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DEFENSE HEALTH CARE

Limits to Older Retirees' Access to Care and Proposals for Change

Statement of Stephen P. Backhus, Director
Veterans' Affairs and Military Health Care Issues
Health, Education, and Human Services Division

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Defense Health Care: Limits to Older Retirees' Access to Care and Proposals for Change

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to be here today to discuss health care options for retired military members and their families. Health care options for these individuals involve complex issues, and proposed alternatives may have wide-ranging effects on Department of Defense (DOD) beneficiaries and federal health programs.

Today's DOD health care system provides coverage for about 8.3 million members, of which over half are retirees and their dependents and survivors.[1] Under the terms of the 1956 Dependents' Medical Care Act, DOD has authority to provide retirees of any age health care in its medical facilities as long as space and resources are available. This is referred to as space-available care. The statute does not entitle retirees to care in military facilities.

When space and resources are available in military facilities, retirees may receive care at little or no cost. When resources are not available, retirees under age 65 may seek care from private health care providers and DOD will pay most of the cost through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS was established in part so that military members, once retired, could have health care coverage until eligible at age 65 for Medicare. At age 65, retirees' only source of DOD-funded care is military facility space-available care.

Major changes in DOD's health care system, including the introducing of a managed care program called TRICARE and the closing or downsizing of many medical facilities, have caused older military retirees, those aged 65 and older, to fear that these changes will eventually end their access to space-available care. As a result, alternatives have been proposed for improving older retirees' access to DOD-funded or directly provided care.

At the Subcommittee's request, we have been reviewing retirees' concerns and the major proposals for addressing them. We have talked with beneficiary associations, DOD headquarters officials, and military medical facility managers and health care providers nationwide to gain perspective on the effects of system changes on retirees. Our work is still under way. As this Subcommittee and others begin to weigh the costs and other trade-offs associated with how best to help military retirees, we welcome the opportunity to share our preliminary observations on the proposed

[1]For the remainder of this statement, the term "retirees" refers to retirees and their dependents and survivors.

alternatives and their likely effects on beneficiaries and the government. Later this spring, we plan to issue a final report addressing these matters in more detail.

Specifically, you asked that we discuss two areas:

- older retirees' options for accessing health care and the related effects of DOD's recent health care system changes on their access to care and
- proposed alternatives for addressing retirees' concerns and their potential effects on beneficiary and government costs.

Results in Brief

In summary, our work has shown that recent system downsizing has reduced all care, including space-available care—the only care retirees may access at military facilities. In the last 10 years, the number of military medical personnel has declined by 15 percent and one-third of military hospitals have been closed, reflecting the one-third reduction in active-duty forces. While further readiness-related downsizing decisions are pending, some predict more system reductions. Meanwhile, TRICARE, which does not allow older retirees to enroll in its Prime health care option (its new health maintenance organization (HMO) option), is moving to maximize Prime enrollment at all the facilities. As this takes place, older retirees' space-available care will further decline at most facilities and eventually end at some. Space-available care at military health facilities, moreover, is episodic and lacks the continuity so important to older retirees who have more frequent, and often chronic, medical problems than younger retirees. And, although retirees may also access care through such government-sponsored programs as Medicare and private supplementary health insurance, many retirees experience coverage gaps and high out-of-pocket costs.

DOD and members of the Congress have proposed alternatives to address the availability, cost, and coverage issues affecting retirees' access to care. These proposals have potentially large price tags or fall short in helping those most affected by base closures and TRICARE's implementation. For example, Medicare subvention, which is based upon DOD's receiving Medicare reimbursement for treating retirees as Prime enrollees at military medical facilities, would be greatly limited by the number of beneficiaries able to participate and susceptible to further downsizing actions.

Allowing retirees to join the Federal Employees Health Benefits Program (FEHBP), on the other hand, or using CHAMPUS as a second payer to Medicare, would provide retirees with more dependable, consistent access to care. Costs, however, would be considerable, in part because retirees whose care is now funded by other sources would most likely join the new program. To mitigate these costs, DOD would probably need to explore measures such as alternative beneficiary cost sharing.

In addition, although not yet fully developed, DOD's pharmacy proposal would provide retirees a single benefit not covered by basic Medicare and could fill the gap in coverage until system restructuring decisions are made and the related consequences known. DOD has not yet decided, however, on benefit eligibility, delivery, or funding details for this proposal; thus, it is too early to judge the cost implications.

DOD System Changes Have Reduced Retirees' Access to Facility Care

In the early 1950s, the military health care system was sized for a large active-duty force. Military retirees and their families made up only 8 percent of the eligible military health care population; health care in military facilities was almost assured for them.

The military health system has changed significantly, however. Beginning in the 1980s, active-duty forces have been downsized by more than one-third, with attendant reductions in medical staff and facilities. Since then, the number of military doctors, nurses, and medical technicians has declined by 15 percent; in the past 10 years, one-third of all military hospitals have been closed. In addition, while the total population eligible for care declined by about 10 percent, the number of retirees grew. Between 1987 and 1997, the number of older retirees increased by about 75 percent, to 1.2 million; and they are projected to outnumber active-duty personnel in the future. These changes have significantly reduced the availability of care for retirees in DOD facilities.

Moreover, recent DOD studies suggest that the military health care system is larger than needed to meet future wartime requirements. If this is true, then medical staff and facilities could be further reduced, with possible reductions in retirees' space-available care at military facilities. DOD is now evaluating its medical requirements but has made no final decisions.

TRICARE may further reduce older retirees' access to care at military medical facilities. Before TRICARE, all retirees, regardless of age, had the same priority for care in military medical facilities. Under TRICARE, those

who get priority for access are those enrolled in TRICARE Prime. As a result, older retirees, who are currently not eligible to enroll in TRICARE Prime, receive the lowest priority for access and can only access space-available care at the facilities.

As of January 1997, most facilities where TRICARE is in place reported having space available for older retirees but that retirees could not be assured of obtaining such care whenever they sought it. According to medical facility officials, many retirees may not make advance appointments for routine or follow-up care or even get urgent care and must persistently call each day hoping for an appointment. As a result, care is episodic and lacks the regularity and continuity that is important to older retirees, who have more frequent and chronic medical problems than younger ones. Looking ahead, as TRICARE Prime enrollment increases, older retirees' space-available care will further decline at many facilities and eventually end at others. If this trend continues, affected retirees will need to depend more on non-DOD sources for their health care in the future.

Older military retirees may now also access other government-sponsored and private health insurance. Virtually all receive Medicare part A insurance, for example, which covers their inpatient hospital, skilled nursing, and home health care needs. By paying an extra monthly premium, they may also receive Medicare part B coverage for physicians and other outpatient services. Recent DOD beneficiary surveys have indicated that 90 percent of older retirees have Medicare part B coverage, and about half have private insurance.[2] Furthermore, in recent years, 31 states have introduced Medicare HMOs, providing some retirees another care option. Finally, military retirees—though not their dependents—are eligible for certain types of care through Department of Veterans Affairs programs.

Unlike other federal retirees and retirees of many private employers who are provided insurance supplementing Medicare, however, older military retirees can experience coverage gaps, high costs, and an otherwise patchwork system that they must learn to navigate to receive their care. Medicare, for example, does not cover outpatient prescription drugs nor does it have a catastrophic limit on patients' out-of-pocket costs. In addition, because Medicare has deductibles and copayment requirements, about a third of older military retirees have purchased supplemental

[2]In the general elderly population, 95 percent have Medicare part B and 75 percent have private health insurance.

Medigap policies from private insurers. Such plans' annual premiums range from about $400 to more than $2,100, and the coverage under the 10 standard policies varies widely. Only the most expensive plans cover outpatient prescriptions and none pay for dental or vision care. Although older military retirees with private or other government employer-sponsored insurance may have more generous coverage than those without such coverage, their costs could still be relatively high depending upon the extent to which such employers share the costs.

Alternatives for Improving Retirees' Access Could Have Significant Cost and Other Implications

The conditions discussed have spurred several alternatives for addressing the availability of, cost of, and coverage for health care that now, and perhaps even more so in the future, confront older military retirees. We have been examining five alternatives for addressing the health care concerns of military retirees aged 65 and older: (1) Medicare subvention, (2) FEHBP enrollment, (3) CHAMPUS as a second payer, (4) Medigap policies, and (5) a mail order pharmacy benefit. All of these proposals would require some congressional action.

Through Medicare subvention, Medicare-eligible retirees could enroll in TRICARE Prime. DOD would receive reimbursement for Medicare-covered services from the Health Care Financing Administration (HCFA) to the extent that older retirees' care exceeds levels that DOD currently provides. For those who enroll, DOD would directly provide or arrange for their full care. Enrollees would have improved access to care in DOD facilities. Thus, enrolled retirees would enjoy the continuity of care many now lack and reduced out-of-pocket costs. The government might also benefit to the extent that DOD facility care is provided less expensively than care provided under Medicare.

The number of older retirees likely to benefit from subvention appears proportionately small, however, because available resource capacity in military facilities continues to decline. DOD estimates that less than half of the older retirees now using the military medical facilities in areas where subvention will be tested would be able to enroll in TRICARE Prime. Under a nationwide implementation, DOD expects to be able to enroll in its facilities a similar proportion of the 300,000 older retirees now using its facilities. Furthermore, subvention would not be available to the many retirees who do not live near military facilities such as those affected by base closures. And, to expand subvention beyond the limits of its facilities, DOD would have to buy care from civilian providers, through its TRICARE contractors or, as HCFA does, on a fee-for-service basis or through HMOs.

There is most likely no cost advantage to the government of DOD's contracting out for this care rather than HCFA's contracting out for it.

In addition, Medicare subvention would add administrative complexity to DOD's system. DOD has just begun implementing cost-accounting and information systems needed to track enrollees' care, reconcile Medicare reimbursements, and accurately calculate spending and service levels. In that regard, DOD's current plans to test the program without HCFA reimbursement seem prudent for the Department to effectively develop the needed support systems.

Other alternatives—such as providing retirees with FEHBP, CHAMPUS, or Medigap policies—would, in effect, supplement retirees' current Medicare coverage. With FEHBP, older retirees could choose from a wide array of health insurance plans, including HMOs, sharing the premium costs with the government. Offering FEHBP, moreover, would provide military retirees the same coverage provided to other federal retirees and help those affected by facility closures, distance from facilities, or reduced facility capacity and those with limited insurance coverage from other sources. The proposal's potential cost, however, appears to be significant. DOD and the Congressional Budget Office have estimated that additional annual costs could exceed $1 billion, assuming that military retirees' cost sharing equals that of other federal retirees. This option would also impose new administrative responsibilities and related costs on DOD and the Office of Personnel Management, such as managing enrollments, withholding premiums from annuities, and preparing and distributing plan materials.

Like the FEHBP proposal, providing CHAMPUS coverage to retirees when they reach age 65 would help those with limited access to military medical facilities or limited insurance coverage. In addition, older retirees could continue coverage under a plan with which they are familiar and pay no premiums. For these retirees, the program would operate as a secondary payer and cover most expenses that Medicare does not now pay, including prescription drug costs. Beneficiaries and providers alike, however, have expressed dissatisfaction with such aspects of the CHAMPUS program as the copayment amounts beneficiaries must pay and the amounts providers are reimbursed. Furthermore, the proposal's annual cost is estimated at approximately $2 billion.

Many of the benefits older retirees would enjoy under FEHBP and CHAMPUS could also be realized if DOD paid for their Medicare part B premium, Medigap plans, or both. The cost implications would also be similar,

roughly $630 million for Medicare part B and up to $2 billion for Medigap plans annually.

One alternative that would perhaps fill a significant health care gap for many older retirees is an expanded pharmacy benefit. DOD is considering a mail order program modeled after its current program in base closure areas. The proposed program also would reduce retirees' prescription expenses for those with limited or no prescription coverage and those who live too far from a military facility pharmacy. The costs of such a program would depend on the amount of retiree cost sharing required, whether retirees can continue to use military pharmacies, whether retirees have other prescription coverage, and the prices the government can obtain from drug suppliers. DOD's preliminary estimates of its additional cost range from $142 million to $360 million. The lower number assumes that only retirees living outside facility catchment areas (generally 40 miles) would be eligible for the mail order benefit. The higher estimate assumes all older retirees would be eligible.

Observations

DOD's responsibilities to a growing retiree population given the availability, cost, and coverage issues discussed today present a problem for the Department. On the one hand, like all responsible employers, DOD seeks to provide the best health care it can for its former employees, particularly during their later years when so many need it most. And DOD has acknowledged an obligation to its retirees, who served their country—many in harm's way—during their most productive years. On the other hand, however, the military's readiness needs determine the size of its health care system. While readiness decisions are now pending, some predict further system downsizing, leading to even less space-available care at military facilities.

Within this context, the Medicare subvention proposal for treating retirees at military facilities appears particularly unlikely to help many retirees. The FEHBP and CHAMPUS as a second payer proposals have potentially large price tags. While DOD health care system restructuring decisions are being made, however, the pharmacy proposal might fill an important benefit gap for retirees with limited or no pharmacy coverage.

Mr. Chairman, this concludes my prepared statement. My colleagues and I will be happy to respond to any questions you or other members of the Subcommittee may have.

Contributors

For more information on this testimony, please call Daniel Brier, Assistant Director, at (202) 512-6803. Other major contributors include Catherine O'Hara, Nancy Toolan, Sandra Davis, James Espinoza, Elsie Picyk, and Timothy Carr.

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