassify amounts and actions within an appropriation without changing the purpose for which the funds were appropriated.

For example, DOD is required to notify the Congress if it shifts funds from the DHP O&M to the DHP procurement component. But the notification requirements do not apply when funds move from one DHP subactivity to another (such as from purchased care to direct care) or between DHP program elements (such as from MCS contracts to CHAMPUS, both within the purchased care subactivity) because such movements are within the same budget activity (administration and servicewide activities). Thus, the movements do not represent a change in the purpose for which the funds were appropriated and fit under the third type of reprogramming procedures.

Congress Has Required DOD to Report Budget Execution Data

To help increase the visibility of DOD funding changes, the reports accompanying recent defense appropriations acts have directed DOD to provide congressional defense committees with quarterly budget execution data on certain other O&M accounts.[23] For example, in fiscal year 1999, DOD is directed to provide data for each budget activity, activity group, and subactivity not later than 45 days past the close of each quarter. These reports are to include the budget request and actual obligations and the DOD distribution of unallocated congressional adjustments to the budget request, as well as various details on reprogramming actions. This type of timely information supports congressional oversight of DOD O&M budget execution and shows the extent to which DOD is obligating O&M funds for purposes other than the Congress had been made aware of.[24]

Under current procedures, DHP obligations are reported at the subactivity and program element levels in the prior-year column when DOD submits its

[23]The fiscal years 1998 and 1999 conference reports require DOD to provide the congressional defense committees such data for each of the active, defensewide, reserve, and national guard O&M accounts.

[24]Quarterly reporting of budget execution data may satisfy the congressional committees' need to know more about such shifting. However, in an earlier report (Year-End Spending: Reforms Underway But Better Reporting and Oversight Needed (GAO/AIMD-98-185, July 31, 1998), we found that budget execution data reported separately to the Office of Management and Budget and to the Department of the Treasury were inconsistent with actual obligations data reported by agencies in formulating the President's budget request. Also, in recent testimony (DOD Financial Management: More Reliable Information Key to Assuring Accountability and Managing Defense Operations More Efficiently (GAO/T-AIMD/NSIAD-99-145, Apr. 14, 1999)), we noted that DOD's systems and controls over its use of budgetary resources were ineffective. DOD's budgetary resources control weaknesses may leave DOD unaware of the actual amount of all funds available for obligation and expenditures in each appropriation account.

budget request justification material to the Congress. However, such information is not reported in a manner that allows easy comparison with the prior year's budget allocations, and thus does not facilitate oversight of funding changes that took place during budget execution. Reprogramming notification regulations do not apply when funds shift from one DHP subactivity to another, and congressional committees have not directed DOD to report DHP O&M budget execution data in the same manner as other O&M accounts.

The information needed to support congressional notification or quarterly budget execution reports is now readily available because DOD officials have instituted their own internal reviews to better track DHP budget execution. For example, DOD now requires internal quarterly budget execution reports from the services to document the shift of funds between subactivities. Therefore, we discussed with DOD officials potential reporting changes that would facilitate congressional oversight of DHP funding adjustments during budget execution. DOD officials told us that subjecting the lump-sum DHP appropriation to the reprogramming procedures that require prior approval from the Congress would eliminate flexibility, making it very difficult to manage the finances of the integrated MTF and MCS contract health care system. However, in our view, subjecting the DHP appropriation to reprogramming procedures for notification, but not prior approval, to the Congress whenever funds above a certain threshold shift from one DHP subactivity to another would not diminish DOD's flexibility. DOD officials agreed that congressional oversight would be enhanced by quarterly budget execution reports on DHP obligations by subactivity and program element. Depending on where the threshold was set and the extent to which special interest DHP subactivities were designated for reporting, notification could involve fewer reports than a quarterly reporting process for DHP subactivities and program elements. Thus, in our view, notification may well offer a less burdensome means of facilitating congressional oversight of DHP funding changes during budget execution.

Conclusions

DOD officials expect future DHP obligations to track more closely with budget requests and allocations, while acknowledging that some movement of funds is inevitable given the lack of a universally enrolled beneficiary population for direct and purchased care. Although DOD is not required to adhere to its own budget requests or reported budget allocations when it obligates funds, in our view, a repeated failure to do so without providing sufficient justification could cause the Congress to

question the validity of DHP budget requests. The Congress, however, will not be made aware of improvements or continuing funding adjustments unless DOD begins to either notify or report to congressional committees on how it obligates DHP appropriations.

In our view, and DOD agrees, additional information on how obligations differ from budget requests and allocations would improve oversight by the Congress and DOD. Since TMA officials already require quarterly budget execution reports to improve their internal budget oversight and budget decisionmaking, DOD would not be burdened by notifying or reporting similar information to the Congress. Such notification or reporting could provide the Congress with a basis for scrutinizing DHP budget request justifications and determining whether additional program controls—such as a universal requirement that all beneficiaries enroll in direct care or purchased care components—are needed.

Matter for Congressional Consideration

The Congress may wish to consider requiring DOD, consistent with current notification standards and procedures, to notify the congressional defense committees of its intent to shift funds among subactivities (such as direct care, purchased care, and base operations). Such notification, while not requiring congressional approval of the funding shift itself, could be initiated whenever the amount of the funding shift exceeded a certain threshold to be determined by the Congress. The notification would specify where funds are being deducted and where they are being added, and the justification for such reallocation. Also, or alternatively, the Congress may wish to consider requiring DOD to provide congressional defense committees with quarterly budget execution data on DHP O&M accounts. These data could be provided in the same manner and under the same time frames as DOD currently provides data for non-DHP O&M accounts.

Agency Comments and Our Evaluation

In its comments on a draft of the report, DOD concurred with the report and its focus of making the DHP funding more visible to the Congress. DOD further agreed that providing additional budget execution data to the Congress, on a regular basis, would be a valuable step toward keeping congressional members informed about the military health care system's financial status. Finally, DOD agreed to modify its current process for internally reporting DHP obligations to report DHP O&M budget execution data to the Congress in the same manner as the non-DHP O&M accounts.

However, DOD did not support requiring it to notify congressional defense committees of its intent to shift funds among DHP subactivities. DOD stated that such notification could potentially limit its ability to obligate DHP funds and affect beneficiaries' timely access to health care. We disagree. As we point out, such notification would not require prior approval of the funding shift itself, but would be initiated whenever the funding shift exceeded a certain amount to be determined by the Congress. These and other details of the notification procedure could be worked out between congressional committees and DOD to further ensure that DOD's ability to obligate funds for the timely delivery of health care services was not impaired. Further, as the report points out, notification could involve fewer reports than a quarterly reporting process for DHP subactivities. Thus, in our view, notification may well offer a less burdensome means of facilitating congressional oversight of DHP funding changes during budget execution.

DOD also suggested several technical changes to the draft, which we have incorporated where appropriate. DOD's comments are presented in their entirety in appendix II.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its date. At that time, we will send copies to Senator Wayne Allard, Senator Robert C. Byrd, Senator Max Cleland, Senator Daniel K. Inouye, Senator Carl Levin, Senator Ted Stevens, Senator John Warner, Representative Neil Abercrombie, Representative Steve Buyer, Representative John P. Murtha, Representative David Obey, Representative Ike Skelton, Representative Floyd Spence, and Representative C.W. Bill Young in their capacities as chairman or ranking minority member of Senate and House committees and subcommittees. We will also send copies at that time to the Honorable William S. Cohen, Secretary of Defense; the Honorable William J. Lynn, III, Under Secretary of Defense (Comptroller); the Honorable Sue Bailey, Assistant Secretary of Defense (Health Affairs); and the Honorable Jacob J. Lew, Director, Office of Management and Budget. Copies will be made available to others upon request.

If you or your staff have any questions concerning this report, please contact Stephen P. Backhus, Director, Veterans' Affairs and Military Health Care Issues, on (202) 512-7101 or Daniel Brier, Assistant Director, on (202) 512-6803. Other contributors to this report include Carolyn Kirby (Evaluator-in-Charge), Jon Chasson, Craig Winslow, and Mary Reich.

Sincerely yours,

Richard L. Hembra
Assistant Comptroller General

Contents

Abbreviations

CBO	Congressional Budget Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CMAC	CHAMPUS Maximum Allowable Charge
CONUS	continental United States
DHP	Defense Health Program
DOD	Department of Defense
MCS	managed care support
MTF	military treatment facility
O&M	operations and maintenance
OCONUS	outside the continental United States
TMA	TRICARE Management Activity

Detailed Defense Health Program Budget Tables

Table I.1: Defense Health Program Budget Requests, Budget Allocations, and Actual Obligations, Fiscal Years 1994-96

Dollars in thousands

Subactivity/ program element	1994			1995			1996		
	Budget request	Budget allocation	Actual obligation	Budget request	Budget allocation	Actual obligation	Budget request	Budget allocation	Actual obligation
Direct care									
Medical centers, hospitals, and clinics—CONUS	$2,583,114	$2,592,596	$3,062,708	$2,706,329	$2,658,394	$2,988,546	$3,035,259	$3,026,670	$2,954,594
Medical centers, hospitals, and clinics—OCONUS	222,816	223,634	235,131	233,444	233,444	265,572	232,605	238,125	288,577
Dental care activities—CONUS	98,612	98,612	129,105	132,718	131,718	126,533	134,787	134,787	131,391
Dental care activities—OCONUS	18,783	18,783	26,523	26,213	33,213	32,587	52,034	53,414	37,559
Subtotal	$2,923,325	$2,933,625	$3,453,467	$3,098,704	$3,056,769	$3,413,238	$3,454,685	$3,452,996	$3,412,121
Purchased care									
CHAMPUS	3,000,669	3,000,669	2,524,500	2,885,100	2,885,100	2,398,800	2,414,000	2,414,000	2,026,225
Managed care support contracts	863,400	863,400	793,600	980,100	980,100	932,300	1,356,100	1,356,100	1,252,621
Care in nondefense facilities	461,613	513,937	453,226	613,087	643,087	450,068	496,997	496,997	441,487
Subtotal	$4,325,682	$4,378,006	$3,771,326	$4,478,287	$4,508,287	$3,781,168	$4,267,097	$4,267,097	$3,720,333
Consolidated health support									
Examining activities—health care	24,294	24,294	22,941	23,456	23,014	24,176	23,089	23,089	26,485
Other health activities	209,726	244,295	252,927	242,279	241,542	345,152	255,894	271,394	348,352
Military public/ occupational health	145,274	169,220	187,507	167,823	163,223	169,444	191,139	191,139	186,230
Veterinary services	8,782	10,229	9,898	10,145	9,859	12,692	9,850	9,850	14,135
Military unique requirements	95,378	111,099	94,782	110,182	108,975	147,373	96,379	99,779	163,352

(continued)

Dollars in thousands

Subactivity/ program element	1994			1995			1996		
	Budget request	Budget allocation	Actual obligation	Budget request	Budget allocation	Actual obligation	Budget request	Budget allocation	Actual obligation
Aeromedical evacuation system	72,115	84,001	83,801	83,308	83,142	80,227	82,688	82,688	78,309
Armed Forces Institute of Pathology	28,377	33,054	31,739	32,781	32,352	40,339	32,484	32,484	41,928
Subtotal	$583,946	$676,192	$683,595	$669,974	$662,107	$819,403	$691,523	$710,423	$858,791
Information management									
Central information management	206,659	224,247	247,640	221,692	211,545	257,003	226,332	224,102	444,569
Management activities									
Management headquarters	24,943	28,479	25,457	26,225	25,539	36,481	25,937	25,937	54,144
TRICARE Support Office[a]	102,472	102,472	75,803	94,000	94,000	80,120	70,000	69,603	86,111
Subtotal	$127,415	$130,951	$101,260	$120,225	$119,539	$116,601	$95,937	$95,540	$140,255
Education and training									
Armed Forces Health Professions Scholarship Program	70,197	70,197	73,479	80,014	79,504	71,513	85,671	85,671	74,081
Uniformed Services University of Health Sciences	39,891	45,756	57,067	40,847	50,457	60,791	43,700	50,552	60,145
Education and training—health care	92,350	130,255	91,966	130,655	130,655	145,239	86,575	86,575	147,719
Subtotal	$202,438	$246,208	$222,512	$251,516	$260,616	$277,543	$215,946	$222,798	$281,945
Base operations/communications									
Environmental conservation	86	86	20	72	72	10	72	72	524
Pollution prevention	76	76	35	64	64	29	64	64	132
Environmental compliance	22,316	22,316	26,287	18,739	18,612	27,167	16,931	16,931	27,864
Minor construction—CONUS	14,969	14,969	50,216	20,024	20,024	69,123	32,583	32,583	52,642

(continued)

Dollars in thousands

Subactivity/ program element	1994			1995			1996		
	Budget request	Budget allocation	Actual obligation	Budget request	Budget allocation	Actual obligation	Budget request	Budget allocation	Actual obligation
Minor construction—OCONUS	2,042	2,042	7,883	2,731	2,731	13,282	4,287	4,287	7,183
Maintenance and repair—CONUS	227,491	227,491	235,430	186,462	190,076	260,349	286,864	286,864	302,666
Maintenance and repair—OCONUS	31,022	31,022	36,156	25,427	25,920	50,663	30,346	30,346	75,970
Real property services—CONUS	154,426	165,452	191,668	200,910	199,105	184,964	209,080	209,080	183,312
Real property services—OCONUS	16,854	18,057	20,918	21,007	20,819	16,269	21,493	21,493	19,286
Visual information activities	10,321	10,321	9,974	12,316	12,148	7,796	11,819	11,819	8,599
Base communication-CONUS	29,881	29,881	36,993	30,741	30,711	39,225	36,853	36,853	40,976
Base communication-OCONUS	4,075	4,075	3,682	4,192	4,188	4,006	3,607	3,607	4,496
Base operations—CONUS	176,864	189,494	219,518	226,559	224,522	254,612	235,771	235,771	260,513
Base operations—OCONUS	20,650	22,124	25,630	23,689	23,476	32,711	24,235	24,235	25,459
Subtotal	$711,073	$737,406	$864,410	$772,933	$772,468	$960,206	$914,005	$914,005	$1,009,622
Total	**$9,080,538**	**$9,326,635**	**$9,344,210**	**$9,613,331**	**$9,591,331**	**$9,625,162**	**$9,865,525**	**$9,886,961**	**$9,867,636**

[a]The TRICARE Support Office program element incorporated only Office of CHAMPUS costs in these years.

Source: TMA Office of Resource Management.

Table I.2: Defense Health Program Budget Requests, Budget Allocations, and Actual Obligations, Fiscal Years 1997-99

Dollars in thousands

Subactivity/program element	1997		
	Budget request	Budget allocation	Actual obligation
Direct care			
Medical centers, hospitals, and clinics—CONUS	$2,771,958	$2,973,647	$2,856,273
Medical centers, hospitals and clinics—OCONUS	271,479	282,330	301,359
Dental care activities—CONUS	140,927	153,630	152,002
Dental care activities—OCONUS	57,949	45,836	38,812
Subtotal	$3,242,313	$3,455,443	$3,348,446
Purchased care			
CHAMPUS	1,048,700	1,048,770	1,495,502
Managed care support contracts	2,439,900	2,439,900	1,919,292
Care in nondefense facilities	447,561	456,103	463,910
Subtotal	$3,936,161	$3,944,773	$3,878,704
Consolidated health support			
Examining activities—health care	28,924	28,924	29,013
Other health activities	325,927	325,927	337,704
Military public/occupational health	144,047	163,233	198,116
Veterinary services	11,713	11,713	13,625
Military-unique requirements	97,215	182,932	197,564
Aeromedical evacuation system	81,711	74,861	75,737
Armed Forces Institute of Pathology	37,982	37,982	42,924
Subtotal	$727,519	$825,572	$894,683
Information management			
Central information management	190,077	314,410	213,139
Management activities			
Management headquarters	25,637	35,930	32,050
TRICARE Management Activity[b]	0	0	46,682
TRICARE Support Office[c]	54,141	54,141	79,457

1998			1999		
Budget request	Budget allocation	Actual obligation	Budget request	Budget allocation	Current estimate[a]
$2,936,809	$2,871,009	$2,856,720	$2,475,717	$2,666,113	$3,140,421
279,003	279,003	279,070	289,293	289,293	282,464
158,027	158,027	174,511	155,704	155,704	150,428
45,723	45,723	40,770	41,130	41,130	38,681
$3,419,562	$3,353,762	$3,351,071	$2,961,844	$3,152,240	$3,611,994
735,120	735,120	1,106,710	573,700	573,700	593,700
2,848,888	2,848,888	2,379,869	3,010,200	3,010,200	2,819,800
470,703	470,703	484,039	486,495	486,495	500,614
$4,054,711	$4,054,711	$3,970,618	$4,070,395	$4,070,395	$3,914,114
29,101	29,101	29,463	30,857	30,857	30,813
379,642	379,642	310,400	372,864	372,864	271,887
171,058	171,058	191,822	170,271	170,271	202,027
12,524	12,524	15,245	13,276	13,276	14,475
154,952	272,177	229,694	160,889	178,239	213,773
79,721	79,721	82,232	79,611	79,611	79,758
38,724	38,724	45,759	39,476	39,476	45,600
$865,722	$982,947	$904,615	$867,244	$884,594	$858,333
222,329	219,329	225,068	274,371	297,871	256,568
91,271	91,271	35,646	36,228	36,228	33,992
0	0	143,807	128,784	128,784	144,087
54,554	54,554	0	0	0	0

(continued)

Dollars in thousands

Subactivity/program element	1997		
	Budget request	Budget allocation	Actual obligation
Subtotal	$79,778	$90,071	$158,189
Education and training			
Armed Forces Health Professions Scholarship Program	83,995	80,842	75,389
Uniformed Services University of Health Sciences	52,000	70,450	74,463
Education and training—health care	123,236	142,501	148,468
Subtotal	$259,231	$293,793	$298,320
Base operations/communications			
Environmental conservation	74	2,400	904
Pollution prevention	66	500	1,262
Environmental compliance	23,106	23,653	20,216
Minor construction—CONUS	33,281	33,384	51,331
Minor construction—OCONUS	6,339	8,727	7,223
Maintenance and repair— CONUS	245,903	285,545	349,450
Maintenance and repair—OCONUS	46,839	60,240	75,308
Real property services—CONUS	184,626	214,058	198,010
Real property services—OCONUS	16,054	24,858	20,050
Visual information activities	9,605	8,174	8,363
Base communication—CONUS	42,047	43,219	43,723
Base communication—OCONUS	4,159	4,820	4,166
Base operations—CONUS	276,888	277,111	276,450
Base operations—OCONUS	34,222	27,157	26,625
Subtotal	$923,209	$1,013,846	$1,083,081
Total	**$9,358,288**	**$9,937,908**	**$9,874,562**

1998			1999		
Budget request	Budget allocation	Actual obligation	Budget request	Budget allocation	Current estimate[a]
$145,825	$145,825	$179,453	$165,012	$165,012	$178,079
85,623	85,623	83,327	84,959	84,959	78,854
51,314	70,314	74,270	55,760	64,560	73,630
163,549	163,549	175,347	157,561	157,561	154,223
$300,486	$319,486	$332,944	$298,280	$307,080	$306,707
1,900	1,900	504	3,124	3,124	3,650
500	500	1,994	417	417	483
30,276	30,276	23,180	18,443	18,443	19,570
31,468	31,468	42,288	33,573	33,573	29,761
8,865	8,865	2,206	8,469	8,469	8,447
280,721	280,721	283,005	272,117	272,117	149,743
63,692	63,692	58,071	48,082	50,202	67,737
221,782	221,782	203,354	232,773	232,773	217,961
25,453	25,453	20,566	31,304	31,304	23,477
8,234	8,234	7,703	8,314	8,314	7,584
43,750	43,750	38,822	41,719	41,719	44,223
5,214	5,214	4,397	5,018	5,018	4,215
287,370	287,370	252,443	287,529	289,529	268,854
22,722	22,722	28,510	25,407	25,407	26,563
$1,031,947	$1,031,947	$967,043	$1,016,289	$1,020,409	$872,268
$10,040,582	**$10,108,007**	**$9,930,812**	**$9,653,435**	**$9,897,601**	**$9,998,063**

[a]Data source for fiscal year 1999 current estimate is the Defense Health Program Justification of Estimates for Fiscal Years 2000 and 2001, Vol. I (Feb. 1999). The total $9,998,063,000 current estimate includes an anticipated $104,561,000 reprogramming from the Air Force O&M account to the DHP O&M account.

[b]DOD established the TRICARE Management Activity program element in fiscal year 1998. The new organization now includes several former management headquarters offices and the TRICARE Support Office. TRICARE Management Activity costs shown in fiscal year 1997 reflect estimates as if the program element existed for that period.

[c]The TRICARE Support Office program element incorporated only Office of CHAMPUS costs in fiscal years 1997 and 1998.

Source: TMA Office of Resource Management.

Other Adjustments to DHP Total Obligational Authority

Following congressional approval of funds for Defense Health Program (DHP) operations and maintenance (O&M) expenses enacted through the annual appropriations act, various other actions by DOD or the Congress result in further adjustments. These adjustments can increase or decrease the total obligational authority available to DOD for DHP O&M expenses. Table I.3 details the other adjustments.

Table I.3: Other Adjustments to Defense Health Program Budgets, Fiscal Years 1994-98

Dollars in millions

Adjustment	1994	1995	1996	1997	1998	Net adjustment, 1994-98
Foreign currency fluctuations	0	0	0	0	–$13.0	–$13.0
Supplemental appropriations	0	$13.2	0	$21.0	1.9	36.1
Program cancellations	0	0	0	–9.3	0	–9.3
Rescissions	0	0	–$15.2	–21.0	0	–36.2
Reprogrammings	$20.9	26.6	29.7	–36.4	–144.2	–103.4
Transfers	0	0	0.2	–3.2	–2.0	–5.0
Withholds	0	0	–8.0	0	–0.5	–8.5
Subtotal	$20. 9	$39.8	$6.7	–$49.0	–$157.8	–139.4
Total obligational authority	**$9,347.6**	**$9,630.9**	**$9,893.6**	**$9,762.1**	**$9,950.2**	**48,584.4**
Unobligated balance at end of fiscal year	**$3.4**	**$5.8**	**$26.0**	**$3.2**	**$19.4**	**$57.7**

Note: Totals may not add because of rounding.

Source: TMA Office of Resource Management.

Table I.4: Funding Increases and Decreases by Subactivity and Program Element, Fiscal Years 1994-98

Dollars in thousands

Subactivity/program element	1994	1995	1996	1997	1998
Direct care					
Defense medical centers, station hospitals, and medical clinics—CONUS	$470,112	$330,152	–$72,076	–$117,374	–$14,289
Defense medical centers, station hospitals, and medical clinics—OCONUS	11,497	32,128	50,452	19,029	67
Dental care activities—CONUS	30,493	–5,185	–3,396	–1,628	16,484
Dental care activities—OCONUS	7,740	–626	–15,855	–7,024	–4,953
Subtotal	$519,842	$356,469	–$40,875	–$106,997	–$2,691
Purchased care					
CHAMPUS	–476,169	–486,300	–387,775	446,732	371,590
Managed care support contracts	–69,800	–47,800	–103,479	–520,608	–469,019
Care in nondefense facilities	–60,711	–193,019	–55,510	7,807	13,336
Subtotal	–$606,680	–727,119	–$546,764	–$66,069	–$84,093
Consolidated health support					
Examining activities—health care	–1,353	1,162	3,396	89	362
Other health activities	8,632	103,610	76,958	11,777	–69,242
Military public/occupational health	18,287	6,221	–4,909	34,883	20,764
Veterinary services	–331	2,833	4,285	1,912	2,721
Military-unique requirements	–16,317	38,398	63,573	14,632	–42,483
Aeromedical evacuation system	–200	–2,915	–4,379	876	2,511
Armed Forces Institute of Pathology	–1,315	7,987	9,444	4,942	7,035
Subtotal	$7,403	$157,296	$148,368	$69,111	–$78,332
Information management					
Central information management	23,393	45,458	220,467	–101,271	5,739
Management activities					
Management headquarters	–3,022	10,942	28,207	–3,880	–55,625
TRICARE Management Activity	0	0	0	46,682	143,807
TRICARE Support Office	–26,669	–13,880	16,508	25,316	–54,554
Subtotal	–$29,691	–$2,938	$44,715	$68,118	$33,628
Education and training					
Armed Forces Health Professions Scholarship Program	3,282	–7,991	–11,590	–5,453	–2,296
Uniformed Services University of Health Sciences	11,311	10,334	9,593	4,013	3,956
Education and training—health care	–38,289	14,584	61,144	5,967	11,798

(continued)

Dollars in thousands

Subactivity/program element	1994	1995	1996	1997	1998
Subtotal	–$23,696	$16,927	$59,147	$4,527	$13,458
Base operations/communications					
Environmental conservation	–66	–62	452	–1,496	–1,396
Pollution prevention	–41	–35	68	762	1,494
Environmental compliance	3,971	8,555	10,933	–3,437	–7,096
Minor construction—CONUS	35,247	49,099	20,059	17,947	10,820
Minor construction—OCONUS	5,841	10,551	2,896	–1,504	–6,659
Maintenance and repair—CONUS	7,939	70,273	15,802	63,905	2,284
Maintenance and repair—OCONUS	5,134	24,743	45,624	15,068	–5,621
Real property services—CONUS	26,216	–14,141	–25,768	–16,048	–18,428
Real property services—OCONUS	2,861	–4,550	–2,207	–4,808	–4,887
Visual information activities	–347	–4,352	–3,220	189	–531
Base communication—CONUS	7,112	8,514	4,123	504	–4,928
Base communication—OCONUS	–393	–182	889	–654	–817
Base operations—CONUS	30,024	30,090	24,742	–661	–34,927
Base operations—OCONUS	3,506	9,235	1,224	–532	5,788
Subtotal	$127,004	$187,738	$95,617	$69,235	–$64,904

Source: TMA Office of Resource Management data.

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

21 APR 1999

Mr. Stephen P. Backhus
Director, Veterans Affairs
And Military Health Care Issues
Health, Education, and Human Services Division
U.S. General Accounting Office
Washington, DC 20548

Dear Mr. Backhus:

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "Defense Health Program: Better Reporting of Funding Adjustments Would Facilitate Congressional Oversight," dated March 30, 1999 (GAO Code 101620/OSD Case 1782).

In general, the DoD concurs with the overall GAO draft report and the focus of making the Defense Health Program (DHP) funding more visible to the Congress. The attachment contains several technical change recommendations for your consideration. These changes are necessary to properly reflect the current policy of health care within the DHP and to better portray the issue of funding allocation versus obligation. DoD comments on the draft report's conclusions and comments for congressional consideration are also included in the attachment.

The Department agrees with the recommendation to report execution data on DHP O&M sub-activities. The Department currently prepares a monthly obligation report (DD-COMP(M) 1002). However, this report does not contain information by sub-activity and is not presently submitted to Congress, as noted in the GAO draft report. DoD proposes to modify this report to include sub-activities and to submit it to Congress monthly. This opportunity to provide monthly financial data is a valuable step towards keeping members of Congress informed on the financial status of the Military Health System.

However, the Department does not agree with the draft report's alternate recommendation to notify congressional defense committees prior to shifting funds among DHP sub-activities. Instead we recommend briefing congressional staff on the DHP as frequently as desired to ensure the committees are fully informed. Requiring the DHP to notify Congress of its intent to move funds between sub-activities could potentially impact beneficiaries' timely access to health care services and our ability to effectively utilize DHP funds for their intended purpose.

Please feel free to address any questions to my project officers on this matter, Ms. Martha Taft (functional) at (703) 681-8948 or Mr. Gunther J. Zimmerman (GAO/IG Liaison) at (703) 681-7889.

Sincerely,

Dr. Sue Bailey

Enclosure:
As Stated

GAO DRAFT REPORT – DATED MARCH 30, 1999
(GAO CODE 101620/OSD Case 1782)

"DEFENSE HEALTH PRGRAM: BETTER REPORTING OF FUNDING ADJUSTMENTS WOULD FACILITATE CONGRESSIONAL OVERSIGHT"

DEPARTMENT OF DEFENSE COMENTS

TECHNICAL CHANGES:

Now on p. 2.

- Page 3. First complete paragraph, Fourth sentence. "DoD decreased its purchase care obligations by about $2 billion and boosted direct patient care and information technology obligations by $1.4 billion." **Recommend** "boosted" be replaced by "increased."

Now on p. 3.

- Page 3. Second paragraph. Fifth sentence. "Between 1994 and 1996, purchased care obligations were $1.9 billion less than allocated due to faulty physician payment and actuarial assumptions." **Recommend** "faulty" be replaced by "revised."

Now figs. 1, 2, and 4.

- Page 7, Figure 1; Page 12, Figure 3; and Page 18, Figure 5. **Recommend** the charts be modified. All charts should be zero-based to properly display proportionality.

Now in table 3.

- Page 10, Table 2. The chart summarizes funding adjustments by Budget Activity Group (BAG) for the DHP. The information displayed is accurate for the BAG detail. However, the message communicated in the "Magnitude of Adjustment line" is potentially misleading because it provides an incorrect amount of funding that has been realigned. A more appropriate display is to show the net of the increases and decreases in the "Magnitude of Adjustments line." **Recommend** the funding totals on this line should be: FY 1994 ($17,575 not $1,337,709); FY 1995 ($33,831 not $1,493,945); FY 1996 (-$19,325 not $1,155,953); FY 1997 (-$63,346 not $485,328); FY 1998 (-$177,195 not $282,845); Magnitude of Increases and Decreases ($208,460 not $4,755,780).

Now on p. 13.

- Page 15. First complete paragraph. "In our view, however, TMA's comments do not explain the often-large differences that have occurred between budget allocations—which are not established until after the congressional appropriation is actually received-and obligations, which follow nearly immediately thereafter." **Recommend** that the draft report be changed to recognize the impact of foreign currency fluctuations, supplemental appropriations, program cancellations, rescissions, reprogrammings, transfers and withholds to the DHP.

Now on p. 14.

- Page 16. First full paragraph, third sentence: "TMA officials stated that, in formulating the DHP budget request, separate cost estimates for MTFs and MCS contracts are essentially arbitrary." **Recommend** "essentially arbitrary" be replaced with "the best estimates based on the best available information at the time."

Now on p. 14.

- Page 16. First full paragraph, fifth sentence: "Moreover, DoD's capitation method (allocating MTF budgets based on the number of enrolled TRICARE prime members) has not kept pace with MTF cost increases for space-available care to non-enrolled beneficiaries for medical services and outpatient prescription drugs." **Recommend** "enrolled TRICARE prime members" be replaced with "users of the Military Health System" and "non-enrolled" be deleted.

Now on p. 14.

- Page 16, footnote #13: "DOD has implemented a new funding system—enrollment-based capitation—which is designed to motivate and reward MTF commanders for maximizing their enrolled population." The Enrollment Based Capitation (EBC) has not been implemented as the initial funding allocation tool. **Recommend** that this portion of the footnote be changed to "DOD has designed a new funding system—enrollment-based capitation—which is intended to motivate and reward MTF commanders for maximizing their enrolled population."

Now on p. 17.

- Page 19, first complete paragraph. Third sentence. "We understand why DoD would be concerned about having adequate funds for the MCS contracts, but do not see how this could trigger an Antideficency violation." Comment: Each MCS contract is a legal liability and as such, the Department is required to ensure sufficient funds are available to pay these contracts. Failure to do so could result in an Antideficienty Action violation. **Recommend**: Replace with "We understand why DoD would be concerned about having adequate funds for the MCS contracts, because if this did not happen, an Antideficiency Act violation could occur."

COMMENTS ON CONCLUSIONS

Overall, the Department concurs with the draft report findings. The Department believes that Congressional awareness of the Defense Health Program (DHP) and the financial aspects of delivering medical care to the entitled beneficiaries (active duty members, their families, survivors, and retirees and their families) is appropriate. The Department believes this can best be achieved by including DHP O&M obligation data by sub-activity as part of the Department's current execution data reporting process to congressional defense committees.

COMMENTS ON MATTER FOR CONGRESSIONAL CONSIDERATON

The draft report makes two recommendations for Congress to consider: 1) The Congress may wish to consider requiring DoD, consistent with current notification standards and procedures, to notify the congressional defense committees of its intent to shift funds among sub-activities (such as direct care, private sector care, base operations); and 2) Alternatively, the Congress may wish to consider requiring DoD to provide congressional defense committees with quarterly execution data on DHP O&M accounts. This data should be provided in the same manner and under the same timeframes as DoD currently provides data for non-DHP O&M accounts.

We disagree with draft report's recommendation regarding notification to the Congressional defense committees on shift of funds among DHP sub-activities. Requiring the DHP to notify Congress of its intent to move funding between subaccounts could potentially impact our beneficiaries timely access to health care services and our ability to effectively utilize DHP funds for their intended purpose. Therefore, we do not support this conclusion.

Although the Department has not required the DHP to submit budget execution reports to Congress, the Department supports the recommendation. Requiring budget execution reports to Congress would provide visibility over obligations of the DHP appropriation.

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