National Security Report on Health and Well-being

The Promise . . . The Reality

Military Health Care Management Revisited

An AUSA Torchbearer Issue

February 2000

Introduction

Military health care management is in trouble—and the trouble is not with the quality of the care but with cost and accessibility for all beneficiaries of the military health care system.

General Henry H. Shelton, USA, Chairman of the Joint Chiefs of Staff, stated in his testimony to the Senate Armed Services Committee in February 2000, "While servicemembers and their families are normally very pleased with the care that they receive once they enter into the system . . . they are very frustrated with TRICARE as a system. It is quite frankly immensely complex, administratively confusing and not very customer friendly. Our servicemembers and their families deserve better." Concerning retirees, General Shelton stated, "I think that the first thing we need to do is make sure that we acknowledge our commitment to the retirees for their years of service, and for what we basically committed to at the time they were recruited into the armed forces."

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Source: Department of the Army

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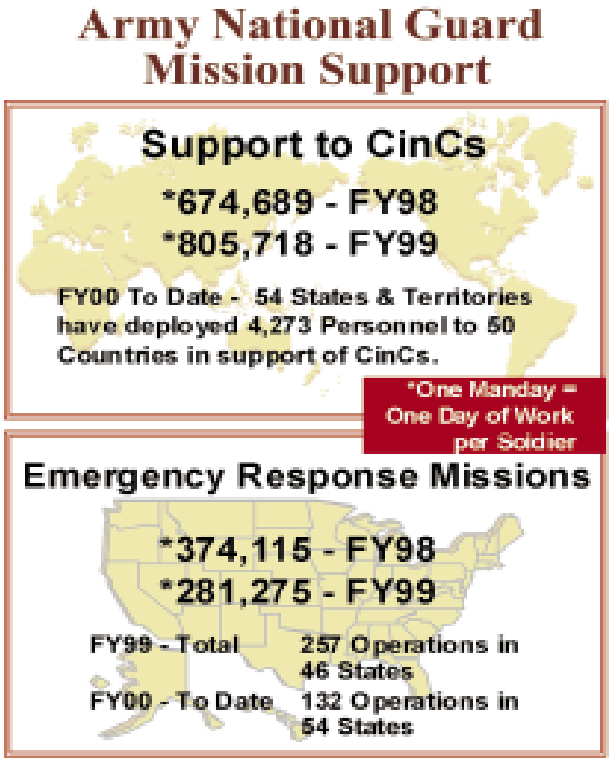
The general also told the members of the committee that the Department of Defense (DoD) has recruiting posters that vividly state that not only would the services provide medical care upon retirement, "but that families would be taken care of. In their [retirees'] minds, we have broken that commitment. And I think we have."

Military health care—an important and complex issue in itself—is also part of a much larger issue: health care in general. Spending on health care in the United States rose 5.6 percent in 1998, according to an annual report by the Health Care Financing Administration. This increase—both by government and in the private sector—was the largest since an 8.7 percent jump in 1993. Health care spending averaged $4,094 per person—the nation spent $1.1 trillion. The report said spending on prescription drugs grew more in the United States than in any other country, climbing by 15.4 percent to $90.6 billion. Costs for military health care and pharmaceuticals are also rising—but not as quickly.

Americans, in and out of uniform, are interested in health care. America's soldiers expect that our nation will provide health care for them and their families. High operating tempo within all components of the Army during the past decade has heightened soldiers' awareness of critical medical needs for their families and has highlighted inequities among health care options for active and reserve component personnel, retirees and family members.

The dramatic loss of military health care providers and hospital/clinics (approximately 40 percent reduction since the end of the Cold War) without a parallel drop in the number of patients has constrained the ability of the military health care system to provide uninhibited access to its quality care. At the same time, the number of retirees in the military community is growing. This, coupled with years of underfunded defense budgets that include health care, has ***created serious concerns among beneficiaries that the medical benefit may be deteriorating. What once was largely free now comes at a cost.***

Concern over health care benefits has affected recruiting and retention. The loss of trained servicemembers increases annual defense costs. In sum, underfunded health



Source: Army National Guard

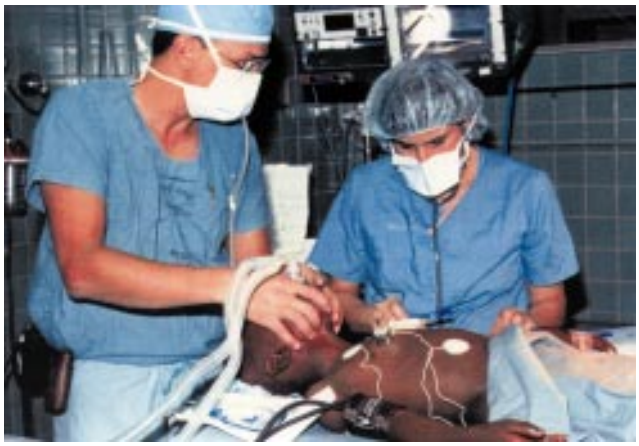
Source: Army Reserve

care budgets—viewed by some as apparent "savings"—actually result in greater overall cost to DoD. This also frustrates the efforts of military medical professionals to provide quality care efficiently and effectively to each beneficiary they treat.

Here's the dilemma for military health care professionals: We require the military medical corps primarily to support the wartime mission. Yet because the active duty soldier is a relatively healthy individual, military medical professionals must look elsewhere to remain proficient in their skills. In the past, doctors enhanced their knowledge and skills by practicing at top-flight military teaching hospitals. But these have been eliminated or severely reduced. Funding the Defense Health Program (DHP) therefore facilitates recapturing workload into military hospitals and clinics and allows military doctors to see additional categories of patients (retirees, for example) who are beneficial for military health care professionals in maintaining currency and retaining a high level of medical proficiency.

The Promise

Soldiering in peace or war is dangerous business. Historically, responsible nations have always considered it their obligation to care for their sick and wounded warriors. Responsible nations also understand that care and support for families are matters of great concern to soldiers. If properly provided and administered, this allows soldiers to concentrate on the duties and responsibilities of defending the nation. Our Army understands that it has the important mission of maintaining the health of the



Army. That includes serving soldiers and their families, and also those who have served and their families, as well as the survivors of soldiers who have lost their lives in the service of their country. These are the beneficiaries of the military medical system: active duty soldiers of all three components (active Army and activated Army National Guard and Army Reserve), drilling Army National Guard and Army Reserve soldiers injured in the line of duty, retirees and families.

In support of these beneficiaries, the Army Medical Department (of which reserve components make up 70 percent) has developed a corps of quality health care providers. All Army hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations. Average scores for the past six years for Army hospitals continue to exceed the national average. More than 90 percent of all Army physicians who have completed their residency training have passed examinations to be board-certified. This is a higher rate than in civilian health systems. More Army dental officers are board-certified than in the civilian sector. The quality of the military

medical professional is not at issue. It is a quality force. This report recognizes that managing medical care in wartime is a key aspect of military health care overall; however, ***the report focuses primarily on managing the peacetime care of all eligible military beneficiaries through TRICARE. It will also address health care options for Medicare eligible beneficiaries.***

History

The United States Army was over 100 years old when medical care for military families was recognized in law. The Army Appropriations Act of 1884 for the first time provided authorization for the treatment of family members, with the following caveat:

> *"Medical officers of the Army and Contract Surgeons shall* **whenever practicable** *attend the families of the officers and soldiers* **free of charge.**" (Emphasis added.)

That act formally recognized a practice that had actually existed for years at remote posts throughout the West.

As our Army grew in the 20th century, so did the number of family members requiring health care. To help meet these burgeoning requirements, Congress responded with the Dependents Medical Care Act of 1956. This act authorized selected inpatient medical treatment at civilian hospitals, on a cost-sharing basis, for the spouses and children of active duty military personnel. It also provided direct care entitlement priorities and inpatient charges for family members and retired enlisted personnel. Entitlement to outpatient care under this program was limited to treatment of accidental injury and prenatal and postpartum care.

During the Cold War, military medical requirements for a war in Europe were known to be great. Consequently, DoD maintained a large infrastructure of medical personnel and facilities. What were these doctors to do until the war came? From the military point of view, providing health care to servicemembers, 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.

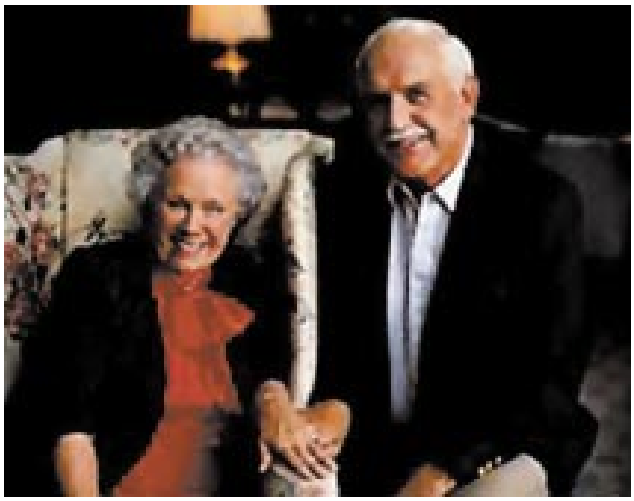
Medical care for soldiers and their families, as well as for retirees and their families, was generally available in Army hospitals and clinics during the Cold War. Priority of care in military medical facilities went to the soldier on active duty. Next was to the soldier's family, on a space-available basis. Retirees and their families were also authorized care on a space-available—but lower-priority—basis. Recognizing that care might not always be accessible or available,

Congress changed health care in the armed forces in 1966 (and in 1967 for retirees). A number of obvious shortcomings of the 1956 act, together with the passage of Medicare legislation in 1965, resulted in amendments that:

- created the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)—the use of civilian doctors to treat active duty families and retirees and their families—for uniformed services personnel under age 65;
- provided authority for retired members to receive care at Veterans Administration facilities for nonservice-connected conditions;
- included spouses and children of active and retired members, retired members themselves, and spouses and children of members who died in retired status.

In limiting CHAMPUS to those younger than age 65, the House Armed Services Committee reasoned, "[M]ilitary retirees would continue to have two medical programs upon reaching age 65—***the use of the military medical facilities on a space-available basis and the Social Security Medicare program."*** CHAMPUS provided a safety net of some degree of care by the civilian medical system. A significant major military operation or war would necessarily require that servicemembers receive priority for military medical care. Unless DoD took other actions, families and retirees would have to rely exclusively on CHAMPUS.

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



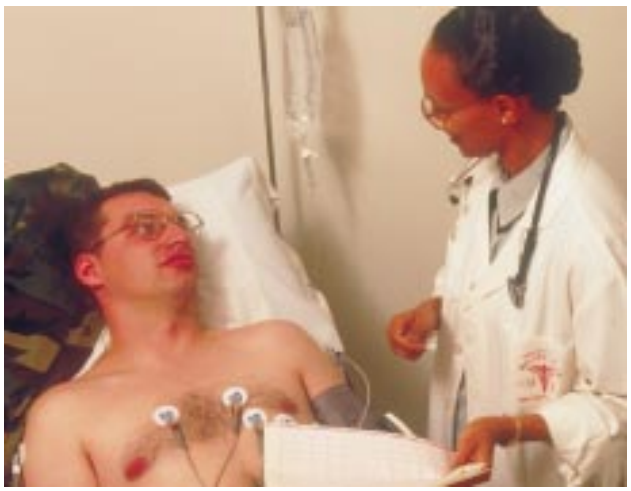
retirees or because of the enormous expense and impact on the CHAMPUS system, DoD decided not to rely on CHAMPUS when military doctors went to Desert Storm. Instead, DoD called reserve component doctors to active duty, in many cases not to serve with their reserve units but to backfill at the active duty military treatment facilities.

In 1988, the CHAMPUS Reform Initiative (the most direct forerunner of TRICARE) was established; it introduced the concept of managed care—health care for all beneficiaries within defined budget limitations—into the military system. The demonstration program was centered in California and Hawaii. Lessons from this popular 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 cost to the government was about 19 percent higher than

traditional CHAMPUS. In part, the reason for the higher costs came through the surfacing of a "ghost population" of beneficiaries who had stopped using the military health care system for a variety of reasons. DoD 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 DoD proposed expanding the reform initiative during the early 1990s, Congress refused because the cost to the government was rising faster in that program than in any other CHAMPUS program.

In the Defense Authorization Act of Fiscal Year 1994, Congress required a new health plan with options for military beneficiaries that improved access but did not cost the government more than existing CHAMPUS. ***Its intent was a "uniform benefit" for all beneficiaries.*** That authorization bill led to the TRICARE system.



The Reality

TRICARE is a population-based managed health care plan.

Key features of TRICARE are:

- triservice coordination to provide for the totality of health needs for DoD beneficiaries within 40 miles of military hospitals and clinics;
- coordination of care by DoD lead agents for 13 geographic DoD health care regions under the control of the Office of the Assistant Secretary of Defense for Health Affairs;
- a choice of three health care plans for active duty and CHAMPUS-eligible (i.e., families of active duty and non-Medicare-eligible) beneficiaries:
    1. a primary care-based, managed care plan—***TRICARE Prime****,* the center around which the other plans operate—patterned after health maintenance organizations (HMOs);
    2. a preferred provider health care plan—***TRICARE Extra***—that purchases discounted care in the civilian network;
    3. a standard fee-for-service health care insurance plan—***TRICARE Standard***—much like the old CHAMPUS plan.
- health care not provided by military hospitals and clinics to be delivered by a local network of civilian health care providers (i.e., doctors, psychologists, nurse practitioners, physicians' assistants, etc.) and hospitals subcontracted by large private health care companies.

- uniform access, waiting time and quality standards for all military hospitals and clinics and civilian hospitals in TRICARE, irrespective of site, military service or private contractor.

As Dr. Sue Bailey, Assistant Secretary of Defense for Health Affairs, stated in her testimony before Congress in 1999, "The Military Health Care System is a vast and extraordinary health system. There is no other like it in the world. We ensure the health of our forces, care for them when ill or injured anywhere around the globe, and we provide comprehensive health coverage to the families of our servicemembers, our retirees, and their families, and the surviving family members of those who have died in service to their country."

If you were a young noncommissioned officer (NCO) with a family at Fort Bragg, North Carolina in 1975, here is what you might have encountered that would have shaped your expectations: a "direct care" system (i.e., on-post military health care facilities and care by uniformed personnel for most of your health needs); and cost-free access for yourself and family members.

If you were retired after 20 years of service in 1995 and are now (year 2000) living in Fayetteville, North Carolina, here's what you encounter today: a "managing care" system, as the U.S. Army Surgeon General refers to it, consisting of a combination of military hospitals and clinics and network civilian health care providers, providing quality care for retirees and family members under 65 (assuming access) at some cost, followed by the Medicare system once the servicemember/family member reaches age 65. (If Fort Bragg was a TRICARE Senior Prime demonstration site, then the soldier and his spouse would be eligible for TRICARE at age 65 and over.)

Army Family Demographics

	1969 (*June)	1999 (*March)
ActiveComponent	**1,509,637**	**464,387**
Officer	172,590	77,144
Enlisted	1,337,047	387,243
% Married		
Officer	76%	73%
Enlisted	40%	53%
Single Parents		
Officer	**NA	4.10%
Enlisted		8.80%
Working Spouses	23%	55%
Female Soldiers	1%	15%

* Data based on Defense manpower statistics
** (1) Data not maintained
(2) HQDA policy until April 1971
- Pregnant enlisted females were involuntarily separated
- Enlisted females who married could apply for discharge
- All sole parents given option to apply for hardship discharge

Source:Department of the Army

In 1999, DoD forwarded to Congress a report outlining reserve component health care issues and recommending Congress bring the reserve components in line with the active component regarding health care benefits. In sum, the criterion is that health care benefits should be based on performance of duty rather than length of duty.

How is military health care doing?

TRICARE has 8.2 million beneficiaries across 13 DoD regions. Implementation has taken four years from the first to the last contracts, and while challenges with timeliness (of claims and payments) and portability (moving from one area to another) have occurred repeatedly, every region to date has reportedly seen improvements within the first 6 to 12 months. The vast majority of TRICARE Prime enrollees elect to remain enrolled after the first year. At present, TRICARE Prime is the only HMO-like alternative from which beneficiaries may choose.

TRICARE Prime facilitates a most important feature of military care in general: health promotion and disease and injury prevention. Military health care leaders and providers are directing attention and resources toward **preventing** avoidable illness and injury, thereby **easing the demand** for services. It is an important feature of force health protection on deployments, and an important means to correctly apply limited resources to those in greatest need.

The TRICARE Management Agency has conducted hospital-by-hospital and clinic-by-clinic surveys of patients using the Military Health Care System and published these monthly for use by hospitals/clinics and senior commanders. Patient satisfaction is among the most important performance measures in use. They are consistently near or above satisfaction with benchmark HMO data. ***Yet there remains dissatisfaction among beneficiaries.***

In the Spring 1999 Sample Survey of Military Personnel, the Army Personnel Survey Office found that officers said they were only 40.1 percent satisfied with the availability of family medical care and only 37.8 percent satisfied with the availability of family dental care. Enlisted personnel said they were 66.8 percent satisfied with access to and cost of dental care for family members.

In the January 2000 Center for Strategic and International Studies (CSIS) report on "American Military Culture in the 21st Century," CSIS found that junior-grade officers and enlisted personnel believe there are major concerns about the adequacy of family medical care. The report recommends that Congress and DoD provide compensation at necessary levels to ensure suitable medical care for families.

The Chief of Staff, U.S. Army (CSA) Retiree Council, in its 39th annual meeting in April 1999, reported that restoration of promised health care for all military beneficiaries continues to be the greatest issue affecting the welfare of the 675,000 Army retirees. In its report to the CSA, the council wrote, "Given that TRICARE is the linchpin of the Military Health System, the CSA

Retiree Council is especially disappointed at the slow, incremental pace in implementing improvements requisite to making TRICARE an accessible, quality, and valued health care program for all military beneficiaries." Location, age and status determine to a large extent what the medical benefit is. Lieutenant General Ellis D. Parker, USA Retired,the council's cochairman, stated, "Whatever unrest and anxiety are existing out in the retiree community—most of it concerns medical care."

What Is Needed

What our armed forces need is military health care which, from the law that enacts it to the system that supports it, provides a uniform benefit and enables the beneficiary access to quality health care with minimal or no cost.

If TRICARE is:

1) an umbrella program providing a uniform benefit for all beneficiaries and encompassing the capabilities of the services, CHAMPUS, and "civilian contractor preferred provider" networks;

2) funded through the Defense Health Program (DHP);

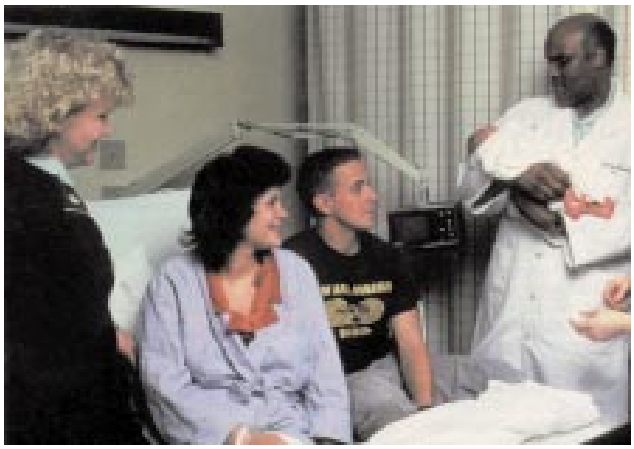
and responds to a congressional mandate for DoD to develop a health care delivery system that uses managed care concepts while maintaining readiness, containing costs, and improving access to health care, then ***access, quality of service to the beneficiary, and cost*** are three criteria to assess whether it is meeting the needs of beneficiaries.

Access

Access consists of eligibility and availability. TRICARE offers most beneficiaries three options—HMO (TRICARE Prime); Preferred Provider (TRICARE Extra); or standard CHAMPUS (TRICARE Standard). However, not all beneficiaries are eligible to choose from the options, creating a serious inequity.

Active duty soldiers and their family members are enrolled in TRICARE Prime at no cost. Retirees and their family members under the age of 65 choose among the three options based on their needs and/or desires, each entailing some degree of cost. However, ***once a beneficiary becomes eligible for Medicare (usually at age 65), that person is no longer eligible for TRICARE.***

To improve access for beneficiaries age 65 and over, the Defense Department has several candidate programs. DoD is testing a plan that enrolls Medicare-eligible beneficiaries in the Federal Employees Health Benefits Program (FEHBP).



FEHBP would recognize the Defense Department's commitment as an employer and provide health care to retirees 65 years of age and older and their families. FEHBP offers hundreds of health plans, including a choice of "fee-for-service" plans and less expensive prepaid plans, some featuring high- and low-coverage options. Many are national plans. FEHBP has no preexisting condition penalties, allows participants to switch plans, and requires the federal government to subsidize 72 percent of the premium. The beneficiary pays a monthly premium. ***FEHBP is available to all other government employees.***

Another DoD candidate plan will offer, at two test sites, the opportunity for retirees age 65 and older to purchase TRICARE as a supplement to Medicare coverage. In most cases, it would cover what Medicare does not pay and provide broad prescription drug coverage with normal TRICARE copayments. DoD envisions that the TRICARE supplemental coverage will have a premium of $576 per person per year—significantly lower than the commercial supplements or FEHBP.

In a third plan, DoD is testing the TRICARE Senior Prime program (also known as Medicare Subvention) permitting Medicare-eligible beneficiaries to enroll in TRICARE Prime. Pending legislation would make the program permanent on a phased basis, expanding first to ten additional sites and then to remaining areas after Fiscal Year 2002.

"Big Five" Civilian Medicare vs. Uniformed Services Coverage

Employer	Employer-subsidized Health Plan		Employer-paid Share of	Retiree Deductible Single/Family	Retiree Cost Share	Other Subsidized Coverage		
	Retiree	Family				Prescription	Dental	Vision
Federal Gov't (military)	No	No	Zero	100% not* covered by Medicare	100% not* covered by Medicare	No	No	No
Federal Gov't (civilians)	Yes	Yes	72%	Depends on plan; often Waived	Nominal; depends on plan	Yes	Yes	No
GM	Yes	Yes	80%	$600	Zero	Yes	Yes	Yes
Ford	Yes	Yes	100%	$250	20% of visits: $500 out-of-pocket-cap for all others	Yes	Yes	Yes
IBM	Yes	Yes	100%	$250 ($340 hospital)	20% outpatient 0% inpatient	Yes	Yes	Yes
Exxon	Yes	Yes	95%	$500	20% copayment; $2,500 out-of-pocket cap	Yes	Yes	No

* Some get space available care in military facilities; civilian plans cover all retirees

Source: Department of Defense

	HMO Plans			Fee for Service Plans	
	Tricare Prime (Subscription)	FEHBP (Kaiser Mid Atlantic)	Medicare (New York Life Care-65)	FEHBP (BlueCross/BlueShield Standard)	Medicare
Annual Costs					
Enrollment fee	Waived	None	None	None	None
Plan Premium	None	$510 (individual)	None	$993 individual	None
Part B premium	$629	$629	$629	$629	$629
Annual Total	$629	$1036	$629	$1129	$629
Hospital Inpatient Care					
Deductible	None	None	None	None	$764 (Part A)
Per diem copay	$0	None	None	None	$0/day: days 1-60; $191/day: days 61-90 $382/day: days 91-150 if using lifetime days[2]
Physician Inpatient Fee					
Deductible	None	None	None	None	$100 (Part B)[3]
Patient copay	None	None	None	None in most cases[4]	
Outpatient Care					
Deductible	None	None	None	None	$100 (Part B)[3]
Patient copay	$45/visit; civilian non-provider None MTF	None	$5 per visit	None in most cases[4]	20% of approved amount (but all costs exceeding approved amount up to 115% of max allowable charge
Outpatient Prescriptions					
Deductible	None	None	None	None	Not covered
Patient copay	$3 retail for 30-day supply None MTF	$7 for 60-day supply	$3 generic $10 name brand for 30-day supply $375 cap/quarter	20%: preferred provider 40%: nonpreferred provider	Not covered
Mail service available copay	Yes, $8 for 90-day supply	Yes, $4 for 60-day supply	Yes, same as above	Yes, no copay	Not covered
Miscellaneous Costs					
Durable medical equipment copay	20%	Patient pays 100%	20% for oxygen, all else no copay	None	20%
Ambulance Service copay	$20	None	None	None	20% (but only for emergencies)
Catastrophic cap	$3,000	No cap	No cap	$2,000 preferred provider $3,750 nonpreferred provider	No cap
Other benefits					
Dental copay	No	Yes	Yes, discount program	Limited benefit	If injury/routine care or requires hospitalization
Eye exam copay	Yes	Yes: $10 exam	Yes: $25/exam	No	No, if routine
Physical exams copay	Yes	Yes	Yes: $5/visit	Yes	Yes
Pap smears copay	Yes	Yes	Yes, $5/visit	Yes	Yes
Home health/ skilled nursing care	Yes: part-time nursing care	Yes	Yes, 60 visits	Yes	Yes
Hospice	Yes	Yes	Yes	Yes	Yes (limited costs for outpatient drugs and inpatient respite care)
Supplemental Coverage Recommended	Members' choice[5]	No	No	No	Yes, most varies by age, state and type of plan

[1] Under FEHBP, BC/BS standard would cost $1,470 for a family and Kaiser $1,380 for a family.
[2] There is a lifetime limit of 60 reserve days.
[3] The annual Medicare deductible is $100, whether care is inpatient, outpatient, or both.
[4] Providers who do not accept Medicare assignment may charge no more than 115% of Medicare's allowable charge. Some FEHBP plans cover up to the entire 115%. Others cover up to 100% of the charge, and the patient pays the balance. Coverage varies by plan and procedure.
[5] Supplemental coverage not needed to cover costs; however, it may be desired to avoid preexisting condition limitations if individual drops Tricare Prime coverage.

Source: The Retired Officers Association

Assuming eligibility, availability of the medical care itself (e.g., appointment system, referrals, etc.) varies from region to region, state to state, post to post, and in some cases (for recruiters, Reserve Officer Training Corps instructors at remote locations, and families of activated reserve component soldiers) may not be available at all. Eligible beneficiaries have difficulty connecting with TRICARE when away from their home region due to lack of portability among regions. A TRICARE Prime beneficiary must obtain a preauthorization for routine (nonemergency) medical care in another region. While in the home region, if using a civilian health care provider, the beneficiary must obtain prior authorization for preventive services such as obstetrical-gynecological (OB-GYN) exams, mammograms for women over age 35, and urological exams for men over age 60.

We must make these services barrier-free and cease placing additional burdens on beneficiaries.

As a partial solution, in October 1999 DoD initiated ***TRICARE Prime Remote*** to provide primary medical care to active duty members who live in the United States but far from military hospitals and clinics. Unfortunately, at this time, ***only family members of active duty personnel in selected regions are eligible for TRICARE Prime Remote.*** Most families of ROTC instructors, students, recruiters, Active Guard and Reserve (AGR) soldiers and others living more than 50 miles from a military hospital or clinic are denied a TRICARE Prime benefit that is afforded to family members of other active duty personnel. ***This inequity must be remedied.***

Quality of Service to the Beneficiary

As stated earlier, ***quality of health care provided by military medical personnel is not at issue.*** Certain aspects of "quality care"—in either the form of a benefit or the administration of a benefit—do concern beneficiaries. Two examples are pharmacy benefits and claims processing.

Through a combination of increased health care costs, the dramatic increase in new pharmaceuticals, the closing of military treatment facilities and hospitals and of Veterans Administration (VA) hospitals, and a sharp rise in the number of retired military personnel, the pharmacy benefit system is in high demand, according to Representative Jim Ryun (R-KS) (*AUSA News*, "Voice of Congress: Military health care's importance," October 1999).

Prescription drug costs are expected to continue to rise at the rate of 15–20 percent per year over the next five years. DoD spent approximately $1.3 billion in FY 1999 on pharmaceuticals, of which the majority—$900 million—was spent in military hospital/clinic pharmacies. DoD increases in spending on prescription drugs parallel those of the civilian sector; however, funding levels have not kept pace with the need for expanded drug formularies and improved access to drugs for military beneficiaries.

The over-65 population is the highest user of drugs with multiple prescriptions. *Newsweek*, in its cover story "HMO Hell" (November 8, 1999), documents that approximately 84 percent of Americans consider affordable and readily accessible prescription drugs the most important part of their overall health care coverage. This trend is no different for the military Medicare-eligible retiree who rates access to and cost of pharmaceuticals as the largest single quality issue, as reported to Congress by the General Accounting Office. Congress has directed that DoD completely redesign its pharmacy benefit to implement an integrated pharmacy information system that will move existing legacy systems into one common database. This database would improve DoD's ability to better manage patients' medications, prevent dangerous drug interactions and reduce overall cost.

In the future, innovative improvements to the pharmacy benefit within DoD include the concept of telepharmacy and the "ATM-like" automated remote dispensing technologies that will improve beneficiary access to pharmaceuticals. Off-the-shelf

technologies such as bar-coding and robotics will further prevent and reduce medication errors and improve operational efficiencies. Pharmaceuticals will continue to have a critical role in health care for the future due to a progressively aging population, revolutionary new drugs, increased consumer awareness and the growing reliance on drugs as the primary means of treating and preventing disease. ***What is needed is an appropriately funded, expanded pharmacy benefit for all beneficiaries (soldiers, retirees and family members)***. It is imperative that the Defense Department incorporate into policy the best business practices of private industry to revamp the pharmacy system and expand the pharmacy benefit program to include all DoD Medicare-eligible beneficiaries.

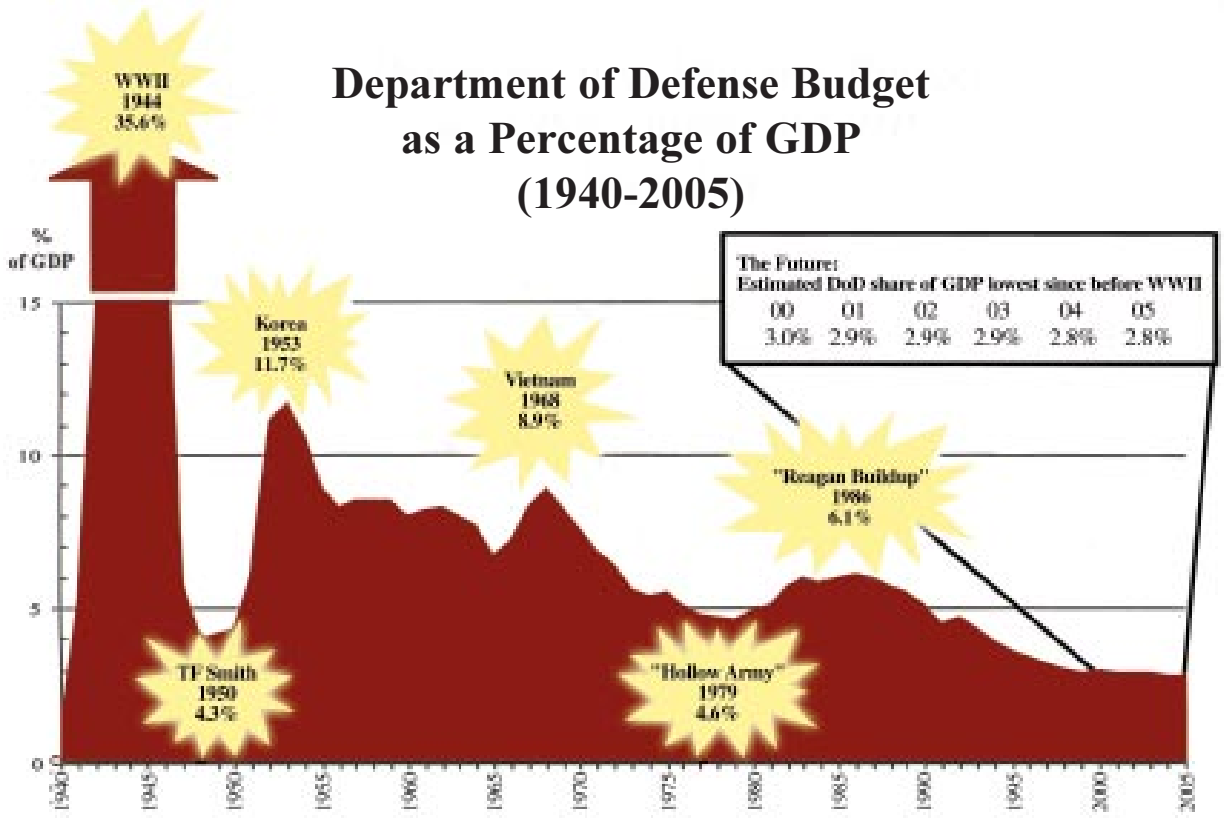
Delays in processing TRICARE claims have frustrated beneficiaries and providers alike. As a result, late TRICARE payments jeopardize the credit ratings of soldiers, retirees and families, forcing them to face collection agencies because of late payments not within their control. Likewise, many private health care providers leave TRICARE, or refuse to join TRICARE networks at all, due to administrative delays

and late or nonexistent payments. Electronic processing may be one business process improvement on which to capitalize. More than 90 percent of Medicare's claims are processed electronically. Electronic claims processing has the potential to provide faster reimbursements to providers and to reduce cost. DoD's intent is to adopt commercial business practices wherever possible.

Cost

There are two aspects regarding cost: the defense budget and beneficiary cost.

Military health costs are running in excess of $16 billion annually. According to DoD's Future Years Defense Program (7 February 2000), ***the DoD health care budget is underfunded by approximately $6.1 billion over the next five years.*** For example, as part of the $291 billion defense budget request for FY 2001, DoD has requested $80 million to improve health care benefits for family members in remote locations and eliminate copayments for off-base treatment. Another $348 million is requested to cover faster-than-expected cost increases in various areas, including in-house



Sources:
- National Defense Budget Estimates for FY 1999
- The Economic and Budget Outlook: An Update, Congressional Budget Office, Aug 1998
- POM 200-2005 FYDP (includes DoD plus-up)

pharmacies, support contract costs, and a new Medicaid "custodial care" benefit that requires DoD to be the first payer for Medicaid. This, unfortunately, does not cover the initiatives that are in development to overcome access and quality-of-service issues. To make these initiatives possible, ***DoD must receive a greater share of the federal budget. The current 2.8 percent of gross domestic product (GDP) is simply not enough; something approaching 3.5 to 4.0 percent is required.*** This increase would begin the process of ending the constant battle between quality of life/well-being issues and equipment needs.

TRICARE also requires some form of payment from most beneficiaries. TRICARE Prime is free only to active duty soldiers and active duty family members who use military hospitals and clinics. Active duty family members using civilian medical facilities, retirees and their family members pay copayments, deductibles and/or enrollment fees (as well as optional supplemental insurance premiums and deductibles) depending on the choice of TRICARE plan. Per-visit copayments in particular are budget-busters for many military families. Also, military families see it as an equality issue. Family members sent to civilian providers under TRICARE Prime have copayments, while those treated at military hospitals and clinics do not.

The DoD dental plan requires active duty family members to pay a monthly premium and copayments to receive care. Retirees and their family members pay premiums and copayments for a basic dental plan that does not cover most of the procedures needed by an aging population. Dental plans for Army National Guard and Army Reserve personnel do not include family members.

What Must Be Done

The Association of the United States Army (AUSA) is committed to achieving unrestricted access to quality health care for every category of military beneficiary, establishment of a top-quality pharmacy benefit, and creation of a "user-friendly" Military Health Care System that is customer-oriented and exists to serve soldiers, retirees and family members.

Congress and the Department of Defense must force improvement to the health care system, fund the program they created, and increase accessibility for those to whom health care was promised.

AUSA strongly recommends that Congress and DoD:

- provide adequate funding to ensure quality health care for all beneficiaries and preclude the imposition of user fees. Specifically, ***fully fund the Defense Health Program (DHP).***

  (The human and material infrastructure of the direct care system must be restored.

For example, military doctors now attempt to handle the same workload as their civilian counterparts with an average of one support staff per provider compared with an industry standard of three support staff per civilian doctor, guaranteeing inefficient care and doctor burnout. Lack of support staff is the greatest concern cited by departing military physicians as their reason for leaving. Chronic underfunding of the DHP also makes it difficult to sustain high-quality care in poorly maintained facilities with outdated equipment.)

For active duty soldiers and their family members, enact legislation and fund TRICARE Prime Remote in the continental United States to approximately $30 million per year (require changes to National Defense Authorization Act). ***Eliminate TRICARE Prime copayments for active duty family members receiving care in the civilian network ($35 million–$50 million per year).***

- Implement business practice improvements in the Military Health Care System to make it effective and efficient. Pharmacy design and claims processing are two areas requiring immediate fixes. Fund an expanded pharmacy benefit for all beneficiaries. Establish a universal enrollment mechanism that can be rapidly accessed at any time for verification of eligibility/enrollment, no matter where the beneficiary is located.
- Expand and fund currently authorized demonstration programs for Medicare Subvention (TRICARE Senior Prime), FEHBP-65, and mail-order and retail pharmacy programs nationwide, ***do the analysis, select the best, and make them permanent.***
- Expand the DoD Retiree Dental Program to cover procedures required by an aging population.
- Fix inequities between reserve component and active component health care.

Finally, Congress and DoD must look beyond TRICARE to transform military health care and explore broader and more responsive approaches to delivering the health benefit. ***Health promotion and disease and injury prevention are keys to the future of health care.*** They currently are an important feature of force health protection on deployments and ***reduce the demand for services*** of peacetime care by avoiding illness and injury. This also enables many more patients with chronic disease and injury to be served, especially among the elderly retired population.

Torchbearer Message

Quality of life and well-being, especially health care, have a direct bearing on the readiness of the force and on the ability to attract and keep quality young men and women to serve this great nation. Soldiers, sailors, airmen and marines continue to list concerns about health care for their families as an issue that weighs heavily on their decision to stay in or leave military service.

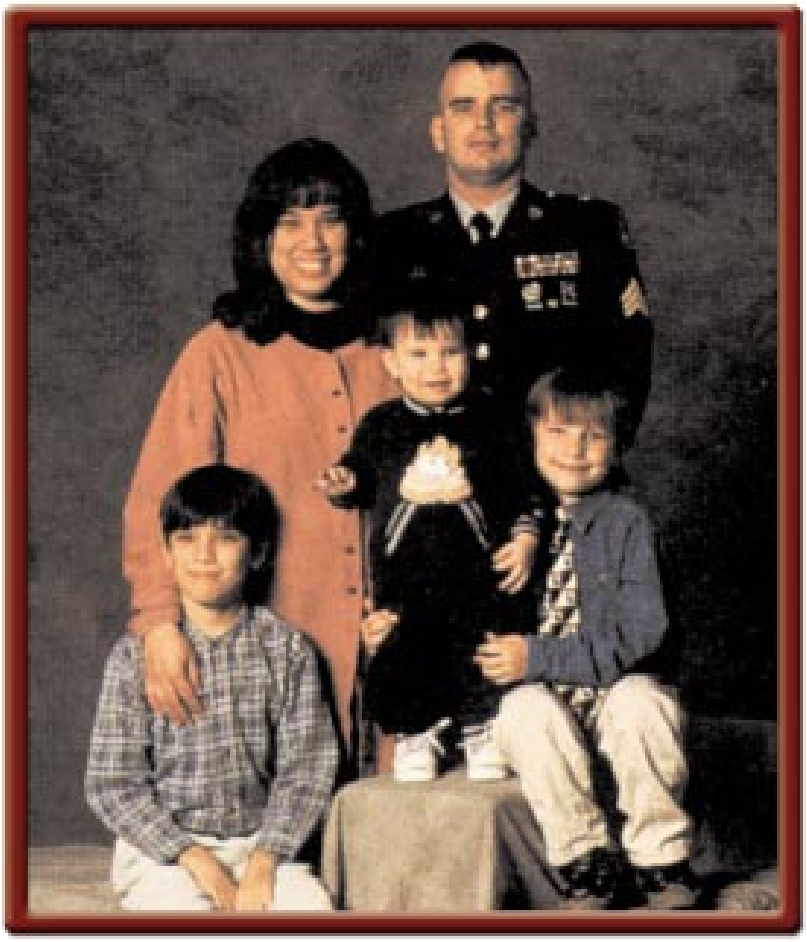
Today's active duty members are tomorrow's retirees. Retirees' number-one concern remains health care. The lack of full medical care, whether implied or actually promised, leaves many retirees with the impression that they have been abandoned in their time of need. This, in turn, impacts on recruiting and retention, since retirees are among the best ambassadors in local communities. Young people and their parents look to retired soldiers for information and counseling concerning military service.

The military health system, TRICARE, has quality professionals, dedicated to providing quality care to each beneficiary they see. ***The system must be accessible and properly funded, and it must provide a uniform benefit.***

Remember—broken health care promises to one generation take a toll on the career decisions of the next.

Accessible, cost-effective, efficient, quality health care for servicemembers from all components (active Army, Army National Guard and Army Reserve), retirees of all ages, and their families is NONNEGOTIABLE.

The Military Health Care System Exists for the Beneficiary



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