



The Promise . . . The Reality:
STATE OF THE MILITARY HEALTH CARE SYSTEM

January 1996



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CONTENTS

Foreword.....	v
Introduction.....	1
The Current Military Health Care System.....	2
Past Reform Efforts.....	2
Military Health Care Benefits.....	3
Active Duty Personnel.....	3
Active Duty Family Members.....	4
Reserve Component Members and Their Family Members.....	5
Retired Beneficiaries.....	5
Military Retiree Family Members.....	6
Medicare Eligible Personnel.....	6
Base Closures and Health Care Beneficiaries.....	6
Future Military Health Care Benefits.....	7
TRICARE.....	8
Concerns About TRICARE.....	12
Federal Employees Health Benefits Program.....	13
Medical Care and Operational Requirements.....	13
In Summary.....	15
Acronyms.....	16
Glossary.....	17
Bibliography.....	19

FOREWORD

The military health care system we have used and become accustomed to is expected to undergo fundamental transformation with respect to both availability and cost of care. So, what does the future hold for the more than eight million military health care beneficiaries (active, retired and reserve, and their families)?

To address this fundamental question, with its many associated issues and concerns, the Association of the United States Army is undertaking an in-depth examination of military health care. Because of the dynamic nature of the subject, some questions must go unanswered in the short term. However, we will make every effort to present as clear and concise a description of military health care and its many related issues as possible.

This is the first in a planned series of papers to address the various facets of the military health care debate. The primary purpose of this paper is to provide a basic framework and to present a look at where we are and where we may be headed. The paper was prepared by Mr. John E. Grady, Mr. John M. Molino, Mrs. Veronica Zearley, and the staff of AUSA's Institute of Land Warfare.



JACK N. MERRITT
General, U.S. Army Retired
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INTRODUCTION

The military health care system is undergoing close scrutiny by the Clinton administration and Congress. The long-established ways of practicing medicine and providing medical care for active duty 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.

Military health care and the alternative reform options under consideration are complex. The exposure which health care and its associated costs have received in the national media only add to the complexity. Any mention of the topic is often sufficient to cause beneficiaries anxiety and concern that future military medical care may not be available. Surveys indicate that health care is at or near the top of the list of concerns for soldiers and retirees and their families. The historic promise of lifetime medical care (never written into law) is coming face to face with the fiscal realities of the post-Cold War era.

At the heart of this is the continuing downsizing of the military medical system of doctors, nurses, medical technicians and associated hospitals and clinics. At the same time, the military beneficiary population continues to grow and will soon exceed eight million people. This is happening at the same time military medicine is under a congressional mandate (in the Fiscal Year 1994 Defense Authorization Act) to improve access for beneficiaries at no additional cost to the government.

The requirement for no additional cost to the government has an immediate and powerful effect on military retirees and family members who are eligible for Medicare. They are not covered under either the existing CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) health benefits program or the emerging TRICARE (Triservice Care) managed care program (both discussed later in this paper). Their access to medical care at a DoD facility is provided solely on a space-available basis. Many beneficiaries are asking: Will the continuing drawdown of medical personnel and facilities and lack of reimbursement from Medicare reduce the capabilities of space-available care in the future?

The status of military medical care is impacted by (1) fewer providers of medical care in uniform; (2) fewer military medical facilities; and (3) a growing beneficiary population. Against this background, this paper describes the current state of military health care; outlines the emerging TRICARE system, which combines the direct-care system and the current CHAMPUS system; and presents other issues and concerns which will shape future military health care.

THE CURRENT MILITARY HEALTH CARE SYSTEM

During the Cold War, military medical requirements in the event of a war in Europe were known to be great. Consequently, the Defense Department maintained a large infrastructure of medical personnel and facilities to be ready for that possibility. What were these doctors to do until the war came? From the military point of view, providing health care to service members, and to families and retirees, was simply a matter of maintaining military readiness; providing care for eligible family members and retirees on a space-available basis also enabled medical personnel to maintain their professional skills. It also fulfilled the promise of continuing medical care to military retirees.

Military health care for soldiers and their families, as well as for retirees and their families, was generally available during the Cold War era. Priority of care in military medical facilities went to the soldier on active duty. Next priority was to the soldier's family on a space-available basis. Retirees and their families are also authorized care on a space-available basis, but on a lower priority basis. Recognizing that care might not always be accessible or available, in 1966 — and in 1967 for retirees — new legislation authorized CHAMPUS. This new program provided a safety net of some degree of care by the civilian medical system.

Today, as during the Cold War, a significant major military operation or war would necessarily require that priority for medical care be primarily for service members. Unless other actions were taken by DoD, families and retirees would have to rely exclusively on CHAMPUS, or on the new TRICARE system.

Ironically, the first real test of this wartime scenario was Operation Desert Shield/Desert Storm. Whether in recognition of the commitment made to family members and retirees or because of the enormous expense and impact on the CHAMPUS system, DoD decided not to rely on CHAMPUS when military doctors went to Desert Storm. Instead, reserve component doctors were called to active duty, in many cases not to serve with their reserve units but to backfill at active duty military treatment facilities.

PAST REFORM EFFORTS

A series of reforms, beginning with the Catchment Area Management demonstrations, was attempted in the 1980s. Hospital commanders could take CHAMPUS money and use it to treat patients within a forty-mile radius of military medical facilities, recapturing medical treatment such as obstetrics, gynecology and mental health that was being done off post. The emphasis was on making sound clinical and business decisions. When care could not be provided in the military treatment facility, beneficiaries were given the names of doctors who would provide the necessary care at a discount to the patient and the military.

In the Washington, D.C., metropolitan area, the military services tried Primus to help improve access to medical care. Primus consists of walk-in, contractor-operated clinics located in off-post neighborhoods. These clinics treat minor ailments and injuries, provide immunizations, and conduct patient medical examinations. Similar experiments under different names were tried in other geographic areas with large concentrations of service members, their families and retirees.

Over the years, the basic CHAMPUS fee-for-service program has added coverages (the kinds of treatment and cost ceilings); cost-share (the amount for which an individual was responsible after CHAMPUS paid its share) has remained the same for outpatient care and increased for inpatient care; and deductibility

(out-of-pocket expenses a person had to pay before CHAMPUS would begin its coverage) has increased. Costs were rising; and there was a major operating shift in the way bills were paid by the Defense Department.

The lessons learned from the 1980s led the Army to create its Gateway to Care program. It was intended to give local hospital commanders more power to bring families and retirees back into military facilities for treatment; it also created local networks of civilian physicians to meet goals to deliver effective health care without relying on standard contracts covering large sections of the country. For the beneficiary, care was to be continuous with little out-of-pocket expense. Where the Army saved money, local commanders could choose to invest the savings in projects aimed at improving local health care operations. Gateway to Care is serving as the Army's transition plan to the new DoD TRICARE.

In 1988, the most direct forerunner to TRICARE, the CHAMPUS Reform Initiative, was established; it introduced the concept of managed care into CHAMPUS. This demonstration program was centered in California and Hawaii.

Lessons from this initiative — such as cutting the paperwork burden placed on beneficiaries — were incorporated in later programs. The CHAMPUS Reform Initiative improved access for active duty family members and many retirees and their families; however, its costs to the government were running about 19 percent higher than traditional CHAMPUS. In part, the reason for the higher costs to the government came through the surfacing of the “ghost population” of beneficiaries. Many beneficiaries had stopped using the military health care system because of problems of access. The Department of Defense discovered that most of these “ghost” beneficiaries left more costly health care plans offered by their employers to take advantage of the savings to individuals and families under the CHAMPUS Reform Initiative.

When the Department of Defense proposed expanding the reform initiative into other regions of the country, Congress said no because the cost to the government was rising faster in that program than in any other CHAMPUS program during the early 1990s. What Congress required in the Defense Authorization Act of Fiscal Year 1994 was a new health care plan with options for military beneficiaries that improved access but did not cost the government more than existing CHAMPUS. This authorization bill led to the new TRICARE system. Access to and costs of military health care are the major concerns for every category of beneficiary.

The section that follows summarizes the military medical care now available and the care that will become available under TRICARE. Care for Medicare-eligible personnel is covered in a separate section.

MILITARY HEALTH CARE BENEFITS

Active Duty Personnel

Over 1.7 million active duty service members receive health care on a first-priority basis at hospitals and clinics operated by the Department of Defense. This benefit includes dental and vision care. Active duty personnel are required to use the military treatment facility. In emergencies, medical care may be obtained from the most readily available, appropriate source; the Department of Defense will pay for the required care. Elective, nonemergency care outside the military medical system is not covered; active duty

service members would have to pay for this. It is always best for service members to seek advice from the closest medical facility before seeking care outside the system. Active duty personnel are not eligible for CHAMPUS.

DoD plans no change to the current policy for active duty personnel. Base closures, realignments and other force structure changes may have an impact on the convenience of using the military hospital or clinic. However, active duty personnel will see no major changes in the way they receive medical care. Care for service members is still the overriding, primary mission of the medical health care system.

Active Duty Family Members

If you are a family member of an active duty service member, you can receive care at military treatment facilities on a second-priority (space-available) basis after active service members and before retirees and their families. As long as there are sufficient numbers of physicians assigned at the medical facility, care can be expected to be provided to family members. Active duty family members have experienced having to wait to obtain an appointment; however, care is generally available.

Vision and dental care for family members is rarely available in military facilities. You are encouraged to check with the health care facility nearest you. CHAMPUS provides none of these benefits. Dental coverage is available through the voluntary Active Duty Dependents Dental Plan paid for in part by the government and in part by the service member.

If the type of care needed is not available at a military treatment facility or if you do not live near a military clinic, you will be given a statement of nonavailability and authorized to use CHAMPUS. CHAMPUS is for active duty family members and retirees and their families who are not eligible for Medicare.

CHAMPUS permits you to find a doctor in the civilian sector. If the doctor accepts CHAMPUS, the doctor may file the CHAMPUS claim for you. Most likely, however, the doctor will expect payment from you. You must then file the CHAMPUS claim and wait for reimbursement. Each fiscal year you are required to pay the first \$150 for an individual and \$300 for a family in allowable civilian medical bills. (An E4 or below pays \$50 and \$100 respectively.) Once you have met this deductible, CHAMPUS payments are authorized.

For families of active duty service members, CHAMPUS pays 80 percent of the allowable bill; you pay the balance. Each CHAMPUS Claims Processing Company has a fee schedule indicating the allowable charge for specific procedures. If your doctor accepts the CHAMPUS allowance, you will be billed only for your cost-share of the bill. If your doctor does not accept CHAMPUS, you would be billed your cost-share plus any charges up to 15 percent above the allowable.

The cost-share amount of 20 percent of the allowable charges for active duty family members is your responsibility until you reach the fiscal catastrophic cap of \$1,000. You can offset out-of-pocket expenses by purchasing a commercially available CHAMPUS supplementary health insurance policy. This policy pays the individual's cost-share as well as the amounts over the allowable charges. AUSA is among many military-related organizations offering this type of coverage.

A word on nonavailability statements: As a rule, you do not need a statement of nonavailability to make the first visit to a doctor of your choice. Keep in mind, however, that you are still required to meet the deductibles, copayments, etc. If the doctor prescribes additional procedures, which can be expensive and may be available at a military facility, you will almost certainly need a statement of nonavailability before obtaining care.

DoD plans call for the spouses and children of active duty service members to be enrolled in the Department of Defense's TRICARE program by 1997. TRICARE is more than merely the successor health plan to CHAMPUS. There are important differences which are explained in the section on TRICARE.

Reserve Component Members and Their Family Members

If you are a member of the reserve components, you are authorized a complete medical physical annually. Additionally, recently enacted legislation entitles reserve component members to an annual preventive dental examination. Beyond that, reserve component members not on extended active duty are authorized no medical or dental care. When on extended active duty, of course, the member of the Army National Guard or Army Reserve is entitled to the same health care as an active duty soldier.

When the sponsor is on extended active duty, eligible family members are entitled to health care benefits. Under these circumstances the same rules of eligibility for treatment in a military hospital or clinic or for care under CHAMPUS that apply to families of active duty personnel apply to the families of Reservists and Guardsmen.

Retired Beneficiaries

If you are a military retiree not yet eligible for Medicare, you may receive medical care through the military system. This includes space-available care in military clinics and hospitals and through CHAMPUS. Military retirees, including those over 65, are entitled to space-available care at military treatment facilities on a priority scale below active duty family members. There is no dental plan for either the retiree or his or her family.

If care is unavailable at the military facility or if you, a retiree under age 65, live too far from a military health care provider, you may obtain care through CHAMPUS. You should contact the CHAMPUS coordinator at the nearest health care facility to obtain current CHAMPUS rules. You will learn when you can go directly to a civilian doctor and when a statement of nonavailability is required. (See the discussion on CHAMPUS in the section above titled "Active Duty Family Members.")

Retirees often use the pharmacy in the military medical facility. This remains an excellent benefit for those fortunate enough to have access. If you rely on CHAMPUS, your pharmacy benefit is limited to 75 percent of the cost of the prescription once you have paid the annual deductible.

Space-available care at military facilities will become less common as bases close and military staffing decreases. CHAMPUS, the current alternative, is scheduled to be integrated into TRICARE by the end of Fiscal Year 1997 on a progressive, regional basis. Military retirees not eligible for Medicare and their family members will be able to enroll in TRICARE. (See the section on TRICARE.)

Military Retiree Family Members

If you are a family member of a military retiree who is not yet eligible for Medicare, you may receive medical care through the military system, including CHAMPUS. Military retirees and their family members have the same status and priority, after active-duty family members. Additionally, retirees pay more than active duty beneficiaries for care under CHAMPUS. There is no dental plan for the retiree or his or her family.

The cost-share amount of 25 percent of the allowable charges for the retiree family member is your responsibility until you reach the fiscal catastrophic cap of \$7,500. You can offset out-of-pocket expenses by purchasing a commercially available CHAMPUS supplementary health insurance policy. This policy pays the individual's cost-share as well as the amounts over the allowable charges. AUSA is among many military-related organizations offering this type of coverage.

Retiree family members seeking care under the military health care system follow the same procedures outlined for the retiree above. The future holds the same expectations as those expressed for the military retiree.

Medicare Eligible Personnel

When you become eligible for Medicare (usually when you reach age 65), you are no longer eligible for CHAMPUS or the successor program, TRICARE. However, you can still use TRICARE service centers to locate providers accepting Medicare assignment. Complicating the problem for these older beneficiaries is a federal regulation that blocks Medicare (through the Health Care Financing Agency or HCFA) from reimbursing military facilities for treating Medicare-eligible patients. In FY 1994, DoD spent over \$1 billion to treat Medicare-eligible beneficiaries in military hospitals and clinics. This spending could increase to about \$2 billion by the end of the 1990s.

If DoD were reimbursed for treating Medicare patients, there would be an incentive for DoD to retain the capability to do so. However, in the absence of reimbursement, Medicare-eligible beneficiaries and other space-available beneficiaries will probably receive less care in the military system because of base closures and cuts in the size of the armed forces and their medical departments.

The Defense Department is exploring the feasibility of Medicare reimbursement, known as Medicare subvention. However, DoD's initiatives are meeting stiff resistance from other federal departments. Medicare has its own financial problems which limit its ability to reimburse DoD for treating Medicare-eligible patients.

Base Closures and Health Care Beneficiaries

Health care facilities are among the last to go when a military base closes. To assist local military beneficiaries in the United States who are affected by a base closure, a substitute managed care "preferred provider network" is put into place. The network consists of doctors who have signed contracts to deliver discounted medical services to military families and retirees not eligible for Medicare, as well as a retail pharmacy network.

The transition planners at closing installations in the United States also identified options for those covered by Medicare. Medicare is not available overseas. If you are Medicare-eligible and reside overseas your options are to return to the United States for care; purchase host nation health insurance; or be prepared to drive further and wait longer at the fewer military hospitals and clinics that will remain open.

A special TRICARE test program that waives traditional copayments and deductibles for 100,000 active-duty family members in the European and Central Commands has been in place since 1994. It has recently been extended through September 1996. Retirees living in Europe, Africa and the Middle East are not eligible for this program. The experimental effort provides off-post care to replace closed military hospitals and clinics in Europe. Active duty family members use an off-post physician, clinic or hospital of their choice. This differs from TRICARE's plan for the continental United States (to be discussed in the next section) under which family members choose from a list of physicians and clinics who have agreed to participate in the plan.

FUTURE MILITARY HEALTH CARE BENEFITS

The most significant immediate 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 some parts of the continental United States; the Department of Defense expects TRICARE to be operational in the 48 contiguous states and Hawaii by 1997. All overseas areas, including Alaska at this time, will be excluded from the program. However, managed care programs are being pursued in Alaska, Europe and the Pacific.

Four goals have been set for TRICARE: predictable, low-cost health care for all beneficiaries; enhanced access; appropriate and timely treatment; and satisfaction with the care received. In your examination of the emerging TRICARE system and its stated goals, several factors need to be kept in mind:

- The need for the military medical system stems primarily from its mission to care for soldiers, sailors, airmen and marines in wartime. Toward this end, military medical personnel train for their wartime mission, deploy with forces on a variety of operations, and also provide care for active duty service members and their families, and retirees and their families.
- The size of the armed forces is being cut and bases are being closed. By FY 1999, the Army's medical department will have absorbed about the same percentage of cuts as the rest of the Army. Still, there are those who say that the cuts do not go deep enough.
- Congress is looking to managed care programs similar to TRICARE as a way of slowing and possibly even cutting the costs the government pays for health care. This trend to limit individual choice in medical care is accelerating as part of the effort to reduce the deficit and balance the budget by FY 2002.

In reviewing TRICARE keep the following points in mind when the time comes to enroll and elect options:

- There are options under TRICARE which did not exist under CHAMPUS. You have to weigh the degree of choice versus out-of-pocket expenses in selecting an option.

- Each family member enrolls separately. Each enrollee will have a toll-free number to call if questions arise when the enrollee is away from his or her local area.
- Space-available care in a military hospital or clinic is probably going to become more difficult to obtain.
- Once the enrollment period is in place in a region, space availability may be cut back in military hospitals and clinics.
- Medicare-eligible personnel who are 65 or older are excluded from TRICARE in the same way they are excluded from CHAMPUS. (However, Medicare-eligible retirees can still use the services of TRICARE benefits advisers and network physicians.)
- You may still need to buy a supplemental health insurance policy since you may continue to have out-of-pocket expenses similar to those under CHAMPUS. This can depend on the TRICARE option you choose.

TRICARE

With fewer military doctors and hospitals, and rising costs to both the government and beneficiaries, military health care has to change. In response to the mandate for change, TRICARE has been designed to provide enhanced access to health care for all beneficiaries within defined budget limitations. The changes that will take place are meant to improve care for beneficiaries at military hospitals, clinics and pharmacies; save money; and shift the focus from treatment to prevention. The emphasis will be on wellness, prevention of disease or illness, and personal responsibility for healthy living.

TRICARE offers three alternatives for the receipt of health care:

TRICARE Standard is CHAMPUS under another name. At this point, the rules for TRICARE Standard and the rules for CHAMPUS are the same. TRICARE Standard will have the customary deductibles and copayments and the requirement for nonavailability statements. You may have to file claims yourself for reimbursement. TRICARE Standard also runs the risk of being out of favor with many doctors in the civilian community.

TRICARE Extra is a variant of CHAMPUS. This option is available for use on a case-by-case basis. It 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. Additionally, the health care provider will file all required paperwork. The standard CHAMPUS annual deductible applies; however, the copayments (i.e., cost-share) are reduced by five percent from the TRICARE Standard.

TRICARE Prime is the managed care or health maintenance organization (HMO) option. It is the most restrictive choice, but requires the least out-of-pocket expense. Currently, this option is projected to be available in all TRICARE regions by 1997. Its focus is on enrolling beneficiaries with a primary care manager in the military hospital or clinic or with a network provider located within the community.

The costs of these options to the beneficiary are shown in table 1.

Table 1**TRICARE Triple Option Costs**

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductibles:			
Families of E-4s and below	\$0	\$50/\$100	\$50/\$100
Other active duty families	\$0	\$150/\$300	\$150/\$300
Retirees and others	\$0	\$150/\$300	\$150/\$300
Annual Enrollment Fees:			
Families of E-4s and below	\$0	\$0	\$0
Other active duty families	\$0	\$0	\$0
Retirees and others	\$230/\$460	\$0	\$0
Civilian Provider Copays:			
Families of E-4s and below	\$6	15% of negotiated fees	20% of allowed charges
Other active duty families	\$12	15% of negotiated fees	20% of allowed charges
Retirees and others	\$12	20% of negotiated fees	25% of allowed charges
Civilian Inpatient Cost Shares:			
Families of E-4s and below	\$11 per day	\$9.50 per day	\$9.50 per day
Other active duty families	\$11 per day	\$9.50 per day	\$9.50 per day
Retirees and others	\$11 per day	\$250 per day plus 20% of negotiated prof fees	\$323 per day plus 25% of negotiated prof fees

Note: This chart does not display all cost-sharing amounts.

TRICARE is a form of managed care for military beneficiaries; it does not include retirees eligible for Medicare. Under TRICARE, beneficiaries receive treatment at military facilities or from civilian doctors who are part of regional networks.

The Defense Department has established 12 regions for TRICARE which encompass the continental United States. The regions vary widely from dense clusters of military installations to areas where many beneficiaries live far from military hospitals. In each region, the commander of a large military medical facility is designated as the lead agent to implement DoD's managed care approach to medicine. Army medical center commanders are lead agents in five regions.

For example, in the southeastern United States, the Eisenhower Army Medical Center at Fort Gordon, Georgia, is developing a plan for South Carolina, Georgia and Florida. As the lead agent, the medical center must address how to provide managed care in the Atlanta metropolitan area with its large population and no significant military treatment facility, and throughout the three-state region.

With congressional direction and support, and barring delays, DoD hopes to have TRICARE fully operational by 1997. Figure 1 indicates the regions and the dates TRICARE is expected to be in place.

The TRICARE Prime or HMO option will be immediately available to beneficiaries living within the catchment area of a military hospital. (A catchment area is defined as a forty-mile radius from the facility.) TRICARE Prime will also initially be offered in some metropolitan areas without a military hospital. The goal is to ultimately have this option available to all beneficiaries. Until then, TRICARE Standard, the option that most closely resembles existing CHAMPUS, will be available. In March 1995, the Department of Defense formally began its TRICARE Prime program in Washington and Oregon, a region of the country familiar with "managed care."

TRICARE service centers will be opened and contracts signed with civilian health care delivery companies to provide additional support. These steps are designed to allow families and retirees their choice of care in a military facility or with a physician network. Under TRICARE Standard, beneficiaries may choose any physician they wish.

A goal of TRICARE is to allow each military department to focus on its needs and strengths and to improve communication, coordination, sharing and planning among the services and, in the process, enhance beneficiary access to care. Though coordination of patient care is stressed, the three services will keep their own medical command and control channels.

TRICARE is designed to function within the regions as follows:

- The military medical treatment facilities within a region will jointly develop a plan to deliver care. The lead agent, usually a major military medical facility commander, will coordinate the development of the plan.
- Next, a managed care support contract will be awarded to expand the medical care network. The contractor will provide "health care finders," enroll beneficiaries in the network, maintain necessary records, and implement marketing and public education plans.

Figure 1

DoD Health Service Regions and Activation Dates



TRICARE EUROPE
(Under Development)

NORTHWEST
(Madigan)
MAR 95

NORTH CENTRAL
(Fitzsimons)
NOV 96

REGION 5
(Wright Patterson)
MAY 97

NORTH EAST
(National Capital)
MAY 97

MID ATLANTIC
(Portsmouth)
MAY 97

SOUTHEAST
(Eisenhower)
MAY 96

GULF SOUTH
(Keesler)
MAY 96

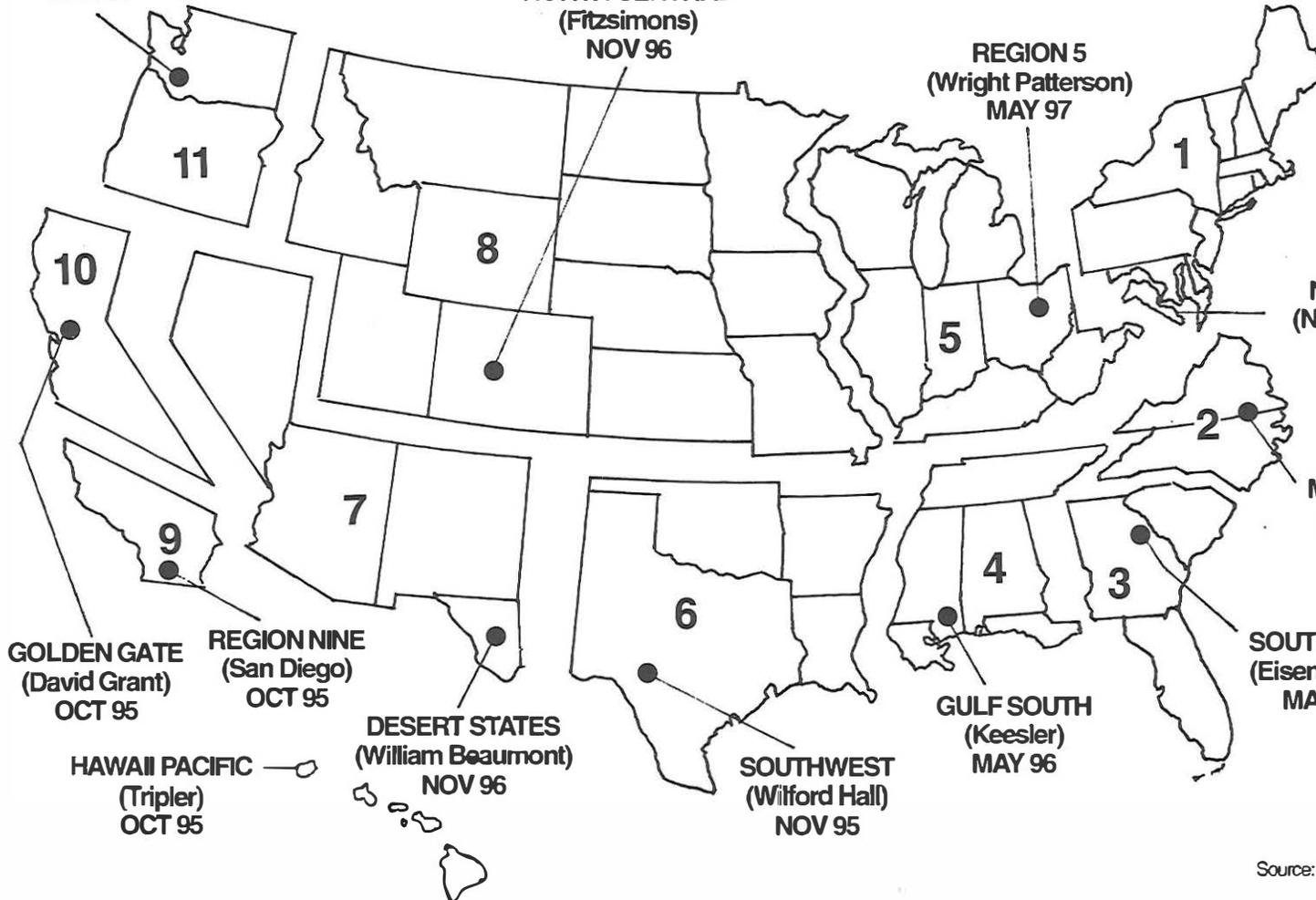
SOUTHWEST
(Wilford Hall)
NOV 95

DESERT STATES
(William Beaumont)
NOV 96

REGION NINE
(San Diego)
OCT 95

GOLDEN GATE
(David Grant)
OCT 95

HAWAII PACIFIC
(Tripler)
OCT 95



Source: Department of Defense
March 6, 1995

- Together, the contractor and the military treatment facilities in the region will eventually offer the three TRICARE options: Prime, Extra and Standard.

Cooperation among the services, the contractor and the lead agent is crucial to the success of TRICARE. The region's TRICARE lead agent serves as a hub for this cooperation. The lead agent has a great deal of influence within the region and bears the responsibility to develop and carry out the managed care plan for the region and see that contract terms are met. TRICARE will be portable when implemented in all regions.

To ensure that the care is consistent and of high quality, the Department of Defense will survey beneficiaries annually. The data will be localized so that military health officials can evaluate individual facilities.

CONCERNS ABOUT TRICARE

Concerned individuals within and outside DoD are watching TRICARE very closely. TRICARE's overall affordability is not yet proven and the ability of the lead agent to fulfill the responsibility that goes with the position is unknown. There are many questions and not many answers. Along with the Defense Department and associations such as AUSA, Congress will be examining TRICARE as it evolves.

The Defense Department is coming face to face with the reality that it may be unable to provide health care to a patient population any larger than the active component. At the same time, the department is coming to grips with the fact that, as a federal employer, it must provide a health care plan for its current, future and retired employees and their families.

Against this background, here are some of our concerns with TRICARE:

The continued exclusion of Medicare-eligible personnel from coverage is wrong. It is doubtful that there are any savings to the government by moving these usually older retirees out of the military health care system into the civilian Medicare program. In fact, costs for services in military facilities have been less than for comparable care in civilian hospitals and clinics.

Congress has mandated that overall TRICARE costs will not exceed the costs of CHAMPUS. Because all options will not necessarily be available within a region, it is important to look at the total cost of TRICARE and not the cost of each option separately. If cost limits are applied to each option, an option could be scaled back to control costs to the government. In effect, this violates Congress' stated goal of improved access to care and setting a uniform standard of care for all beneficiaries.

Because of the large dollar value of the regional contracts, few companies can afford to bid on them. The financial stakes are high for the bidders. The contract for the relatively small area of the northwestern United States was for \$436 million. The Department of Defense estimates that the 12 regional contracts will cost about \$17 billion. We are concerned that this lack of competition will keep costs high for the beneficiary and the government. We also see the cumbersome and contentious procurement process, with its appeals and claims, causing delays and confusion among beneficiaries. This has already happened in three regions.

We believe that there should be another option in TRICARE for Medicare-eligible beneficiaries and retirees and their families who do not live near a military hospital or clinic. One possibility is the Federal Employees Health Benefits Program discussed in the next section.

While TRICARE Prime, the HMO option, appears to offer the most services at the lowest cost, a family's insurance needs may dictate choosing TRICARE Standard. If you have a child in college outside the TRICARE catchment area, that child will likely best be covered by TRICARE Standard.

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

An alternative that would recognize DoD's commitment as an employer and still provide health care to active duty personnel might be the Federal Employees Health Benefits Program (FEHBP). FEHBP would cost beneficiaries a defined amount of money. In offering FEHBP to military beneficiaries, the promise of free, lifetime medical care would be formally broken. In practical terms, it already has been broken. However, unlike the current situation, FEHBP would provide a defined benefit for the money paid.

About nine million people — federal employees, retirees and survivors — are currently enrolled in the Federal Employees Health Benefits Program. There are about 400 different health care programs available nationwide; usually 20 or more are available in a given area. The programs range from traditional plans to health maintenance organizations.

As with TRICARE, enrollment is for a year in any one of the different health care plans; but unlike TRICARE, coverage does not end when a person turns 65 or becomes Medicare eligible. Also unlike TRICARE, many plans in FEHBP offer both vision and dental coverage.

FEHBP is portable; if you move during the course of a year you may enroll in another plan at your new location. There are no bars against "preexisting conditions" in enrollment. If a person is eligible to enroll, that person may enroll regardless of past medical history. The federal government currently picks up between 60 and 75 percent of the cost of an individual plan. The beneficiary pays the rest.

The Federal Office of Personnel Management is given great flexibility in negotiating rates and benefits of plans. Competing plans offer a wide range of services, including hospital and physicians' services, tests, immunizations and preventive examinations, and a limit on out-of-pocket expenses. Many plans offer dental and vision coverage. Table 2 (page 14) provides comparative data on TRICARE and FEHBP fees.

MEDICAL CARE AND OPERATIONAL REQUIREMENTS

Mission readiness is primary. Military medicine's bottom line exists to support combat forces in war and, in peacetime, to maintain and sustain the well-being of the fighting forces in preparation for war. This includes routine preventive care, as well as treatment for injury and illness.

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. They would scale down medical department personnel by up to 50 percent, a level believed sufficient to meet peacetime soldier care and wartime casualty care. There would be corresponding cuts in hospitals and clinics.

**Table 2
Comparison of TRICARE Prime and FEHBP Fees**

	TRICARE Prime Fee and Copayment Schedule			FEHBP Sample HMO Plans	
	AD Families of E4 and of Below	AD Families E5 and Above	Retirees and Their Families	Kaiser Mid-Atlantic	Group Health Puget Sound Standard Option
Annual Enrollment Fee or Premium	\$0/\$0	\$0/\$0	\$230-Ind. \$460-Fam.	\$463-Ind. \$1,318-Fam.	\$488-Ind. \$1,129-Fam.
Deductible					\$100
Civilian Outpatient Visits	\$6	\$12	\$12	\$0	\$5
Emergency Room Visits	\$10	\$30	\$30	\$0	\$100
Prescriptions	\$5	\$5	\$9	\$7	\$7
Civilian Inpatient Per Diem, General	\$11	\$11	\$11	\$0	\$0
Civilian Inpatient Per Diem, Mental Health/Substance Use	\$20	\$20	\$40	\$0*	20%*
Average Family Beneficiary Costs	\$110	\$160	\$800	\$1,700	\$2,500
* Plan pays in full after \$1,500 individual/\$3,000 family.					

The surgeons general of the military services have testified that if the military medical departments are cut to meeting only wartime needs, the armed forces would have great difficulty recruiting and retaining physicians, surgeons, physicians' assistants, technicians, nurses and other specialists. This is because medical personnel need to provide care to a broad range of patients — from children through the elderly — to keep themselves proficient and current in their specialties.

The surgeons general are also questioning the computer models used to predict casualties in future combat. Current DoD models use Operation Desert Storm as the base for analysis and do not factor in the use of chemical, biological or nuclear weapons on the battlefield. New studies are under way in the Department of Defense and in Congress to improve both the models and the predictions of casualties in future combat. The studies will go a long way in determining the infrastructure of military hospitals and clinics, physicians' specialties, and training and experience needed to achieve the appropriate level of readiness.

What size military health care system is needed for military requirements is still an open question. The GAO notes: "The Army . . . must plan to meet a variety of wartime environments, from a sophisticated battlefield with an infrastructure of communication and facilities, to a relatively unsophisticated battlefield in which it may have to create an infrastructure or choose to fight without one This requires the Army Medical Department to provide mobile, flexible support across long distances in a variety of environments."

Purely wartime medical requirements are lower than the sum total of all types of operational requirements. Other operational requirements must also factor in medical needs for missions such as humanitarian efforts in treating disease and wounds (such as for Rwandan refugees), establishing a new government health care system (such as in Haiti), and supporting U.S. forces deployed to such areas as Kuwait.

In the final analysis, making size and structure decisions affecting military health care cannot be based solely on wartime requirements or the costs to the government.

IN SUMMARY

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 eight million men, women and children who are eligible for care. Currently, several outcomes appear inevitable:

- Health costs for beneficiaries will be rising.
- There will be fewer medical personnel in uniform and fewer military medical facilities as the armed forces downsize and bases continue to be closed. Access to military hospitals and clinics could become more difficult.
- There seems little likelihood that military facilities will be reimbursed for treating Medicare-eligible beneficiaries, at least in the near term.
- Congress will consider alternatives to TRICARE, particularly if problems of access and cost to both government and beneficiaries escalate and if 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 aware of the various alternatives being proposed and to realistically assess 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.

ACRONYMS

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DEERS	Defense Enrollment Eligibility Reporting System
DoD	Department of Defense
DME	Durable Medical Equipment
FEHBP	Federal Employees Health Benefits Program
HMO	Health Maintenance Organization
HCFA	Health Care Financing Agency
MTF	Military Treatment Facility
TRICARE	Triservice Care

GLOSSARY

Allowable charge: An amount set by CHAMPUS which is used to figure a beneficiary's cost-share.

Beneficiary: Anyone eligible for military health care, including active duty/reserve/retired military personnel and their families.

Catastrophic cap: The upper limit that an individual or family will have to pay for health care in any fiscal year.

CHAMPUS: The health benefits program for all the uniformed services. The acronym stands for Civilian Health and Medical Program of the Uniformed Services.

CHAMPUS supplemental insurance: Health benefit plans designed to supplement CHAMPUS benefits. They generally pay most or all of whatever is left after CHAMPUS has paid its share of the cost of covered health care services and supplies.

Copayment: See "cost-share."

Cost-share: This is the portion the beneficiary pays of the allowable charges for care. This term is synonymous with copayment.

Deductible: The amount the beneficiary pays on medical care bills each fiscal year. It is separate from, and in addition to, cost-share.

Direct care: Care given in a military treatment facility by military or civil service providers.

DEERS: Defense Enrollment Eligibility Reporting System. To receive treatment in a military health care system, eligible individuals (including newborns) must be enrolled in DEERS.

Federal Employees Health Benefits Program: A variety of health care plans offered to federal civil servants, their families, retirees and survivors. The employee and the federal government contribute to the cost of the program.

Health care provider: A physician, physician's assistant, nurse practitioner, nurse or other professional provider of health care.

Health maintenance organization: A health plan to which you pay a fixed premium for an assortment of medical services, usually including primary and preventive care. The HMO employs physicians, therapists and other health care professionals to serve your medical needs.

Lead agent: The commander of a DoD medical activity responsible for implementing the TRICARE health plan in one of the 12 geographic regions.

Managed care: Health care delivered to enrolled members by an organization such as an HMO, which controls costs by closely supervising and reviewing the delivery of care.

Medicare: A federal health insurance program offered for those eligible for Social Security benefits. While generally applying to men and women over 65, Medicare benefits are extended to certain disabled individuals as well. A person eligible for Medicare benefits is ineligible for CHAMPUS and TRICARE.

Military treatment facility: A regional medical center, community hospital or clinic operated by the Department of Defense.

Nonavailability statement: A certification from a uniformed service hospital that it cannot provide care needed by a beneficiary.

Operational medical requirement: Sufficient medical personnel and facilities to meet combat casualty care needs in a theater of operations.

Preferred provider: A network of health care providers who provide services to patients at discounted rates on a cost-share basis.

Space available: Health care treatment in military facilities after active duty service members are treated.

Subvention: Payment by Medicare to Department of Defense medical facilities for treating Medicare-eligible patients. A quirk in federal law bars the financing arm of Medicare from paying either DoD or Veterans Affairs for treating older patients.

TRICARE: A Department of Defense regional managed care program designed to improve beneficiary access to care and assure affordable and high quality care.

BIBLIOGRAPHY

Executive

Directions for Defense, Report of the Commission on Roles and Missions of the Armed Forces, May 24, 1995.

Medical Readiness Strategic Plan 1995-2001, Department of Defense, Office of the Assistant Secretary of Defense, March 1995.

Report on Other Medical Issues (Submitted in Support of the Comprehensive Study of the Military Medical Care System), Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, April 1994.

The Economics of Sizing the Military Medical Establishment, Department of Defense, Office of Program Analysis and Evaluation, April 1994.

Section 733 Study of the Military Medical Care System, Department of Defense, Office of Program Analysis and Evaluation, April 1994.

Congressional Testimony

Statement of the Assistant Secretary of Defense for Health Affairs Before the Personnel Subcommittee of House National Security Committee, March 30, 1995.

Statements of the Surgeons General of the Army, Navy and Air Force Before the Personnel Subcommittee of House National Security Committee, March 30, 1995.

Statements of the Directors of the Nurse Corps of the Army, Navy and Air Force Before the Personnel Subcommittee of House National Security Committee, March 30, 1995.

Statement of Director for Logistics/The Joint Staff Before the Personnel Subcommittee of House National Security Subcommittee, March 30, 1995.

Statement of the General Accounting Office Before the Personnel Subcommittee of House National Security Committee, March 30, 1995.

Statement of the Congressional Budget Office Before the Personnel Subcommittee of House National Security Committee, March 30, 1995.

Statement of The Military Coalition Before the Personnel Subcommittee of House National Security Committee, March 30, 1995.

Statement of the National Military Families Association Before the Personnel Subcommittee of House National Security Committee, March 30, 1995.

Statements of the Surgeons General of the Army, Navy and Air Force Before the Defense Subcommittee on Appropriations, June 13, 1995.

Statements of the Directors of the Nurse Corps of the Army, Navy and Air Force Before the Defense Subcommittee on Appropriations, June 13, 1995.

Statement of Director, Program Analysis and Evaluation, Office of the Secretary of Defense, April 19, 1994.

Reports to Congress

Health Care Fact Sheet, CRS Report for Congress, Congressional Research Service, April 19, 1993.

Report on Federal Employees Health Benefits Program for the House Committee on Post Office and Civil Service, May 1992.

Report on Defense Health Care: Problems with Medical Care Overseas are Being Addressed, General Accounting Office, July 1995.

Report on Defense Health Care: Issues and Challenges Confronting Military Medicine, General Accounting Office, March 1995.

Restructuring Military Medical Care, CBO Papers, Congressional Budget Office, July 1995.

Other Publications

What to do About Medicare, Backgrounder, Heritage Foundation, June 16, 1995.

Open Season for America: A Symposium on the Federal Employees Health Benefits Program, The Heritage Lectures, Heritage Foundation, November 9, 1992.

Consumer Choice in Health: Learning From the Federal Employee Health Benefit Program, Backgrounder, Heritage Foundation, November 9, 1992.

CHAMPUS Handbook, Office of Public Affairs, CHAMPUS, October 1994.

Army Budget Fiscal Year 1996: An Analysis, Institute of Land Warfare, Association of the United States Army, May 1995.

TRICARE: Quality Care for the Uniformed Services, Department of Defense, Office of the Assistant Secretary of Defense for Health Affairs, May 1995.

National Defense Authorization Act for Fiscal Year 1994, Government Printing Office, 1994.

National Defense Authorization Act for Fiscal Year 1993, Government Printing Office, 1993.