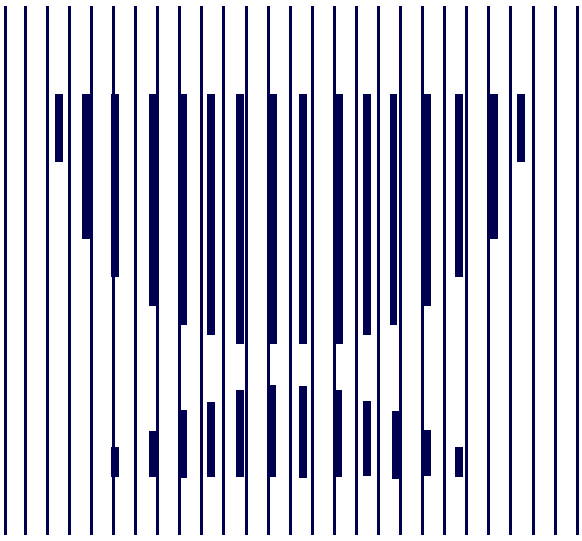
CBO MEMORANDUM

EVALUATING THE COSTS OF EXPANDING MILITARY HEALTH CARE BENEFITS INTO LEAD AGENT REGION 6

February 1994



CONGRESSIONAL BUDGET OFFICE

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CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Provisions of the Department of Defense Authorization Acts for Fiscal Years 1993 and 1994 require the Congressional Budget Office (CBO) and the General Accounting Office to evaluate any proposals made by the Department of Defense (DoD) to expand contracts for managed health care beyond the states of California and Hawaii (excluding expansion into areas where military bases are being closed). DoD has proposed to expand managed care into Arkansas, Oklahoma, and parts of Louisiana and Texas. This CBO memorandum has been prepared in compliance with the provisions of the authorization acts. The memorandum summarizes the findings of CBO's evaluation, which focused on evaluating DoD's cost analysis.

Ellen Breslin Davidson of CBO's National Security Division and Amy Plapp of CBO's Budget Analysis Division prepared the memorandum under the direction of Neil M. Singer, R. William Thomas, and Michael A. Miller. The authors gratefully acknowledge the useful comments provided by their CBO colleague Carla Pedone, as well as the valuable assistance of Jonathan Berg. Sherwood Kohn edited the manuscript, and Christian Spoor provided editorial assistance. Cynthia Cleveland prepared the paper for publication.

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INTRODUCTION

The Defense Authorization Act for Fiscal Year 1993 required that the Congressional Budget Office (CBO) and the General Accounting Office evaluate the Department of Defense's (DoD's) decision to certify the expansion of managed care contracts beyond the states of California and Hawaii. The fiscal year 1994 authorization act amended this requirement by adding that the Secretary of Defense must assure that expanding a managed care contract into another location of the country is indeed cost-effective; that is, that total government costs for the Military Health Services System will not increase. CBO focused on evaluating the department's cost analyses, and this paper summarizes its evaluation of DoD's latest certification of the expansion of managed care into a region that includes Arkansas, Oklahoma, and parts of Louisiana and Texas. CBO's conclusion is that while DoD's analysis may be too optimistic, the proposed expansion of managed care is unlikely either to save or to add very much compared with the current costs of providing care to military beneficiaries. By themselves, the improved benefits associated with DoD's proposed change probably would raise costs, but by less than 3 percent. DoD, however, plans to combine the improved benefits with savings from reducing health care use that would offset much or all of the cost increase.

BACKGROUND ON MILITARY HEALTH CARE

The Department of Defense operates one of the nation's largest health care systems. Eligible military beneficiaries--active-duty personnel and retirees and their families--receive care through the Military Health Services System (MHSS). The majority of the care provided through the MHSS is delivered through the direct care portion of the system, which consists of approximately 140 hospitals and several hundred clinics in the United States. When care is not available through the direct care system, families of active-duty personnel and retirees and their dependents under the age of 65 may use civilian providers. DoD reimburses those providers through a traditional fee-for-service insurance program known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Together, the care delivered through CHAMPUS and by the direct care system make up the MHSS.

In response to dissatisfaction among beneficiaries and substantial growth in CHAMPUS costs, the Congress authorized the CHAMPUS Reform Initiative (CRI) in 1987 to test managed care in the military and improve the coordination of service delivery between military facilities and CHAMPUS. Most significantly, CRI offered two alternatives to the standard version of CHAMPUS: CHAMPUS Prime, an option that contains some features

similar to those found in civilian health maintenance organizations (HMOs), and CHAMPUS Extra, an optional preferred provider organization (PPO).

In 1993, RAND, under contract to DoD, released the results of its examination of beneficiaries' access, satisfaction, health care utilization, and costs under CRI. Although RAND found that beneficiaries' access and satisfaction generally improved under CRI in California and Hawaii, the study concluded that CRI, as put into effect in California and Hawaii, increased the total costs of the MHSS by 8 percent.

EXPANDING A REVISED CRI PROGRAM INTO WASHINGTON AND OREGON

On August 20, 1993, DoD proposed extending a revised version of the CRI program to the states of Washington and Oregon. The department certified that the most efficient method of providing health care in the two additional states would be to offer CRI with a revised version of the CHAMPUS Prime benefit currently in effect in California and Hawaii, coupled with changes in the structure of the CRI contract and the management of health care. In its statement, DoD estimated that the revised CRI benefit in Washington and Oregon in 1993 would have cost 6.2 percent more than the benefits available under CHAMPUS without CRI, but that the various changes in the program's

structure could offset those higher costs. Indeed, under DoD's more optimistic assumptions about the effects of those factors, putting a revised version of CRI into effect in Washington and Oregon might actually decrease net costs by at least 2 percent, compared with the costs of CHAMPUS without CRI in 1993.

In compliance with the requirements of the 1993 Defense Authorization Act, on September 20, 1993, CBO submitted a report to the Congress summarizing the findings of its evaluation of DoD's certification. Those findings, as well as a detailed description of CBO's estimating methodology, were summarized in a CBO paper, "Evaluating the Costs of Expanding the CHAMPUS Reform Initiative Into Washington and Oregon" (November 1993). CBO's analysis suggested that the revised CRI benefit, coupled with changes in the structure of the CRI contract and the management of health care, was likely to increase costs by 3.1 percent in Washington and Oregon above the costs of CHAMPUS without the revised CRI program in 1993. That conclusion differed only slightly from DoD's finding that the costs of the new program could be fully offset. Under a more optimistic set of assumptions, however, CBO concluded that carrying out the revised CRI program could actually reduce costs in Washington and Oregon by 3.2 percent, compared with the costs of CHAMPUS without CRI in 1993. That finding was consistent with DoD's conclusion. But under other, equally

plausible assumptions explored in that analysis, carrying out the revised CRI program in Washington and Oregon could cost 17 percent above the costs of CHAMPUS without the revised CRI program in 1993. The wide range of estimates presented in that paper underscored the significant degree of uncertainty about the cost-effectiveness of expanding the revised CRI program into Washington and Oregon.

DOD'S CERTIFICATION OF THE MCS CONTRACT INCLUDING THE TRICARE BENEFIT PACKAGE INTO REGION 6

To reflect the President's plans for national health care reform and appropriate nomenclature, DoD has retired the original program name of CHAMPUS Reform Initiative and introduced the at-risk Managed Care Support (MCS) contract with what it calls the Tricare benefit package. The MCS contract including the Tricare benefit package retains many of the successful elements of the original and revised CRI programs, but it alters those programs to reinforce the reforms planned for the direct care portion of the MHSS. Accordingly, CHAMPUS Prime is now called Tricare Prime (the HMO option) and Extra is now called Tricare Extra (the PPO option), while the standard version of CHAMPUS is now called Tricare Standard. Despite the name change, however, the Tricare benefit package is exactly the same as the revised CRI benefit package that is outlined in detail in CBO's

paper on evaluating the expansion of the revised CRI program into the states of Washington and Oregon.

In compliance with the new requirements set forth in the Defense Authorization Act for Fiscal Year 1994, on December 27, 1993, DoD certified that the extension of the MCS contract with the Tricare benefit package to what DoD refers to as Lead Agent Region 6 would be "the most efficient method" for providing health care services in the new sites.[1] Lead Agent Region 6--DoD's designation for the major medical center responsible for the at-risk managed care contracts in a health service region--consists of Arkansas, Oklahoma, and portions of Louisiana and Texas. It is one of 12 Lead Agent Regions designated as part of DoD's Lead Agent initiative under national health care reform. According to DoD, introducing the MCS contract including the Tricare benefit package into Lead Agent Region 6 would "very likely" reduce the total government costs of the Military Health Services System in that region by about 3 percent to 4 percent. At worst, DoD estimates that the government would "break even."

1. Letter from Edward D. Martin, Acting Assistant Secretary of Defense, to the Congress, December 27, 1993.

DoD Methodology Used to Analyze the Effects on Costs of the MCS Contract with the Tricare Benefit Package

In order to judge how the extension of the Managed Care Support contract including the Tricare benefit package in Region 6 would affect total government costs for the Military Health Services System, DoD estimated the total government costs for supporting CHAMPUS and the direct care system during fiscal years 1995 through 1999 without the contract with the new benefit package, and then compared those estimates with the cost of the MCS contract including the Tricare benefit package.

Adopting the framework of analysis used by CBO in its November 1993 report to the Congress, DoD examined the ways in which a range of assumptions about key factors would affect total government costs for the MHSS. DoD grouped the various assumptions into three cases: a base case reflecting its most likely estimate, a higher-cost case incorporating a set of assumptions that lead to high costs, and a lower-cost case incorporating a set of assumptions that lead to low costs.

DoD based its range of assumptions on several sources, including RAND's evaluation of CRI in California and Hawaii and the results of experiments with managed care in the civilian sector. In DoD's base case, the assumptions reflect much of the experience in California and Hawaii, thus

combining a favorable set of assumptions about savings with an unfavorable set of assumptions about costs. The assumptions used in the lower-cost case incorporate or go beyond the most favorable results from the experience of CRI in California and Hawaii in putting managed care strategies into effect. For example, DoD assumes that discounts negotiated with providers in Region 6 will be higher than those negotiated in California and Hawaii. In addition, the lower-cost case reflects the potential for higher savings in the areas of utilization management that arises from the unusually high rates of health care use in Region 6 (see the Appendix). The higher-cost case, conversely, incorporates higher levels of induced demand, higher administrative costs, and smaller savings from utilization management and other managed care strategies, such as provider discounts.

How the MCS Contract with the Tricare Benefit Package Affects Costs

Under its base and lower-cost cases, DoD found that the extension of the Managed Care Support contract including the Tricare benefit package would be cost-effective. Even under DoD's higher-cost case, total costs of the Military Health Services System would increase by less than 1 percent over the period from fiscal year 1995 to fiscal year 1999 (see Table 1).

DoD estimates that government costs for the Military Health Services System will total $8.1 billion in Region 6 in the period from fiscal year 1995 to fiscal year 1999. This amount includes the cost of care for all beneficiaries in Region 6 and the cost of CHAMPUS and the direct care system without the MCS contract including the Tricare benefit package.

Under its base case, DoD estimates that extending the MCS contract with the Tricare benefit package to Region 6 would "very likely" reduce total government costs for the MHSS in Region 6 by about 3 percent to 4 percent. Savings would begin in fiscal year 1995 and remain fairly constant through fiscal year 1999. Under the lower-cost case, DoD estimates that the contract including the benefit package would reduce total government costs for the

TABLE 1. DoD'S ESTIMATES OF CHANGES IN MILITARY HEALTH SERVICES SYSTEM COSTS FOR THE FISCAL YEAR 1995-1999 PERIOD UNDER VARYING ASSUMPTIONS ABOUT EXTENDING THE MANAGED CARE SUPPORT CONTRACT INCLUDING THE TRICARE BENEFIT INTO REGION 6

	Current Policy (In millions of dollars)	MCS Contract with Tricare Benefit Package	
		Millions of dollars	Percentage Change
Base Case	8,132	7,846	-3.5
Higher-Cost Case	8,132	8,198	0.8
Lower-Cost Case	8,132	7,504	-7.7

SOURCE: Estimates based on calculations by Lewin-VHI, Inc., for the Department of Defense.

NOTES: DoD = Department of Defense; MCS = Managed Care Support.

MHSS by 7.7 percent, or by an additional 3 to 4 percentage points. According to DoD's analysis, under its higher-cost case the government would "at worst break even."

CBO'S ASSESSMENT OF DOD'S COST ESTIMATES

CBO expects that if the Managed Care Support contract including the Tricare benefit package is extended, the government will almost break even. Over the period from fiscal year 1995 to 1999, it is possible that costs would fall, but not by much, even under the most optimistic set of assumptions. At the same time, under even the most pessimistic set of assumptions, the government would probably experience only small net increases in costs.

CBO Methodology Used to Analyze the Effects on Costs of the MCS Contract with the Tricare Benefit Package

In order to facilitate comparisons, CBO followed DoD's approach. It estimated total government costs for the Military Health Services System from fiscal year 1995 to 1999 for Region 6 without the MCS contract including the Tricare benefit package, and then compared those estimates with the cost of introducing the new program.

The methodology used in this analysis is very similar to that used to estimate the costs of expanding the revised CRI program into Washington and Oregon, with a few exceptions. (See CBO, "Evaluating the Costs of Expanding the CHAMPUS Reform Initiative Into Washington and Oregon.") First, CBO projected costs for the Military Health Services System, including CHAMPUS and the direct care system, for each fiscal year over the 1995-1999 period without the MCS contract containing the Tricare benefit package, based on MHSS costs for fiscal year 1992. Second, CBO estimated the total number of beneficiaries who rely on the MHSS (and use either a military treatment facility or CHAMPUS for their health care), in order to project the number who would enroll in Tricare Prime, participate in Tricare Extra, or continue using Tricare Standard. Third, CBO estimated the effects of factors that changed costs in relation to government costs for the MHSS without the MCS contract containing the Tricare benefit package.

In response to a Congressional mandate, DoD and CBO now measure the effects of extending the Managed Care Support contract including the Tricare benefit package into Region 6 on the total costs of the MHSS instead of on CHAMPUS alone. Along with that change, DoD has also altered its methodology. The one change with the greatest impact on costs is a proposal to allow commanders of the local military treatment facilities (MTFs) in Region 6 to purchase utilization management services from the MCS

contractor. In practice, the MTF commander will be allowed to hire the MCS contractor to apply utilization controls to the MTF, thereby reducing unnecessary or inappropriate utilization of care at the MTF. As a byproduct of freeing up capacity at the MTFs, local commanders may be able to reduce their CHAMPUS work load by providing those services in-house at the MTF.

DoD's methodology assumes that 50 percent of the MTF commanders in Region 6 would purchase utilization management services from the MCS contractor. (Some of the MTF commanders would probably choose a utilization management system of their own.) As DoD emphasizes in its certification report, local commanders are strongly motivated to curb any unnecessary use of health care services at the MTFs. In fiscal year 1994, DoD started a system of budgets based on per capita allowances for medical care for the purpose of allocating MHSS resources to MTF commanders. Under this system of budgeting, DoD will hold local commanders responsible for managing all MHSS costs in their catchment areas and staying within budget, thereby giving commanders an incentive to purchase utilization management services from the contractor to hold down costs. (A catchment area around a military hospital covers a rough circle with a 40-mile radius.)

Without a doubt, DoD has room to reduce inpatient and outpatient utilization rates in Region 6 without jeopardizing beneficiaries' health. DoD

estimates that CHAMPUS-eligible people under the age of 65 in Region 6 who rely on the MHSS--including families of active-duty personnel and retirees and their families--use an average of 843 days of inpatient care per 1,000 persons between the MTF and CHAMPUS, compared with only 251 days used per 1,000 inpatients for people under 65 who belong to HMOs nationwide. On the outpatient side, the average CHAMPUS-eligible person under the age of 65 makes 10.2 visits per year, compared with only 5.5 civilian visits per HMO enrollee. Health care use rates in Region 6 are high even when compared with the inpatient and outpatient rates for the average CHAMPUS-eligible person nationwide. For instance, CBO estimates that CHAMPUS-eligible people under the age of 65 who rely on the MHSS for care average around 700 days per 1,000 people between the MTF and CHAMPUS nationwide, compared with the 843 days in Region 6.

The MCS contract that includes the Tricare benefit package provides a vehicle for local commanders to bring military utilization rates in line with civilian HMO utilization rates. DoD could move forward with this initiative now without introducing the MCS contract that includes the Tricare benefit package. But without the savings from reduced utilization, which the department plans to realize at the same time as the other savings from the Tricare benefit package in Region 6, CBO's estimates imply that DoD would have difficulty certifying this program as cost-effective.

Defining Three Cases

The various assumptions that CBO considered can be grouped into a base case, an optimistic case, and a more pessimistic one. In the base case, CBO used most of the assumptions that DoD used to develop its own base case, adjusting only for the less mature managed care market in Region 6 than in California and Hawaii, as well as the results from the RAND evaluation of CRI in those two states. For example, CBO assumes higher costs for administration and profit, and slightly smaller savings from both utilization management efforts and discounts negotiated with mental health providers. In the best case, CBO also patterned its set of assumptions of costs and savings after the assumptions underlying DoD's lower-cost case, but assumed slightly higher costs for administration and profit and smaller savings from negotiating discounts with mental health providers. CBO's pessimistic case, however, uses more extreme cost estimates than does DoD's higher-cost case, to reflect the less mature managed care market in Region 6 as compared to California (see the Appendix for more discussion). In several areas CBO assumes higher costs, including administration and profit and induced demand by retirees.

As a footnote to this discussion, there are also significant differences in the assumptions that CBO used to estimate the costs of extending the MCS

contract including the Tricare benefit package in Region 6, as compared with the assumptions used in assessing the costs of expanding CRI into the states of Washington and Oregon. These differences reflect the different patterns of health care spending between Region 6 and Washington and Oregon, as well as differences in the maturity of the managed care markets in those two regions.

Costs Under CBO's Three Cases

Under the assumptions of the base case, extension of the MCS contract with the Tricare benefit to Region 6 would leave costs unchanged (see Table 2). For all cases, however, total MHSS government costs for Region 6 from fiscal year 1995 to 1999 would change only modestly.

Government Breaks Even in the Long Run, Pays in the Short Run. In all three cases, the government would just about break even. In the short run, the government should expect increases in the cost of the Military Health Services System in Region 6. In the last two to three years of the program, however, CBO expects the government to realize savings under the base and optimistic cases. But under the pessimistic case, CBO expects savings in neither the long run nor the short run.

The narrow range of the estimates around the base case suggests that the risk to the government of future increases in costs from extension of the Managed Care Support contract including the Tricare benefit package is quite low. By the same token, the savings to the government are not likely to be very high. Indeed, under the most optimistic set of assumptions, CBO estimates that total MHSS costs for Region 6 could fall by 3 percent to 4 percent.

TABLE 2. CBO'S ESTIMATES OF CHANGES IN MILITARY HEALTH SERVICES SYSTEM COSTS FOR THE FISCAL YEAR 1995-1999 PERIOD UNDER VARYING ASSUMPTIONS ABOUT EXTENDING THE MANAGED CARE SUPPORT CONTRACT INCLUDING THE TRICARE BENEFIT INTO REGION 6, WITH AND WITHOUT SAVINGS FROM UTILIZATION MANAGEMENT AT THE MTFs (In percent)

	Percentage Compared with MHSS Without MCS Contract with Tricare Benefit Package	
	With MTF UM Savings	Without MTF UM Savings
Base Case	0	1.7
Optimistic Case	-3.6	-0.4
Pessimistic Case	2.5	3.3

SOURCE: Congressional Budget Office.

NOTES: CBO = Congressional Budget Office; MHSS = Military Health Services System; MCS = Managed Care Support; UM = utilization management; MTF = military treatment facility.

Costs are measured as a percentage change in total government costs for the MHSS in the absence of the MCS contract including the Tricare benefit package. CBO used a baseline of $8.4 billion in its calculation.

CBO's assumptions about the phase-in of savings is primarily responsible for the increases in costs in the short run. Savings under the MCS contract including the Tricare benefit package stem from four features of the program: negotiated discounts with providers, more efficient claims processing, resource sharing, and utilization management programs. CBO estimates that savings from utilization management, including those achieved by applying utilization management controls at the military treatment facilities, make up nearly 65 percent of the program savings in fiscal year 1999.

The assumptions about savings in fiscal year 1999 from the various utilization management programs--applying controls on inpatient and outpatient utilization at the MTFs, curbing the use of outpatient care at the MTFs by Tricare Prime enrollees, and reducing the use of civilian inpatient and outpatient care by beneficiaries enrolled in Tricare Prime and participating in Tricare Extra--do not differ very much from the savings assumed by DoD from these programs. But because of the significant contribution that these savings make in offsetting the cost increases associated with introducing the program, CBO's assumptions about phasing in savings make an important difference in its estimates. If CBO had used DoD's assumptions about phasing in savings under its base case, its costs in Region 6 would have fallen by 2 percent instead of just breaking even.

Based on experience with utilization management in both civilian experiments and the application of CRI in California and Hawaii, CBO assumed that the ultimate level of savings could not be realized as quickly as DoD had assumed. For example, DoD assumed that 90 percent of the ultimate level of per capita savings from applying utilization controls to both inpatient and outpatient care, in both military and civilian settings, could be achieved in fiscal year 1995, the first year of the contract, and that by the second year the full effects of reducing utilization could be realized. Similarly, DoD assumed that 100 percent of the per capita savings from curbing the use of outpatient care at the MTFs by Tricare Prime enrollees could be achieved in the first year of the contract.

By contrast, CBO assumed that 20 percent of the per capita savings from two of the three utilization management strategies--curbing the use of outpatient care at the MTFs by Tricare Prime enrollees and applying controls on use at the MTFs--could be realized in the first year of the contract and only 20 percent more could be realized each year through 1999. Somewhat more optimistically, however, CBO assumed that DoD would achieve 25 percent of its goal of reducing civilian inpatient and outpatient care by beneficiaries enrolled in Tricare Prime and participating in Tricare Extra. By fiscal year 1998, the fourth year of the program, 100 percent of the per capita savings from that strategy would be achieved. In addition, although a minor

consideration in comparing the differences in assumptions about phasing in savings, CBO assumed that savings from applying controls on utilization of care used by beneficiaries at the MTFs would apply only to those participating in Tricare Extra and using Tricare Standard, but not--as DoD did--to Tricare Prime enrollees, who presumably would already face stronger controls on the utilization of care provided under CHAMPUS.

Savings from Controls on Utilization at the MTFs Help Certify That the MCS Contract Including the Tricare Benefit Package is Cost-Effective. Adding this new component to the cost methodology makes a significant difference in the cost-effectiveness of the MCS contract that includes the Tricare benefit package. Without the savings in the direct care system from reducing utilization rates at the MTFs, the range of estimates around the costs is even more narrow than with these savings (see Table 2). With the savings from the military treatment facilities, CBO predicts that the range of estimates is from -3.6 percent to 2.5 percent, as compared with a range of -0.4 percent to 3.3 percent without those savings. In fact, if MTF commanders make extensive use of this opportunity to purchase services from the MCS contractor, the savings could be higher than even those in CBO's optimistic case.

Although DoD's analysis includes savings from utilization management at the MTFs, it is important to note that these savings could occur in the

absence of the MCS contract with the Tricare benefit package. But as the high rates of health care use in Region 6 might suggest, there is no guarantee that the same level of savings would occur in the absence of the MCS contractor. MCS contractors could very likely serve as the catalyst for applying controls on health care at the military hospitals. Indeed, the fact that these savings coincide with the introduction of the MCS contract and Tricare benefit brightens the picture and reduces the risk for the government.

Still, DoD expects to realize a substantial share of the savings from curbing excess use of outpatient care at the MTFs. At present, outpatient care is free at the MTFs. Curbing the use of outpatient care by beneficiaries at the MTFs through the use of gatekeepers may be possible, but it may prove to be very difficult for commanders--even in the event that utilization management services are purchased--without applying copayments at the military treatment facilities to deter beneficiaries from using them.

APPENDIX: DIFFERENCES BETWEEN THE ASSUMPTIONS USED BY DOD AND CBO FOR ESTIMATING THE EFFECTS ON COSTS OF THE MCS CONTRACT WITH THE TRICARE BENEFIT PACKAGE

In developing a set of assumptions for the base, optimistic, and pessimistic cases, the Congressional Budget Office considered market conditions specific to Lead Agent Region 6 (see Box A-1). In a few instances, this analysis caused CBO to modify the assumptions set forth by DoD in its three "matching" cases. For instance, many of the assumptions underlying DoD's base case reflect the experience of CRI in California and Hawaii, such as the assumptions of savings from managed care strategies. Several key differences, however, between Region 6 and California and Hawaii will almost certainly affect the potential for Region 6 to achieve savings comparable to those achieved in California and Hawaii.

These same market conditions were examined in CBO's paper "Evaluating the Costs of Expanding the CHAMPUS Reform Initiative Into Washington and Oregon" (November 1993) and were used to shape the set of assumptions finally incorporated in the base, optimistic, and pessimistic cases for Washington and Oregon. For purposes of simplification, these market conditions fall into two categories: those that would improve the chances of increased savings to the government, and those that would reduce the chances of savings and thereby increase costs.

BOX A-1.
EXPLANATION OF THE ASSUMPTIONS USED BY CBO

The various assumptions that the Congressional Budget Office (CBO) considered can be grouped into three cases: a base case, a more optimistic one, and a more pessimistic one. Appendix Tables A-1, A-2, and A-3 compare the assumptions used by CBO with those used by the Department of Defense (DoD) in its "matching" cases. All assumptions are for fiscal year 1999 only.

The first category of assumptions on each of the appendix tables shows the rates of enrollment in Tricare Prime and participation in Tricare Extra and Tricare Standard, measured as a percentage of the population that is eligible for the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and relies on the Military Health Services System (MHSS) in Region 6.

The second category shows those assumptions that underlie three factors that increase costs: induced demand, ghost participation, and administration and profit. Those military beneficiaries who do not rely on the military health care system are called "ghosts." To calculate induced demand, CBO used the demand-response results of the RAND Health Insurance Experiment (RHIE) for Tricare Prime enrollees and Tricare Extra participants under all three cases, but assumed an additional increase in demand above and beyond the RHIE of 5 percent in CHAMPUS visits for retirees and their dependents who were Tricare Prime enrollees in the base case, and 15 percent in the pessimistic case. To calculate the demand response of "ghosts" to lower out-of-pocket costs under Tricare Prime in relation to Tricare Standard, CBO used an elasticity of 0.1 in all three cases (except for using an elasticity of 0.15 to calculate the demand response of retirees and their dependents to lower out-of-pocket costs under the pessimistic case). That is, for each reduction of 10 percentage points in out-of-pocket costs, relative to Tricare Standard, 1 percent of the ghost population would enroll in Tricare Prime. For purposes of comparison with DoD figures, CBO shows the final factor--administration and profit--as a percentage of total CHAMPUS health care costs under the original Prime benefit offered in California and Hawaii.

The third category shows those assumptions that underlie five factors that decrease costs: negotiated discounts with providers, claims processing, utilization management programs for CHAMPUS, productivity improvements at the military treatment facilities (MTFs), and controls on utilization at the MTFs. To estimate the effects of savings from negotiating discounts with providers, CBO assumed that the same payment discount rates apply to both Tricare Prime and Tricare Extra for all inpatient and outpatient categories. Next, CBO shows a savings of 1 percent in CHAMPUS health care costs from better claims processing. CBO also assumed that the contractor would be able to achieve a higher level of per capita savings for Tricare Prime enrollees than for Extra participants from CHAMPUS utilization management programs. Other assumptions about the productivity and utilization management at the MTFs show the effects of the contract on the direct care system of the MHSS. The actual savings from the resource-sharing program and gatekeeper mechanism are both measured as a percentage of CHAMPUS health care costs. Finally, CBO shows the per capita savings rates from applying utilization management services to all beneficiaries using the MTFs, except for Tricare Prime enrollees.

For more details about these factors and their underlying assumptions, see Appendixes A and B of the CBO paper "Evaluating the Costs of Expanding the CHAMPUS Reform Initiative Into Washington and Oregon" (November 1993).

Unfavorable Conditions: Managed Care Market Less Mature in Region 6

The most important factor of all is the maturity of the civilian managed care market in which the program will be applied. A market that is not mature may be less receptive to negotiating the discounts that DoD envisions and less sophisticated in managing the use of care by beneficiaries. Additionally, a less mature market may have higher administrative costs or lower savings from competition.

The managed care market in Region 6 is very different from that in California and Hawaii. By contrast with Region 6, California is one of the nation's leaders in the development of managed care. In 1992, 34.4 percent of California's total population was enrolled in health maintenance organizations, compared with only 11.5 percent in Texas and 2.5 percent in Arkansas. Another significant difference is California's leadership in enrolling Medicaid recipients in HMOs; by contrast, none of the HMOs in any of the states in Region 6 has been willing to enroll Medicaid recipients. Differences like these suggest that DoD may be limited in its ability to achieve savings by negotiating discounts with health care providers and introducing utilization management programs.

Favorable Conditions: High Levels of Mental Health Spending and Use

Region 6 is characterized by high levels of spending on mental health, and equally important, high rates of health care utilization. Reducing inpatient use of mental health services and negotiating discounts with mental health providers played a significant part in achieving savings for CRI in California and Hawaii, where spending on mental health constitutes almost 20 percent of spending on inpatient care provided under the Civilian Health and Medical Program of the Uniformed Services. The opportunity for savings may be as good or better in Region 6, where spending on inpatient mental health provided under CHAMPUS constitutes nearly 33 percent of all inpatient spending. The impetus for providers to negotiate these discounts with DoD may even be slightly enhanced by the slightly lower occupancy rates for psychiatric hospitals in the civilian sector in Region 6 compared with those in California. For instance, the occupancy rate in psychiatric hospitals in 1991 in Texas was 66.1 percent, as compared with 72.4 percent in California.

In addition, the extraordinarily high use of health care in Region 6 offers the possibility of higher savings from utilization management. Utilization management programs are designed to achieve savings primarily by reducing unnecessary or inappropriate admissions and lengths of stay. As the managed care literature suggests, the higher the patterns of utilization, the greater the

potential for savings, providing solid justification for adopting the more optimistic assumptions that underlie both DoD's base and lower-cost cases.

TABLE A-1. BASE-CASE ASSUMPTIONS USED IN ESTIMATING THE CHANGE IN MILITARY HEALTH SERVICES SYSTEM COSTS FROM EXTENDING THE MANAGED CARE SUPPORT CONTRACT INCLUDING THE TRICARE BENEFIT INTO REGION 6 (In percent)

	Congressional Budget Office	Department of Defense
Enrollment and Participation Under the Tricare Benefit Package		
Tricare Prime		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	33	29
Pay grades E-5 and above	21	21
Retirees	23	23
Tricare Extra		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	37	41
Pay grades E-5 and above	49	49
Retirees	47	47
Tricare Standard		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	30	30
Pay grades E-5 and above	30	30
Retirees	30	30
Factors Increasing Costs		
Induced Demand	RHIE + 5	RHIE + 3
Ghost Elasticity	10	10
Administration and Profit	17	15

(Continued)

TABLE A-1. CONTINUED

	Congressional Budget Office	Department of Defense
Factors Decreasing Costs		
Discounts		
Inpatient psychiatric	25	30
Inpatient nonpsychiatric	1	1
Outpatient psychiatric	10	10
Outpatient nonpsychiatric	2	2
Claims Management	1	1
CHAMPUS Utilization Management for Tricare Prime		
Inpatient psychiatric	40	40
Inpatient nonpsychiatric	10	10
Outpatient psychiatric	0	5
Outpatient nonpsychiatric	0	5
CHAMPUS Utilization Management for Tricare Extra		
Inpatient psychiatric	32	32
Inpatient nonpsychiatric	8	8
Outpatient psychiatric	5	5
Outpatient nonpsychiatric	5	5
MTF Productivity		
Resource sharing	5	5
Gatekeeper	1.5	1
MTF Utilization Management		
Inpatient	20	20
Outpatient	10	10

SOURCE: Congressional Budget Office based on assumptions made by Lewin-VHI, Inc., contained in the certification report submitted by the Department of Defense to the Congress.

NOTES: All assumptions are for fiscal year 1999. RHIE = RAND Health Insurance Experiment; CHAMPUS = Civilian Health and Medical Program of the Uniformed Services; MTF = military treatment facility.

TABLE A-2. LOWER-COST ASSUMPTIONS USED IN ESTIMATING THE CHANGE IN MILITARY HEALTH SERVICES SYSTEM COSTS FROM EXTENDING THE MANAGED CARE SUPPORT CONTRACT INCLUDING THE TRICARE BENEFIT INTO REGION 6 (In percent)

	Congressional Budget Office	Department of Defense
Enrollment and Participation Under the Tricare Benefit Package		
Tricare Prime		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	27	24
Pay grades E-5 and above	17	17
Retirees	19	19
Tricare Extra		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	43	46
Pay grades E-5 and above	53	53
Retirees	51	51
Tricare Standard		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	30	30
Pay grades E-5 and above	30	30
Retirees	30	30
Factors Increasing Costs		
Induced Demand	RHIE	RHIE
Ghost Elasticity	10	10
Administration and Profit	15	13

(Continued)

TABLE A-2. CONTINUED

	Congressional Budget Office	Department of Defense
Factors Decreasing Costs		
Discounts		
Inpatient psychiatric	30	36
Inpatient nonpsychiatric	1.2	1.2
Outpatient psychiatric	12	12
Outpatient nonpsychiatric	2.4	2.4
Claims Management	1	2
CHAMPUS Utilization Management for Tricare Prime		
Inpatient psychiatric	48	48
Inpatient nonpsychiatric	12	12
Outpatient psychiatric	0	6
Outpatient nonpsychiatric	0	6
CHAMPUS Utilization Management for Tricare Extra		
Inpatient psychiatric	38.4	38.4
Inpatient nonpsychiatric	10	9.6
Outpatient psychiatric	5	6
Outpatient nonpsychiatric	5	6
MTF Productivity		
Resource sharing	6.5	6.6
Gatekeeper	2.4	2.0
MTF Utilization Management		
Inpatient	30	30
Outpatient	15	15

SOURCE: Congressional Budget Office based on assumptions made by Lewin-VHI, Inc., contained in the certification report submitted by the Department of Defense to the Congress.

NOTES: All assumptions are for fiscal year 1999. RHIE = RAND Health Insurance Experiment; CHAMPUS = Civilian Health and Medical Program of the Uniformed Services; MTF = military treatment facility.

TABLE A-3. HIGHER-COST ASSUMPTIONS USED IN ESTIMATING THE CHANGE IN MILITARY HEALTH SERVICES SYSTEM COSTS FROM EXTENDING THE MANAGED CARE SUPPORT CONTRACT INCLUDING THE TRICARE BENEFIT INTO REGION 6 (In percent)

	Congressional Budget Office	Department of Defense
Enrollment and Participation Under the Tricare Benefit Package		
Tricare Prime		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	35	34
Pay grades E-5 and above	22	25
Retirees	24	28
Tricare Extra		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	35	36
Pay grades E-5 and above	48	45
Retirees	46	42
Tricare Standard		
Dependents of active-duty personnel		
Pay grades E-1 through E-4	30	30
Pay grades E-5 and above	30	30
Retirees	30	30
Factors Increasing Costs		
Induced Demand	RHIE + 15	RHIE + 5
Ghost Elasticity	10	10
Administration and Profit	19	17

(Continued)

TABLE A-3. CONTINUED

	Congressional Budget Office	Department of Defense
Factors Decreasing Costs		
Discounts		
Inpatient psychiatric	20	24
Inpatient nonpsychiatric	0.8	0.8
Outpatient psychiatric	8	8
Outpatient nonpsychiatric	1.6	1.6
Claims Management	1	1
CHAMPUS Utilization Management for Tricare Prime		
Inpatient psychiatric	32	32
Inpatient nonpsychiatric	8	8
Outpatient psychiatric	0	4
Outpatient nonpsychiatric	0	4
CHAMPUS Utilization Managment for Tricare Extra		
Inpatient psychiatric	25.6	25.6
Inpatient nonpsychiatric	6.0	6.4
Outpatient psychiatric	0	4
Outpatient nonpsychiatric	0	4
MTF Productivity		
Resource sharing	2.5	2.5
Gatekeeper	0.7	0
MTF Utilization Management Savings		
Inpatient	10	10
Outpatient	5	5

SOURCE: Congressional Budget Office based on assumptions made by Lewin-VHI, Inc., contained in the certification report submitted by the Department of Defense to the Congress.

NOTES: All assumptions are for fiscal year 1999. RHIE = RAND Health Insurance Experiment; CHAMPUS = Civilian Health and Medical Program of the Uniformed Services; MTF = military treatment facility.