CBO TESTIMONY

Statement of
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on
the Peacetime Mission of the
Military Medical System

before the
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Committee on National Security
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NOTICE

This statement is not available for public release until it is delivered at 2:00 p.m. (EST), Tuesday, March 28, 1995.

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Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss the major efforts under way to reform the military health care system. My testimony will cover a range of topics, including:

- A brief review of the current military medical system and Tricare;
- The Congressional Budget Office's (CBO's) evaluation of the Tricare proposal; and
- The effectiveness of alternative approaches to providing care for military beneficiaries, including the issue of Medicare reimbursement to the Department of Defense (DoD).

BACKGROUND

The military health care system today is made up of not one but two parts: the direct care system and CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services. Together, the Army, Navy, and Air Force operate about 120 hospitals and more than 500 clinics worldwide. When care is not available at a military medical facility or when facilities are located too far away, eligible beneficiaries may seek care from civilian providers who are reimbursed by CHAMPUS or Medicare.

Over the years, that complex system has given rise to a number of criticisms and complaints:

- Access to care for beneficiaries, especially at military medical facilities, varies widely by geographic location. By 1999, over 30 percent of all beneficiaries, and about 40 percent of retirees and their families--including almost half of those over age 65--will live outside the service areas of the direct care system.

- Only active-duty personnel have guaranteed access to the direct care system. Dependents and retirees receive care only when space and resources are available.

- Out-of-pocket costs for beneficiaries vary widely and are hard to plan for.

- The direct care system uses resources inefficiently, leading to increasing reliance on CHAMPUS and use of only part of the capacity of military facilities. Moreover, beneficiaries use military health care at levels that far exceed those in the civilian sector.

To address those issues, the Department of Defense has tested many new approaches to health care delivery during the past decade. Out of those tests, and other considerations including budgetary pressures and military downsizing, has come the proposed Tricare program. Among the major elements of Tricare are the following:

- Responsibility for managing health care delivery in each of 12 regions nationwide would be assigned to a *lead agent*, the commander of a major military hospital in the region. The lead agent would coordinate the delivery of care by military and civilian providers.

- Management support in that effort would be provided by a *private-sector contractor* that would have responsibility for developing access to civilian health care. The contractor might also assist in utilization management--that is, ensuring that unnecessary care is not provided.

- DoD would budget for those regional plans on the basis of *capitation*. Each military service, and then each hospital commander, would be allocated health care resources based on a fixed amount per beneficiary within each catchment area. Capitated budgeting is intended to foster stability in planning and to provide incentives for providing care efficiently.

- Beneficiaries would have access--in as many locations as DoD could arrange--to a so-called *triple option benefit*: enrollment in Tricare Prime, a plan modeled after private-sector health maintenance organizations (HMOs) but offering additional flexibility; case-by-case use of Tricare Extra, a preferred provider option offering discounts for care from a network of selected providers; and continued reliance on Tricare Standard, essentially today's CHAMPUS coverage.

- Active-duty personnel would automatically be enrolled in Tricare Prime. Their *dependents would receive priority* in electing enrollment in Tricare Prime. Retirees under age 65 would be able to enroll in Tricare Prime based on a combination of factors, including the remaining capacity of the direct care system in particular areas. Enrollment would be free for active-duty personnel and dependents, but retirees would pay an annual fee of $230 for single and $460 for family coverage.

- Tricare Prime would offer *substantial incentives for enrollment* in preference to Tricare Extra or Standard, chiefly through priority access for enrollees within each beneficiary category. Enrollees would also benefit from reduced paperwork and potentially from enhanced coverage. In return, they would forgo access to nonnetwork providers except at a higher price, and a primary care physician would manage their access to care.

- DoD would try to *enroll as many active-duty families* in Tricare Prime as possible. As a result, retirees would receive even less access to the direct care system. Retirees age 65 and older and their families would not be allowed to enroll in Tricare Prime, under provisions governing CHAMPUS eligibility.

Congressional requirements underlie many of the provisions of Tricare. The Congress directed DoD to develop a uniform and stable benefit nationwide for all eligible beneficiaries and mandated the triple option benefit structure, capitated budgeting, a regionally based system, and competition for managed care contracts. In addition, the Congress stipulated that both the triple option and the HMO option by itself--Tricare Prime--must not be any more costly than the present system.

CBO's Assessment

The Tricare program is already under way in parts of the country, and by fiscal year 1997 DoD plans to award managed care support contracts covering all 12 planning regions. Because Tricare is an outgrowth of DoD's earlier approach to managed care under the CHAMPUS Reform Initiative (CRI) program, CBO's analyses of CRI expansion provide some basis for evaluating the Tricare program.

Effect on Beneficiaries

Tricare is likely to fail to offer all military beneficiaries uniform access to all three options in the mandated benefit package. Many beneficiaries will not receive the opportunity to enroll in Tricare Prime. Others, who receive coverage under Tricare Extra or Standard, will face limited access to care at military facilities. Active-duty members and dependents living near military medical facilities are likely to enjoy the greatest benefits under Tricare. In contrast, under DoD's plan to improve access to military facilities for enrollees in Tricare Prime, some retirees--particularly those age 65 or older--would receive fewer benefits and might actually find their out-of-pocket costs increasing under Tricare compared with today.

The requirement of budget neutrality will make it difficult for DoD to offer Tricare Prime outside military hospital catchment areas. That factor will cause the net costs of health care for beneficiaries living far from military hospitals to be higher than those for beneficiaries in catchment areas. Moreover, a further inequity arises: under Congressional mandate, some beneficiaries affected by hospital closings under the base realignment and closure process have been offered an HMO benefit along with a prescription drug benefit and thus will be treated better than others in noncatchment areas.

More generally, retirees may experience greater difficulty in gaining access to the direct care system under Tricare than they do now. DoD's policy of encouraging active-duty families to enroll in the Tricare Prime program will reduce the space available in the military facilities to serve retirees. The access of retirees would be reduced still more by DoD's emphasis on caring for Tricare Prime enrollees in military facilities to ensure that those beneficiaries experience lower out-of-pocket costs and that the HMO option achieves budget neutrality.

Finally, beneficiaries are likely to find inequities stemming from differences in civilian managed care health markets. Because of the requirement for budget neutrality, DoD will be better able to offer Tricare Prime in noncatchment areas with developed networks of managed care providers (and thus lower costs of care) than in other noncatchment areas where managed care is relatively uncommon. Thus, availability of the Tricare Prime option will vary even among noncatchment areas.

Effect of Tricare on DoD's Costs

On balance, CBO expects that Tricare will increase DoD's costs of health care delivery, despite the statutory requirement that it be budget neutral. Based on a range of assumptions about how key factors would affect costs--which are described in detail in CBO's previous analyses of CRI--CBO concludes that if Tricare was fully

operational in 1996, the total cost of DoD's peacetime health care mission would probably increase by about 3 percent, or about $300 million. That estimate is highly sensitive to many assumptions about the behavior of beneficiaries and DoD's ability to realize savings from managed care. But the effects of Tricare are likely to range somewhere between additional costs of about 6 percent (over $500 million) and savings of less than 1 percent ($100 million).

That range of estimates reflects uncertainty about DoD's ability to make major changes in the way it organizes its health care delivery system. The department plans to adopt several managed care strategies: applying utilization management to curb the use of care by beneficiaries in military facilities and the civilian sector; negotiating discounts with providers; and improving coordination between military facilities and the civilian sector to optimize the use of military facilities. Savings from those strategies would be needed to offset higher costs stemming from improved benefits under Tricare Prime and Extra, as well as the added administrative costs of the managed care support contracts.

Effect of Tricare on Health Care Management

Tricare stops short of making major changes in many of the current relationships built into DoD's health care delivery system that would affect its overall efficiency. For

example, the lead agents should be able to improve coordination among the services. But a lead agent from one service may find it difficult to exert authority over hospital commanders from other services as long as they continue to report to their separate Surgeons General. Capitated budgeting might help improve efficiency if it permitted transfers of funds among facilities within the same health care region, but at present DoD plans to continue to allocate resources separately through each service.

Similarly, Tricare includes many features intended to coordinate the delivery of care between the direct care system and CHAMPUS. Improving coordination is important to manage the total volume of care that beneficiaries receive. But DoD's plans for reviewing utilization management do not require that decisions about use made by a military hospital commander be binding on the private contractor providing managed care support within that hospital commander's jurisdiction. Nor would decisions by a contractor that certain types of care were medically unnecessary have to be binding on a military hospital commander, who could choose to furnish such care if resources were available.

Another aspect of efficient management concerns identifying the population for whom health care is to be provided. Historically, DoD has been unable to plan accurately because it has had no enrollment system for beneficiaries. Tricare would require enrollment under only one option, Tricare Prime, so the department would still face the possibility that eligible beneficiaries who were not currently using the system

might return to it for their care at any time. That factor introduces considerable uncertainty: CBO estimates that less than half of the non-active-duty beneficiaries using the system today will enroll. Furthermore, about 30 percent of those eligible to use military health care in the United States--2 million beneficiaries--do not do so at present. That "ghost" population would continue to create major cost and management uncertainties under Tricare.

Finally, Tricare does not go very far to enlist the help of beneficiaries in improving the efficiency of the health care system. Today's system does not impose copayments for outpatient care at military facilities and requires only minimal copayments for hospitalization. DoD is considering copayments under Tricare Prime for retirees and their families, but not for the active-duty members and dependents who would receive the preponderance of care delivered at military facilities.

Modifications to the Tricare Program

In summary, as CBO concluded last year in testimony before this Committee, Tricare is unlikely to solve all of the problems of the military health care system. But the program could be modified in ways that would boost its chances of reducing costs and improving efficiency. As Tricare goes forward, the Congress might want to consider requiring some of the following changes:

- *Establish a tri-service command and control structure* that would provide each lead agent with management control over all personnel and resources from other services. Resources would no longer continue to be allocated separately through each service but would go directly to the lead agent.

- *Require DoD to integrate utilization review activities* throughout CHAMPUS and the direct care system, thereby letting the department control the total volume of care delivered to military beneficiaries. The Congress might also require DoD to identify the services provided in either military or civilian medical facilities. Without such requirements, the department would have no way to eliminate the provision of unnecessary care and thus would not be able to hold down costs.

- *Adopt a universal enrollment requirement* that all beneficiaries who plan to use the military health care system enroll in a military health care plan. Military providers need to be able to plan for the health care needs of a defined population in order to develop per capita budgets and build cost-effective health care delivery networks. Those strategies can be put into effect only if all eligible beneficiaries commit themselves either to use a military plan or to rely on civilian sources of care.

- *Impose a premium and copayments* for health care benefits--for both military and civilian care--at levels approaching those in civilian plans. That change would offer beneficiaries incentives to use care efficiently. Premiums would also minimize the risk of ghosts reentering the military health care system, facilitating both regional management of the system and capitated budgeting. For DoD to institute that change, however, the requirement that Tricare Prime must lower out-of-pocket costs for beneficiaries would have to be repealed.

- *Allow enrollment to serve as the basis for access to care* at military treatment facilities. In doing so, DoD could provide all military beneficiaries with a greater incentive to enroll in a military health care plan. At present, however, statutory language requires that DoD give priority access to active-duty personnel and their dependents.

- *Consider removing the requirement* that the HMO option by itself be budget neutral. That requirement would limit DoD's ability to offer the HMO benefit in noncatchment areas, where costs to DoD are likely to be higher than the costs of care furnished in military facilities. Removing the requirement thus would offer DoD greater flexibility to provide all beneficiaries with the triple option benefit structure.

MEDICARE REIMBURSEMENT FOR MILITARY CARE

Who should bear the cost of care furnished by military medical facilities to beneficiaries eligible for Medicare? That issue arose in the course of last year's debate about national health care reform. In fiscal year 1996, about 1.2 million retired military personnel and their dependents who are entitled to Medicare insurance coverage will also be eligible to receive care in the medical facilities of the Department of Defense. For a number of reasons, including the access to available space that those beneficiaries are granted, only 25 percent to 30 percent of them will actually use military health care. But for those who do use it, DoD will pay the cost of care out of its annual appropriations, with no reimbursement from Medicare.

During last year's Congressional debate, both this Committee and the Senate Armed Services Committee considered proposals to authorize Medicare to make payments to DoD to cover the cost of such care (termed "Medicare subvention"). Similar proposals have been made in this Congress. One approach included in many proposals is to provide for payments based on the overall rate per enrollee, or capitated amount, that Medicare currently uses to reimburse eligible organizations, such as health maintenance organizations, that have Medicare risk-sharing contracts. Beneficiaries who choose to use the military health care system would have to designate DoD as the sole provider of care, meaning that they would be required to enroll in the Tricare program.

The budget stakes in this issue are significant. In estimating the costs of last year's proposals, CBO assumed that roughly the same number of beneficiaries eligible for Medicare who receive most of their care in military facilities today--about 25 percent of the eligible population--would enroll in a DoD Medicare HMO option. Based on that assumption, total Medicare payments to DoD would amount to about $2.7 billion by fiscal year 2000.

Last year's legislation on Medicare subvention was subject to the pay-as-you-go procedures of budget enforcement. It allowed DoD to spend any amounts it collected from Medicare without subsequent appropriation action. In budget parlance that is called "direct spending" and would require offsetting reductions in mandatory or entitlement spending or increases in revenues to be deficit neutral. Without specific legislative remedies, the increase in Medicare spending for beneficiaries treated in military facilities would simply constitute an additional expenditure from the Medicare Hospital Insurance Trust Fund, which is already projected to run short of funds early in the next century.

One might ask whether there would be a compensating reduction in DoD's appropriations. Wouldn't that maintain deficit neutrality? Unfortunately, it would not because DoD's appropriations are tracked along with other discretionary spending on a separate "scorecard" from pay-as-you-go spending. As long as there are fixed caps

on discretionary spending, any savings in DoD's budget from Medicare subvention can be spent on other defense or nondefense discretionary programs. Thus, enacting Medicare subvention alone would increase the deficit by the amount of the Medicare payment.

Securing reimbursement from Medicare on the basis of capitated payments would help DoD to defray the cost of providing health care, but it would not necessarily guarantee beneficiaries eligible for Medicare any better access to a military facility than they have today. Access to a military facility would continue to be determined on the basis of location, capacity, and priorities. DoD could arrange for an enrollment option for those eligible for Medicare in areas without military facilities. But doing so would simply duplicate benefits currently available from Medicare HMOs in the civilian sector.

ALTERNATIVES TO TRICARE

Even if Tricare worked as DoD projects--that is, if it led to improved access to care, efficiencies in health care delivery, and costs no higher than under the present system--its additional benefits would accrue unevenly. Perhaps 60 percent of the population of current users of military health care (active-duty members and their families) would receive improved access at lower cost under Tricare. But retirees and their

dependents and survivors, who make up the remainder of users, would probably find their costs of care higher and their access to military facilities more limited.

Instead of changing the military health care system, some beneficiaries have proposed expanding the options for health care, at least for beneficiaries other than active-duty personnel. Military beneficiaries could receive access to health care from nonmilitary providers in many ways. One particular approach, supported by the National Military Family Association, would give beneficiaries access to care through the Federal Employees Health Benefits (FEHB) program rather than through the military health care system. In requesting a CBO study of military medical care, this Subcommittee directed CBO to consider FEHB alternatives to Tricare.

The reduction in wartime medical requirements from Cold War levels creates an opportunity to reconsider DoD's peacetime and wartime medical missions. According to DoD's Congressionally mandated study on the military medical system--referred to as the 733 study--and supporting analysis by RAND, the department could close the majority of its hospitals and medical centers and still provide through its own facilities roughly double the share of total wartime needs that it planned to meet during the Cold War. (As DoD has historically planned, the Department of Veterans Affairs and civilian hospitals under agreement with the National Disaster Medical System could meet additional wartime needs.)

Downsizing the direct care system to such an extent would make it impossible to provide peacetime care in military facilities to most military beneficiaries. But the downsizing would offer substantial savings--$10 billion or more annually--that could be used to pay for medical care from alternative sources such as the FEHB program. CBO's evaluation of the FEHB alternative includes an estimate of the savings from downsizing the direct care system.

Under such an approach, most military medical personnel would no longer be responsible in peacetime for caring for military beneficiaries. How to use those medical resources to enhance wartime readiness will be addressed in our testimony at the Subcommittee's next hearing on March 30.

The Federal Employees Health Benefits Program

The Federal Employees Health Benefits program is the source of health insurance for more than 9 million people. That number includes employees and retirees of the federal government and their dependents. Enrollment in the FEHB program is voluntary. In fact, not everyone who is eligible for enrollment chooses it: about 15 percent to 20 percent of the total eligible population of federal workers and retirees decide not to enroll in FEHB for a variety of reasons, such as a married person who opts for coverage through the employer of his or her spouse.

Participants in FEHB have a wide range of choices of types of plans and providers. Premiums and levels of benefits vary among plans. Two basic types of health insurance plans are offered: fee-for-service plans (perhaps including preferred provider options) and prepaid plans such as HMOs. In addition to the choice of plan, enrollees must also elect either self-only or self and family coverage.

The cost of each plan's premium is shared between the federal government and enrollees. In fiscal year 1995, the average premium contribution that the government will pay will be about 72 percent; employees and annuitants will pay the remaining 28 percent (except for Postal Service personnel, who pay a smaller share). The share of the premium paid by any individual employee or annuitant varies by plan.

FEHB as a Provider of Care for the Military

For purposes of comparison, CBO has developed an FEHB alternative consistent with the Subcommittee's request. Under this illustrative alternative, DoD would offer active-duty dependents and retirees and their family members the opportunity to enroll in the FEHB program on a voluntary basis. In addition, the department would ensure that all of its military beneficiaries over the age of 65 had full coverage under Medicare, including both coverage under Part A (Hospital Insurance) and voluntary coverage under Part B (Supplementary Medical Insurance). Those who are eligible

would receive primary coverage through Medicare, with most FEHB plans providing a wraparound policy to cover what Medicare does not.

Beneficiaries other than active-duty personnel would no longer have the option to receive care from the military system. The direct care system would be reoriented toward the wartime medical mission. As a result, the availability of peacetime care in military facilities would be sharply curtailed. DoD would retain the responsibility to provide care for active-duty personnel, which it could meet through some combination of its military hospitals, clinics, and care purchased from the civilian sector. CBO's testimony at the Committee's next hearing will discuss the provision of care for active-duty personnel at greater length.

Effects of FEHB on Coverage and Access to Care

One major effect of this approach is that it would place all categories of beneficiaries on equal footing. Today's military health care system puts active-duty personnel before active-duty dependents; retirees and their families have lowest priority. The FEHB approach would eliminate that ranking, since all beneficiaries would have equal access through their chosen plans.

Because most FEHB plans would provide full wraparound coverage for services and cost-sharing requirements not covered by Medicare, military beneficiaries who are eligible for Medicare would also benefit substantially from this option. For example, most FEHB plans would provide 100 percent coverage for prescription drugs for such beneficiaries, all of whom would have their employee premiums for enrollment under Medicare Part B paid by DoD.

Even under the FEHB approach, access to care could still vary by region, since not all FEHB options are available in all parts of the country. But military beneficiaries would have many more choices than they have today through the military health care system. Active-duty dependents could have at least as many choices as federal civilian employees, ranging from fee-for-service plans (with or without a preferred provider option) such as Blue Cross/Blue Shield to prepaid HMOs. The lack of available information on where retirees live makes it difficult to determine what plans might be available to them, but the availability of plans other than fee-for-service ones seems not to be particularly important to most federal retirees. Over 85 percent of all federal annuitants enroll in fee-for-service plans that enable them to choose their physicians. Blue Cross/Blue Shield alone is chosen by over 55 percent of annuitants.

A military beneficiary's actual choice to enroll in a plan of the FEHB--and the plan actually chosen--depends on many more factors than just the number of choices.

How the department implements this option, how much it would contribute to each plan's premium, and the alternative options that beneficiaries may have for private health insurance will all affect their behavior. Those considerations underlie CBO's analysis of the costs of the FEHB approach.

Effect of FEHB on Government Costs

In estimating those costs, CBO assumes that the present approach to calculating FEHB premiums would be retained. DoD would pay at least the government's share of the premiums of the plans actually selected by beneficiaries, or an average of about 72 percent of the plans' cost. (Under current statute, the actual contribution that the department would make toward any plan's premium could not exceed 75 percent of any plan's premium.) Enrollees would pay the remaining 28 percent of the average premium.

CBO will provide a detailed cost analysis of the FEHB alternative as part of the study that we are conducting for this Subcommittee. Because that analysis has not yet been completed, our testimony today is limited to discussing the likely effects of FEHB. It now appears that the costs of providing military beneficiaries with coverage under the full range of FEHB plans would be substantially less than the savings that could be realized by downsizing and restructuring the military's direct

care system. Net annual savings after full implementation could be on the order of $1 billion or more. Savings would probably be somewhat greater in comparison with Tricare once it is fully established.

The estimated cost of providing coverage for active-duty dependents and retirees and their families under FEHB includes an evaluation of how adding those beneficiaries to the covered population would affect the costs of both DoD and Medicare. As well as the cost to DoD of providing military beneficiaries with coverage under FEHB, the estimate assumes that Medicare costs would increase under both Part A and Part B. In addition, the estimate assumes that DoD would pay an enrollee's premium under Medicare Part B, including fees for those beneficiaries who waived coverage when they first became eligible.

Some or all of those savings could be used to defray the added costs to military beneficiaries under FEHB. CBO is evaluating a variety of options for reducing the net costs to beneficiaries. Adopting any such option, however, would add to DoD's costs in two ways. First, individual participants would receive greater benefits than under basic FEHB. Second, the more generous benefits would probably induce some additional beneficiaries to elect coverage. Those added costs could offset some--perhaps even more than 100 percent--of the savings from the FEHB approach, depending on how the option was designed and carried out. Those issues will also be discussed in detail in CBO's forthcoming analysis.

Effects of FEHB on Beneficiaries' Costs

FEHB coverage would alter the net cost to beneficiaries compared with Tricare. For most beneficiaries, the largest effect would stem from additional premium costs. In addition, under some plans beneficiaries would face copayments different from those under any of the three Tricare options. Further, the improved coverage that many FEHB plans would offer might enable some beneficiaries to save by canceling CHAMPUS supplemental insurance policies or other private coverage.

Under Tricare, costs for different groups of beneficiaries will depend heavily on access to treatment in military facilities (see Table 1). Tricare Prime would cost active-duty dependents less than some HMO plans offered through FEHB, but for retirees, FEHB alternatives could be less costly than Tricare Prime. A similar pattern applies for beneficiaries choosing Tricare Standard: active-duty dependents would pay less than in some FEHB fee-for-service plans, but many retirees could pay substantially more than under FEHB alternatives.

Administrative Factors

In fiscal year 1995, the total cost of FEHB to the federal government is about $16 billion. If coverage was provided to all 6.6 million potential DoD beneficiaries--

TABLE 1. ESTIMATED OUT-OF-POCKET AND PREMIUM EXPENSES FOR BENEFICIARIES UNDER TRICARE OPTIONS AND PLANS OFFERED UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM (In dollars)

Plan and Beneficiary Category	Tricare	FEHB	Difference
Tricare Prime/Health Maintenance Organization			
Active-duty dependents[a,b]	100	700	600
Retirees			
Younger than 65[b,c]	1,000	700	-300
Older than 65[d]	1,700	700	-1,000
Tricare Standard/Traditional Fee-for-Service Plan			
Active-duty dependents[a,b]	200	1,100	900
Retirees			
Younger than 65[b,c]	1,100	1,100	0
Older than 65[d]	1,700	600	-1,100

SOURCE: Congressional Budget Office.

NOTES: FEHB = Federal Employees Health Benefits program.

Numbers assume expenses for an individual under the Tricare program and two different plans offered under the FEHB: Kaiser Permanente and the Standard Option of Blue Cross/Blue Shield. Actual expenses could be higher or lower than estimated here depending on many factors, including health status, income, and the actual plan selected by an individual under the FEHB program. Expenses are estimated for 1996 omitting any expenses incurred outside the military health care system, with the exception of expenses for CHAMPUS supplemental coverage, or the plan of choice under FEHB. Costs are rounded to the nearest hundred.

a. Includes expenses for beneficiaries for care provided in the civilian sector; all other care received is considered to be free of charge at military medical facilities.

b. Assumes than an enrollee in a health maintenance organization plan offered under the FEHB program would assume the behavior of a typical active worker in that plan.

c. Includes beneficiary expenses for care provided in the civilian sector and for a CHAMPUS supplemental policy; all other care received is considered to be received free of charge at military medical facilities.

d. Assumes that military beneficiaries over the age of 65 are not eligible for Tricare Prime or Standard. Instead, military beneficiaries over the age of 65 would incur the same acute care expenses as other Medicare eligible individuals for all services covered by Medicare plus one-third of their out-of-pocket expenses for prescription drugs; DoD would pay the rest of their prescription drug expenses. Two assumptions are central to this estimate: that Medicare is the beneficiaries' only health coverage, and that the only expense for beneficiaries over the age of 65 would be their premium for a plan under the Standard Option of Blue Cross/Blue Shield. Expenses are assumed to fall for military beneficiaries over the age of 65 enrolled in a plan offered under the FEHB for two reasons: their premiums would be paid by DoD for coverage under Medicare Part B, and the Standard Option of Blue Cross/Blue Shield would reduce out-of-pocket expenses to zero.

including ghosts--the size of the FEHB program could increase by almost 75 percent. Even if the ghost population was excluded, the increase in volume would surely increase administrative costs for the program. Those added costs, which CBO has not been able to estimate, would offset some of the potential savings.

Apart from the increase in the volume of work, expanding FEHB to cover dependents of military personnel and retirees would raise several administrative issues. One issue that would emerge is how to handle enrollment for active-duty families, who move much more often than other federal workers. Another issue concerns self-only and self and family policies. This option assumes that active-duty spouses would be permitted to purchase policies, even though the active-duty member is the employee. Further, in many cases, a spouse without children or an only child in a single-parent family might benefit from purchasing a lower-cost self-only policy. The Office of Personnel Management would have to resolve those administrative questions in a manner consistent with the interests of military families.

Budgetary Treatment of FEHB Costs

Like Medicare subvention, this option would have pay-as-you-go implications for budgetary enforcement. First, the employer contribution for premiums of annuitants is considered to be an entitlement subject to pay-as-you-go procedures. Second,

legislation that raised participation in either Medicare Part A or Part B would also be subject to those procedures. The FEHB option would raise Medicare participation because people who now receive care in military treatment facilities would instead be treated in the civilian sector under Medicare.

In this case, as with the Medicare subvention option, the presence of fixed caps on discretionary spending would prevent a reduction in DoD's budget for health care from automatically reducing net discretionary spending. Under the scoring rules of the Omnibus Budget Reconciliation Act of 1993, putting an FEHB option into place for military personnel would require offsets in pay-as-you-go spending and perhaps in the legislative cap on discretionary spending.

A final issue for this Subcommittee's concern is jurisdiction over the FEHB program. At present, jurisdiction in the House of Representatives resides with the Civil Service Subcommittee of the Committee on Government Reform and Oversight. Any proposal to extend the FEHB program to military beneficiaries presumably would have to receive the approval of that committee as well as this one.

CONCLUSION

Despite DoD's efforts, Tricare is not yet a fully developed vehicle for providing medical care to military beneficiaries. A number of questions remain unanswered about the program's costs, its effect on access to care for different groups of beneficiaries, and DoD's commitment to undertaking needed administrative and structural reforms.

In this testimony, CBO has outlined an alternative approach to providing care for the military population. The FEHB approach might offer savings compared with both Tricare and today's military medical system, while simultaneously improving access and equity for beneficiaries. Integrating the FEHB approach with Medicare, however, would raise issues associated with budgetary treatment. Those issues and others will be addressed in more detail in the forthcoming study that CBO is conducting for this Subcommittee.