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United States General Accounting Office
Washington DC 20548

B-287619

July 5, 2001

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

Dear Mr. Chairman:

This responds to your inquiry of April 4, 2001, concerning the legal requirements for recognizing and recording obligations under the Defense Health Program (DHP). You asked us to examine the legal basis for obligations incurred by TRICARE Management Activity for, among other services, medical services provided directly by DOD to beneficiaries as well as medical services provided by civilian contractors who subsequently bill DHP for those services. You also asked us to examine the legal basis for obligations for costs of change orders or other negotiated settlements. Finally, you asked whether the Antideficiency Act applies to DHP obligations and expenditures.

By letter dated May 3, 2001, we asked the Acting Assistant Secretary of Defense for Health Affairs for information on DHP's obligations and DHP's views on the legal issues presented. On June 22, 2001 the Acting Assistant Secretary of Defense for Health Affairs responded to our request. (DOD response). We have incorporated information provided by DOD's response as appropriate throughout this opinion.

In the discussion that follows we have set out the general rules for obligating funds for the medical services provided to beneficiaries and contractor provided services, and we conclude that DOD's practices in obligating funds are consistent with our holdings. For the reasons explained below, we conclude that due to DOD's legal liability for providing medical services to eligible beneficiaries, DOD may enter into obligations in excess of available budgetary resources without violating the Antideficiency Act. While DOD may enter into obligations in excess of available budgetary resources, it must obtain appropriations sufficient to liquidate those obligations.

BACKGROUND

Defense Health Program

The Department of Defense's (DOD) primary medical mission is to maintain the health of active duty service members in peacetime and during military operations. DOD also provides health care to other individuals, including dependents of active duty members, military retirees and their dependents.[1] DOD's health program, known as TRICARE, provides medical care to eligible beneficiaries through a combination of direct care and civilian provided care. DOD provides direct medical care through its military hospitals and clinics, known as military treatment facilities (MTFs). Medical services provided at MTFs include outpatient and inpatient care for medical and surgical conditions, pharmacy services, physical examinations, dental care, and diagnostic, laboratory and radiological tests and services.

DOD supplements direct care with contracted civilian medical care. The TRICARE program provides beneficiaries with a choice among a health maintenance organization (TRICARE Prime), a preferred provider network (TRICARE Extra), and a fee-for-service benefit (TRICARE Standard). DOD contracts with managed care support contractors to administer its TRICARE program on a regional basis, which presently consists of seven contracts covering eleven geographic TRICARE regions. The TRICARE contracts consist of a base period and five option years.[2] The TRICARE contractors perform administrative services, such as developing civilian provider networks, verifying provider credentials, negotiating reimbursement discounts, enrolling beneficiaries, referring and authorizing beneficiaries for health care, and processing health care claims. DOD awarded the TRICARE contracts as fixed-price, at-risk contracts in which the contractor assumes liability for payment of medical services subject to the requirements of the contract. The at-risk care refers to the civilian health care services provided under a fixed price arrangement in which the contractor approves and makes payment to the provider or beneficiary. The other arrangement is referred to as not-at-risk care or pass through costs. For payment of pass through costs, the contractor provides information to DOD to seek approval for payment. If DOD approves payment, the contractor is notified to pay the claim.

TRICARE is managed at multiple levels. Congress appropriates funds for the Defense Health Program's operation and maintenance (O&M), procurement, and research,

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[1] For ease of reference and consistent with DOD regulations, we refer to active duty members and their dependents, military retirees and their dependents as beneficiaries of DOD's health program. See 32 C.F.R. § 199.2(b).

[2] The base period, which varies by contract, consists of a transition period, ranging from 6-9 months, and the early months of health care delivery.

development, test and evaluation (RDTE) expenses.[3] See Department of Defense Appropriations Act, 2000, Pub. L. No. 106-79, 113 Stat. 1212, 1228 (1999). DHP appropriations are used to pay the costs of providing medical care in the MTFs, purchasing care from civilian medical providers and paying TMA contractors for administrative services. The Office of the Assistant Secretary of Defense for Health Affairs sets policy for MTFs and civilian provided medical care and establishes regulations in coordination with the Army, Navy and Air Force. The TRICARE Management Activity (TMA) is delegated responsibility for policy execution, shared with the military Surgeons General who are responsible for implementing TRICARE policy within their respective services. TMA performs program-wide support functions, such as managing TRICARE's information technology and data systems, preparing the budget and managing the accounts. TMA selects, directs and pays managed care support contractors, who maintain the civilian provider network and perform services assisting beneficiaries and management of the program. In each TRICARE region within the United States, a lead agent coordinates MTF and contractor activities; usually the commander of the region's largest MTF. The MTF commanders report to the Surgeon General of their respective service who allocates part of the service's appropriated funds to each MTF. MTF officials have input into private provider network size and composition but lack direct authority over the providers or the network, which is managed by the managed care support contractor.

Active duty military members are automatically enrolled in TRICARE Prime and their dependents also may enroll in TRICARE Prime without paying an enrollment fee. Military retirees and their dependents must pay an enrollment fee to join TRICARE Prime. Enrollees do not have to meet an annual deductible. An enrollee chooses a Primary Care Manager who is the primary physician that provides or coordinates all healthcare for that enrollee. When an enrollee receives medical care directly from an MTF, there is no copayment and the costs of providing care are part of the costs of operating the MTF. Medical care under TRICARE Prime is usually provided in MTFs, but civilian provided care is used when a Primary Care Manager refers an enrollee for such care.

Participating civilian medical providers join a network managed by the TRICARE contractors where they are paid for services provided in accordance with a negotiated reimbursement rate. If enrollees go to a Prime civilian provider, the provider submits the claim for reimbursement to the TMA contractor. Active duty military members and their dependents do not pay a copayment for civilian provided services except for pharmacy services and services under the Program for Persons with Disabilities. Military retirees and their dependents, on the other hand, pay a fixed dollar amount as copayment for civilian provided services. A TRICARE Prime enrollee may also use civilian provided care without requesting a referral from their Primary Care Manager under the Point of Service Option. Under the Point of Service

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[3] In addition to the DHP appropriations, Congress appropriates military personnel and military construction funds to cover those costs of the military health program. Civilian personnel costs are paid from the DHP O&M appropriation.

Option, the requirements of TRICARE Standard described below, such as deductibles and cost sharing, apply.

TRICARE Extra functions as a preferred provider option in which participating civilian medical providers join a network managed by the TRICARE contractors. The participating civilian medical providers are paid for services provided in accordance with a negotiated reimbursement rate. Under TRICARE Extra, beneficiaries pay less than they would if using non-network providers. Medical providers who do not join the network may provide care under TRICARE Standard, a fee for service option, for which they are reimbursed up to a maximum rate established for the service provided.[4] Under TRICARE Standard medical providers can bill the beneficiary for up to an additional 15 percent above the established rate. Under TRICARE Extra and TRICARE Standard, beneficiaries do not have to enroll or pay enrollment fees, but they must pay a deductible each year and are responsible for cost sharing, that is, the copayment or amount of money for which the beneficiary is responsible.

The reimbursement process for civilian provided care is essentially the same under the three TRICARE options. When a beneficiary receives medical care from a civilian medical provider, the provider submits a claim for reimbursement to the TRICARE contractor for adjudication in accordance with DOD regulations. 32 C.F.R. Part 199. A beneficiary, who has paid the health care provider directly for medical services, may submit a claim for reimbursement for services provided. For the payment of care that is at-risk, the TRICARE contractor reviews the claim to verify the eligibility of the beneficiary, determine whether the medical services provided are allowable, and determine the amount to be paid. Once the TRICARE contractor adjudicates and settles a claim, the contractor issues a check to the claimant. For payment of care that is not at-risk, referred to as "pass through", the contractor transfers information electronically to seek approval from DOD for payment. If DOD approves payment, the contractor is notified to release payment. If a claim is denied, medical providers and beneficiaries may appeal the determination. 32 C.F.R. § 199.10.

ANALYSIS

Recognition and Recording of Obligations for Medical Services and Related Contractor Provided Administrative Services

Medical Services

Under 31 U.S.C. § 1501(a), an amount should be recorded as an obligation against an available appropriation when supported by documentary evidence of a legal liability of the government. As explained below, we believe that DOD's practices in obligating

[4] Prior to TRICARE, DHP implemented the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), which like TRICARE Standard, was the equivalent of a health insurance plan that reimbursed beneficiaries for portions of the costs of health care received from civilian providers.

funds are consistent with our holdings. With respect to direct care, DOD determines a beneficiary's eligibility for treatment, the type of treatment to be provided and incurs the costs of treatment. For direct care, DOD's costs are the expenses of operating the MTFs, such as paying the costs of acquiring supplies, paying employees and other related expenses of operating the facilities. The rules for recognizing obligations for these costs are the same as those applicable to typical internal agency operations. As a general rule, supplies acquired for use during the current fiscal year are a bona fide need of that year and are chargeable to the current fiscal year's appropriation. 60 Comp. Gen. 361 (1981). Costs such as paying employees are obligations at the time the salaries are earned, that is, when the services are rendered, generally on a pay period basis. 24 Comp. Gen. 676, 678 (1945). Other costs of operating facilities, such as paying utilities or maintenance services, are generally obligations at the time the services are performed. B-259274, May 22, 1996; 34 Comp. Gen. 459, 462 (1955). Thus, DOD should record those costs as obligations chargeable to the appropriation current at the time the services are provided.[5]

In contrast to the cost of care provided beneficiaries directly through MTFs, both the TRICARE contractors and DOD determine the liability for payment of costs of civilian provided care through the adjudicative process after the medical services are provided in accordance with applicable laws, regulations and DOD policy. For the at-risk payment portion, which is fixed, DOD informed us that it records an obligation when the contracting officer enters into the option period. Where the obligation is fixed, an agency may record the obligation in an amount equal to the least quantifiable amount of the government's liability. See 62 Comp. Gen. 143, 146-147 (1983); 48 Comp. Gen. 497, 502 (1969).

For pass through care, DOD informed us that it records an obligation when DOD approves the payment and notifies the contractor to make such payment. Where an agency has an adjudicative administrative process of review and approval for medical services, the presumption is that the agency is not liable for the costs until a qualified employee has approved and accepted the invoice. 46 Comp. Gen. 895 (1967). The approval of the services constitutes the agency's agreement or legal liability to pay and is the documentary evidence required by 31 U.S.C. § 1501(a). Id. The claims process for payment of civilian provided services does not establish DOD's liability for payment until the TRICARE contractor processes the claim and DOD has determined that the beneficiary is eligible to receive treatment, that the services provided are allowable, and the amount billed is proper. 32 C.F.R. Parts 199.3, 199.4 and 199.7. DOD regulations[6] make medical providers and beneficiaries aware that

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[5] An exception to this rule is provided in 10 U.S.C. § 2410a, which authorizes DOD to use current fiscal year appropriations to finance a severable service contract that continues into the next fiscal year.

[6] DOD regulations for the CHAMPUS and TRICARE programs are found at 32 C.F.R. Part 199. Parts 199.1 through 199.16 contain provisions established for the CHAMPUS program, while Parts 199.17 through 199.22 apply to the TRICARE program. However, the CHAMPUS provisions are also applicable to the TRICARE

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such adjudication establishes liability for payment of their claims. Thus, in accordance with 46 Comp. Gen. 895, DOD should record the obligation at the time, and in the amount, of the approved claim. See also, B-133944, January 31, 1958 (Fiscal year appropriation properly charged on monthly basis to cover amounts of bills approved for the costs of prescriptions filled for veterans); B-92679, July 24, 1950 (Cost of emergency hospitalization or medical and dental treatment without prior authorization chargeable to the appropriation current at time the claim for reimbursement is approved).

TRICARE Contractor Services

The services performed by TRICARE contractors in administering the TRICARE program include developing civilian provider networks, verifying provider credentials, negotiating reimbursement discounts, enrolling beneficiaries, referring and authorizing beneficiaries for health care, and processing health care claims. With respect to service contracts, for obligational purposes, the issue is whether a service is severable or nonseverable. B-277165, January 10, 2000. The nature of the services performed determines whether a service is severable or nonseverable. Id. Nonseverable services involve services that represent a single undertaking, or, in other words, provide value when the entire project is complete. Id. Severable services generally involve continuing or recurring services often reflecting the day to day operational needs of an agency. Id. For obligational purposes, agencies should charge the costs of severable services to the appropriation current at the time the services are rendered. Id. The types of services provided by TRICARE contractors, such as ensuring provider credentials, enrolling beneficiaries, referring and authorizing care, and adjudicating claims are severable into components that independently provide value to DOD as performed and meet a separate and ongoing need. See 60 Comp. Gen. 219 (1981) (Technical and management assistance tasks are severable and should be charged to appropriation current at time services are rendered). Thus, DOD should record obligations against the appropriation current at the time the services are rendered.

TRICARE Contracts and Change Orders

Although the TRICARE contracts were awarded as fixed-price at-risk contracts, DOD may make several types of contract adjustments that affect the contract performance and price, namely bid price adjustments, equitable adjustments, and change orders. DOD designed the contracts to include adjustments for health care cost increases beyond the contractors' control, with other costs, such as administrative costs, remaining fixed. These bid price adjustments (BPAs) are based on conditions such as shifts in workload between the MTFs and civilian providers, or changes in the number of beneficiaries due to geographic transfers of active duty members and their

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program, including claims submission and approval requirements, except where TRICARE provisions specifically take precedence over CHAMPUS provisions. See e.g., Part 199.4(a)(ii).

dependents. To calculate such adjustments, DOD uses a formula that includes cost, population shifts, inflation and utilization. TRICARE contractors also initiate requests for equitable adjustments (REAs) to cover unforeseen changes in contract conditions, such as higher than anticipated claim submissions that increase administrative expenses.

Since you asked us to address the obligational requirements for change orders, we will focus on that process. Generally, government contracts contain a Changes clause that permits the contracting officer to make unilateral changes within the general scope of the contract. 48 C.F.R. § 43.201. Change orders are a type of contract modification defined by the Federal Acquisition Regulation (FAR) as " a written order, signed by the contracting officer, directing the contractor to make a change that the Changes clause authorizes the contracting officer to order without the contractor's consent." 48 C.F.R. § 43.101.[7] If a change causes an increase or decrease in the contractor's cost of, or time required for, the performance of work under the contract, the contracting officer must make an equitable adjustment and modify the contract in writing. 48 C.F.R. §§ 52.243-1 (fixed price contract) and 52.243-2 (cost reimbursement contract).

Change orders may result from new laws or regulations, or from DOD initiatives.[8] The TRICARE change orders range in scope from administrative changes, such as changes to billing procedures, to significant benefit expansions, such as addition of a hospice benefit or elimination of copayments for active duty dependents, which could significantly add to program costs. By June 30, 2000, DOD had made a total of over 1,000 change orders to the TRICARE contracts. While DOD had independent government estimates of the cost of the change orders, DOD implemented many of these change orders prior to negotiation of the final terms of the modification including payment terms. Between December 2000 and February 2001, DOD eliminated most of its large backlog of outstanding change orders under a short-term effort using global settlements to settle all outstanding contract adjustments.[9]

The issue of the proper obligation of the costs of change orders cannot be separated from the underlying events triggering the government's liability for medical services provided to beneficiaries and administrative services provided to DOD. The change orders to the TRICARE contracts relate to the nature and amount of medical services

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[7] This section was amended by FAC 97-22, May 11, 2001 to include this definition in 48 C.F.R. § 2.101.

[8] As reported in 1997, the most recent data available to GAO showed that one-third of all TRICARE change orders resulted from new laws or regulations while the remaining two-thirds were self-initiated. Defense Health Care: Actions Underway to Address Many TRICARE Contract Change Order Problems (GAO/HEHS-97-141, July 14, 1997).

[9] Defense Health Care: Continued Management Focus Key to Settling TRICARE Change Orders Quickly (GAO-01-513, April 30, 2001).

provided beneficiaries and to the management of the TRICARE program. For medical services provided to beneficiaries directly from the MTFs, DOD's liability consists of the costs incurred in operating the MTFs and providing medical services to the beneficiaries and those costs should be recorded as discussed above. For medical services provided through civilian contracted care, DOD's liability for at-risk payment is determined by the fixed price established by the contract and should be recorded at the time DOD executes the contract or option. For medical services provided through civilian contracted care, DOD's liability for pass through payment is determined through the adjudicative process after the medical services are rendered. As discussed above, those costs should be recorded at the time of the claim approval. Similarly, for the costs of contractor provided administrative services in carrying out the TRICARE program, DOD should record obligations as those services are rendered. To the extent change orders affect services to be provided in the future, DOD should obligate in accordance with the above rules.

The resolution of the change orders by negotiation or settlement goes to the price of the change orders, i.e., the amount of DOD's liability. 48 C.F.R. § 52.243-4. The negotiated global settlements totaled about $900 million for current and prior fiscal years. We have not audited the amounts related to change orders, BPAs or REAs for services provided during each fiscal year covered by the global settlements nor has DOD advised us as to those amounts.

Prior to DOD finalizing the global settlements, Congress, in July 2000, provided supplemental appropriations of $615,600,000 for the Defense Health Program in amounts not to exceed:

> "$90,300,000 . . . for obligations and adjustments to obligations required to cover unanticipated increases in TRICARE contract costs that (but for insufficient funds) would have been properly chargeable to the Defense Health Program account for fiscal year 1998 or fiscal year 1999; and . . . $525,300,000 . . . for obligations and adjustments to obligations required to cover unanticipated increases in TRICARE contract costs that are properly chargeable . . . for fiscal year 2000 or fiscal year 2001"

Military Construction Appropriations Act, 2001, Pub. L. No. 106-246, § 105-106, 114 Stat. 511, 529 (2000). To the extent the amounts appropriated and otherwise available cover the costs allocable to those years, DOD should so obligate.[10] DOD informed us that when final settlements were reached, contract modifications were issued to incorporate the settlement price and obligations were recorded against the applicable appropriations. To the extent that the amounts appropriated in the supplemental are inadequate to cover those costs, DOD would require additional appropriations from Congress.

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[10] In addition, Congress appropriated $695,900,000 for DHP to remain available for obligation until the end of fiscal year 2002. Pub. L. No. 106-246, § 107, 114 Stat. at 530.

Applicability of the Antideficiency Act

The purpose of the Antideficiency Act is to prevent the officers of the government from making or authorizing obligations or expenditures in excess of or in advance of available appropriations. The Antideficiency Act's prohibitions are directed at discretionary obligations incurred by government officers. 65 Comp. Gen. 4, 9 (1985); 39 Comp. Gen. 422, 425 (1959); B-225801, March 2, 1988. The Antideficiency Act specifically provides an exception for obligations authorized by law to be made in excess of or in advance of appropriations. 65 Comp. Gen. at 9.

We have previously identified situations where Congress has expressly mandated an agency to incur obligations without regard to the availability of budgetary resources to cover the obligations. Id. For example, in B-225801, March 2, 1988, we pointed out that the Veterans Administration (VA) becomes legally liable for compensation and pension benefit payments to a veteran on the date it administratively adjudicates a veteran's claim as due and payable. Since no further congressional action is needed to establish a right to payment, the obligation for these benefits occurs by operation of law, and should be recorded under 31 U.S.C. § 1501 regardless of the amount of available budgetary resources at such time. Id. In obligating amounts in excess of available budgetary resources, the agency does not violate the Antideficiency Act. Id. In 65 Comp. Gen. 4 (1985), we held that where Congress authorized the Department of Education to extend loan guarantees in amounts which could at any time far exceed available funding,[11] and then required the Department to promptly pay beneficiaries of those guarantees upon the borrower's default, it expressly authorized the Department to incur obligations in excess of or in advance of appropriations. We noted that the Department's administrative officers did not have any control over the amount the Department would be required to pay under applicable statutory provisions. Id. Thus, the obligation to make payments on the loan guarantees were not discretionary expenses covered by the Antideficiency Act but rather fell within the Antideficiency Act's "unless authorized by law" exception. Id. Similarly, in 39 Comp. Gen. 422 (1959), we held that the administrative action granting pay increases to wage board employees effective on a specified date not only imposed a legal liability on the government to pay additional compensation, but created an obligation against the appropriation current at the time the liability arose regardless of whether the applicable appropriation had sufficient funds.[12]

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[11] Subsequent to the decision in 65 Comp. Gen. 4 (1985), Congress enacted the Federal Credit Reform Act of 1990, as amended, which provides that beginning with fiscal year 1991, for covered loans and loan guarantees, an agency must cover the cost of loan and loan guarantee programs with budget authority. Pub. L. No. 101-508, Title XIII, 104 Stat. 1388-610 (1990).

[12] In the cases noted above, we also held that the agencies would have to request supplemental appropriations to liquidate those obligations if there were insufficient funds to cover those payments.

We think that DHP obligations for medical services fall into the category of obligations mandated by law. Medical services at MTFs are available to beneficiaries according to a statutorily established priority. Active duty members of the armed forces are "entitled to medical and dental care in any facility of any uniformed service." 10 U.S.C. § 1074(a). Dependents of active duty members are "entitled, upon request, to the medical and dental care . . . in facilities of the uniformed services, subject to the availability of space and facilities and the capabilities of the medical and dental staff." 10 U.S.C. § 1076(a)(1). Military retirees "may, upon request, be given medical and dental care in any facility of any uniformed service, subject to the availability of space and facilities and the capabilities of medical and dental staff." 10 U.S.C. § 1074(b).[13] Dependents of military retirees "may, upon request, be given the medical and dental care . . . in facilities of the uniformed services, subject to the capabilities of the medical and dental staff." 10 U.S.C. § 1076(b). However, apart from the medical services available at MTFs, dependents of active duty members, military retirees and their dependents are entitled to receive medical care from civilian providers. 10 U.S.C. §§ 1079 and 1086. In this regard, sections 1079 and 1086 direct the Secretary of Defense to assure by contract that medical care is available for these beneficiaries subject to deductibles and copayments prescribed by law.

While the order of priority for, and the provider of, medical services varies according to the status of a beneficiary, DOD is required to provide medical care to beneficiaries as provided by law. The statutes authorizing the DHP services set forth the beneficiaries' entitlement to medical services, the medical services available, and the limitations on the amounts of deductibles and copayments required for such services. Under these statutory provisions, a beneficiary need only present himself for medical treatment subject to applicable deductibles and copayments; if the statutory requirements are met, DOD must pay for or reimburse the beneficiary or medical provider for those medical services. Thus, we conclude that DHP actions are "authorized by law" regardless of the amount of available budgetary resources and do not violate the Antideficiency Act.[14] To the extent DOD incurs obligations in excess of available budget authority to cover the costs of services required, DOD would need to obtain additional appropriations to cover payments for these obligations.

This opinion does not address DOD's management of the defense health program. For a discussion of some of the challenges DOD faces in managing the defense health program, see Defense Health Care: Lessons Learned From TRICARE Contracts and Implications for the Future (GAO-01-742T, May 17, 2001) and products listed therein.

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[13] While not in effect during the period relevant to this opinion, Medicare eligible military retirees and dependents will be eligible, under TRICARE for Life, for the same benefits as retirees under age 65. National Defense Authorization Act for Fiscal Year 2001, Pub. L. No. 106-398, 114 Stat. 1654 (2000). However, these changes do not affect our analysis.

[14] While recognizing that the DHP is "essentially an entitlement program", DOD informed us that it is managed in accordance with the Antideficiency Act requirements.

CONCLUSION

DOD should obligate for the medical services provided to beneficiaries and contractor provided services in accordance with the rules described above. Given DOD's legal liability for providing medical services to eligible beneficiaries, we conclude that such actions are "authorized by law" regardless of the amount of available budgetary resources and do not violate the Antideficiency Act. We trust that this responds to your request. Should you have any questions, please contact Mr. Jeffrey Jacobson (202) 512-8261 or Ms. Edda Emmanuelli Perez of my staff at (202) 512-2853.

/signed/
Anthony H. Gamboa
General Counsel