Defense Report

from AUSA's Institute of Land Warfare

MILITARY HEALTH CARE IN TRANSITION

The long-established ways of providing medical care for soldiers, military retirees, and family members are changing. The bond with career soldiers for lifetime medical care — though not an entitlement in law — is being redefined. The historic promise of free lifetime medical care is coming face to face with the fiscal realities of the post-Cold War era.

During the Cold War, the Defense Department maintained a large medical infrastructure of personnel and facilities. Providing health care for service members (and for families and retirees on a space-available basis) was a means to maintain medical skills and readiness. It also fulfilled the promise of continuing medical care to retirees.

The bond with career soldiers for life-time medical care ... is being redefined.

In the post-Cold War era, military medical resources are more constrained. The continuing reduction of the military medical system of doctors, nurses, medical technicians and associated hospitals and clinics is having an impact on the availability of medical care to the total military population. Space-available care will become less common as medical staffing and facilities decrease.

More than 1.7 million active duty service members *will* continue to receive health care on a first-priority basis at hospitals and clinics operated by the Department of Defense. As long as there are sufficient numbers of physicians assigned at the medical facility, care can also be provided to family members. If care is not available or the family member does not live near a military clinic, a statement of nonavailability will be issued, authorizing use of CHAMPUS. When on extended active duty, reserve component soldiers and their families will receive the same health care as active duty soldiers and families.

In this resource-constrained environment, a military retiree and family members, not yet eligible for Medicare, *may* receive space-available care in a military clinic or hospital. If care is unavailable at the military facility or the patient lives too far away, the retiree or family member will have to obtain care through CHAMPUS.

When the military retiree or family member becomes eligible for Medicare, space-available care in a military facility may *not* be an option. This is because of a federal regulation that blocks Medicare from reimbursing military facilities for treating Medicare-eligible patients. In the absence of reimbursement, Medicare-eligible beneficiaries (and other space-available beneficiaries) will probably receive less care in the DoD medical system simply because DoD cannot afford the additional resources. Further complicating the situation, the Medicare-eligible retiree is not eligible for alternative care under CHAMPUS (or the successor program, TRICARE).

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The most significant change in military health care is the introduction of TRICARE, DoD's regional managed care program. Individuals eligible for CHAMPUS are eligible for TRICARE. The change has begun in selected areas of the United States and is scheduled to be fully operational in the continental United States and Hawaii by 1997. Alternative managed care programs are being pursued in Alaska, Europe and the Pacific.

TRICARE offers three options for the receipt of health care. TRICARE Standard is CHAMPUS under another name. TRICARE Extra is a variant of CHAMPUS and offers the advantage of a network of health care providers who accept a reduced CHAMPUS payment in return for the business the local military facility refers to them. TRICARE Prime is the managed care or health maintenance organization (HMO) option. Its focus is on enrolling beneficiaries with a primary care manager (the military hospital or clinic or a network provider).

Serious and concerned individuals within and outside DoD are watching TRICARE very closely. Congress, as well as the Defense Department and associations such as AUSA, will be examining TRICARE as it evolves.

In light of the resource-constrained military medical system, some elements in DoD, the recent Commission on Roles and Missions of the Armed Forces, the General Accounting Office and the Congressional Budget Office have asked if the military medical departments should be providing peacetime health care to anyone other than active duty service members. Some would scale down medical department personnel by up to 50 percent, a level believed sufficient to provide peacetime soldier care and wartime casualty care. There would be corresponding cuts in hospitals and clinics.

The surgeons general of the military services have testified that if the military medical departments are cut to meet only wartime needs, the armed forces would have great difficulty recruiting and retaining physicians, surgeons, physicians' assistants, technicians, nurses and other specialists. What size military health care system is needed for military requirements is still an open question.

From this brief discussion it is obvious that military medical care, and health care in general, is in a state of transition. Any changes that are promulgated will affect the readiness of the medical departments of the armed forces and the more than 8 million men, women and children who are eligible for care.

Currently, several outcomes appear inevitable:

- Health costs for beneficiaries will increase as government resources become more constrained.

- There will be fewer medical personnel in uniform and fewer military medical facilities as the armed forces are reduced in size and bases continue to be closed. Access to military hospitals and clinics will become more difficult.

- There is little likelihood that military facilities will be reimbursed in the near term for treating Medicare-eligible beneficiaries.

- Congress will examine TRICARE closely; alternatives to TRICARE will be considered if problems of access and cost escalate and TRICARE is unable to provide a uniform benefit.

Where does this leave the military beneficiary?

In response to the recommendation of the Commission on Roles and Missions of the Armed Forces, DoD is examining medical readiness and health care benefits. At the same time, Congress is seeking ways to reduce health care costs in federal medical programs as part of the effort to reduce the federal budget deficit. It is therefore incumbent on all beneficiaries to be well informed of the various alternatives being proposed and to assess realistically their impact. Proposals for change are not inevitable; each of us must enter into the debate to ensure that the consequences of each proposal are aired and the direct and indirect effects on the armed forces are brought out for open debate.

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