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TRICARE

(AUSA's Institute of Land Warfare sponsors a series of small issues conferences to examine defense topics impacting on the U. S. Army. This paper presents a synopsis of the titled conference presented by Dr. Stephen C. Joseph, Assistant Secretary of Defense (Health Affairs) from notes taken by the ILW staff and reported by 1LT(P) Leslie Ballard, USAR. This conference was held on 28 March 1996.)

Military health care has a two-pronged mission. Its highest priority is to support active duty soldiers — and in the event of war or other conflict, all deployed soldiers. The other side of health care involves providing services to a largely civilian population of families of active duty servicemembers, and to retirees and their families. The major challenge in light of the enormous pressures of downsizing is to provide peacetime care. Increasingly, this will have to be done on a regional basis.

The military health care system is prepared to continue to provide top-quality health care in support of military operations and to members of the armed forces and others entitled to DoD health care. Toward this end there is a constant need for emphasis on the maintenance and monitoring of health care to continue to ensure its overall quality. The major problem in military health care is access. Difficult and limited access to medical care holds particularly true for retirees — especially those over the age of 65.

Of the present medical treatment facilities (MTFs), almost half of the 124 hospitals are Army. Since FY 1988, the number of hospitals has decreased by 35 percent and the number of medical centers by 33 percent. What compounds the problem of limited access is that while the infrastructure has gone down, the number of eligible users has remained almost constant, thus exacerbating the access problem. Cost containment is also a major consideration.

The top goal of the Assistant Secretary of Defense (Health Affairs) is to ensure efficiency despite downsizing. With added pressure to further downsize medical staff and facilities, debates continue to intensify.

Realistically, future medical health care facilities will be unable to handle user demand at the present rate. Consequently, many question why the military health system goes beyond just care of active duty personnel. The answer is that in order to remain in the forefront of medical technology and maintain high-quality recruitment and retainment of medical professionals, a medical infrastructure is required. For instance, it is uncommon to perform neurosurgery on healthy 25-year-olds. Military doctors would not have the opportunities to hone their skills as their civilian counterparts do. The peacetime military health system also maintains wartime readiness. Without the system, corpsmen and medics would not have consistent training to qualify them for real battlefield situations. The

military hospital is the only place where they can receive nonsimulated, hands-on training. To treat only active duty personnel and send all others to civilian care givers would only "box in" the military health system to a point where valuable exposure, experience, quality and growth would be suppressed.

In order to provide continued quality health care and better access amidst downsizing, however, more users will have to be managed through the civil sector. This is where TRICARE comes in.

What is TRICARE? TRICARE, which will be fully implemented in the fall of 1997, is a regionalized military-managed care program for members of the uniformed services, their families and survivors, and for retired members and their families. TRICARE will offer all eligible users three health care options, which will be cost-neutral to the government. The options are:

- TRICARE Standard — replacing CHAMPUS and characterized by service fees, cost-sharing and deductibles.

- TRICARE Extra — a preferred provider organization of physicians who provide services to users at reduced cost shares but with standard deductibles.

- TRICARE Prime — a health maintenance organization (HMO) option with enrollment and minimal cost shares; automatic for active duty soldiers.

The goals of TRICARE are to:

- maintain medical readiness;
- increase access to health care;
- improve quality of healthcare;
- enhance efficiency of health care delivery.

A key feature of TRICARE is the lead agent concept. To counter the inevitable inefficiencies of an overly large and centralized organization, health care will be approached through regions. Military health care recipients will be designated to a region or lead agent based upon where they live. There will be 11 regions in the continental United States and one each in Europe and the Pacific. DoD will assign each region its own budget. Respective services will designate one commander per region who will be directly responsible for that region and its budget. The regions are as follows:

- Region 1 - Northeast
- Region 2 - Mid-Atlantic
- Region 3 - Southeast
- Region 4 - Gulf South
- Region 5 - Great Lake states
- Region 6 - Southwest
- Region 7 - Desert states
- Region 8 - North Central
- Region 9 - Southern California
- Region 10 - Northern California
- Region 11 - Northwest
- Region 12 - Hawaii/Pacific
- European Region

By mid-1996, TRICARE will cover approximately half of the eligible population. Regions 7 (desert states) and 8 (North Central) will be activated by the end of the year.

There are other issues currently being debated, to include:

- medicare reimbursement to DoD;
- demonstration programs;
- subvention for retirees;
- Federal Employees Health Benefits Plan (FEHBP).

To make the intricacies of military health care and TRICARE more user-friendly, DoD is working on a simple and understandable brochure which will include briefing slides, a script and two videos. These will be available soon to the respective TRICARE regions.

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