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MILITARY RETIREES' HEALTH CARE

Costs and Other Implications of Options to Enhance Older Retirees' Benefits

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The Honorable Steve Buyer
Chairman
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Ranking Minority Member
Subcommittee on Military Personnel
Committee on National Security
House of Representatives

Today, 4.3 million military retirees,[1] their dependents, and survivors are eligible for care under the Department of Defense's (DOD) health care system. But this system has changed significantly in the last decade. As a result of these changes, which include the establishment of a nationwide managed care program called TRICARE and the closing or downsizing of many medical facilities, many military retirees, especially those aged 65 and older, fear they will lose the access they now have to care in military medical facilities.

In recent testimony before your Subcommittee,[2] we reported that military facilities and resources available to care for older retirees will decrease and eventually disappear in many locations as enrollment in TRICARE increases, leaving many retirees without DOD-sponsored health care. Because of your concern about this issue, we agreed with your office to describe various proposals that have been made to enhance older retirees' DOD health care benefits, as well as to provide cost estimates, where possible, for implementing the options, based on specific variables and assumptions. The options, each of which would require legislative action to implement, include (1) enrolling Medicare-eligible[3] retirees in TRICARE Prime, TRICARE's health maintenance organization (HMO), and paying for their care with Medicare funds (referred to as "Medicare subvention"); (2) using DOD funds to pay retirees' Medicare part B premiums and to furnish Medigap policies; (3) providing the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)[4] as a Medicare supplement;

[1]For the remainder of this report, the term "retirees" refers to retirees and their dependents and survivors. Further, the term "older retirees" refers to retirees who are aged 65 or older.

[2]Defense Health Care: Limits to Older Retirees' Access to Care and Proposals for Change (GAO/T-HEHS-97-84, Feb. 27, 1997).

[3]Medicare is a national health insurance program for people 65 years of age and older, certain younger disabled people, and people with kidney failure.

[4]CHAMPUS is an insurance-like program administered by DOD that pays for a portion of the care military families and retirees under age 65 receive from private sector health care providers.

(4) extending the Federal Employees Health Benefits Program (FEHBP) to retirees as a Medicare supplement and using DOD funds to pay part of the premium; and (5) expanding DOD's current mail-order prescription program to Medicare-eligibles who do not live near military medical facilities. This report also discusses the uncertainties about and limitations of these options, including their potential effects on cost and administrative requirements as well as considerations surrounding the military medical system's size and mission.

To do our work, we examined legislative proposals and available studies relating to each option; analyzed DOD data; and interviewed DOD health experts and officials from DOD, the Office of Personnel Management (OPM), the Congressional Budget Office (CBO), the Congressional Research Service (CRS), and military beneficiary associations. A more detailed discussion of our scope and methodology and cost estimates for the options examined appear in appendix I.[5]

Results in Brief

Our analyses of the various proposals to improve DOD-sponsored health care benefits for older retirees and their dependents indicate that the proposals vary in their potential costs; coverage; and other effects on DOD, eligible beneficiaries, and Medicare (see table 1). For example, Medicare subvention, under which DOD would receive payment from Medicare for treating Medicare-eligible retirees in TRICARE Prime, seeks to ensure that neither DOD nor the Health Care Financing Administration (HCFA)[6] would incur added costs by enrolling retirees. However, DOD lacks the cost and care use data needed to estimate its current spending level for Medicare-eligible retirees—the level that would be DOD's spending limit under this proposal and that, once reached, would trigger HCFA's payments to begin. Moreover, it is uncertain whether HCFA's subvention payment rates, which would be lower than those it pays to Medicare HMOs, would equal DOD's actual care costs. Finally, relatively few retirees (about 75,000) could be accommodated by subvention at military medical facilities because of facility capacity and financial constraints.

[5]We did not attempt to estimate the cost of implementing the Medicare subvention option, for the reasons given in app. I.

[6]HCFA is the agency in the Department of Health and Human Services responsible for administering the Medicare program.

Table 1: Comparison of Proposed Military Retiree Health Care Options

Option	Benefit description	Estimated annual cost to DOD	Estimated cost to beneficiary
Medicare subvention	Using Medicare funds, this option guarantees inpatient and outpatient care and prescriptions at military medical facilities or through the TRICARE network. We estimated subvention at military facilities would accommodate about 75,000 participants.	The goal is to be budget neutral, but uncertainties remain regarding (1) DOD's actual costs for providing full care for all enrollees and the resulting difficulty in setting DOD's baseline spending level and (2) whether HCFA's payment levels would be appropriately set to ensure cost-neutrality.	Medicare part B is required, costing $526/year for each covered beneficiary. The beneficiary pays TRICARE Prime copayments when care is received outside DOD facilities: $12 per outpatient visit; $11 per day, minimum $25 per inpatient admission; and $9 per prescription.
Medicare part B and Medigap policy	DOD pays for Medicare part B premium and a Medigap policy to supplement Medicare for inpatient and outpatient care and prescription drugs. Offered to all Medicare-eligible retirees.	$2.2 billion per year ($629 million for part B premiums and $1.6 billion for Medigap policies); $1,833 per participant ($526 for part B premium and $1,307 for Medigap policy).	Participant pays no copayments for Medicare-covered inpatient and outpatient care but does pay a 50-percent prescription copayment, with annual dollar limits.
CHAMPUS as a Medicare supplement	DOD extends CHAMPUS to supplement Medicare for inpatient and outpatient care and prescription drugs. Offered to all Medicare-eligible retirees.	$1.8 billion per year; $1,520 per participant.	Medicare part B is required, costing $526/year for each covered beneficiary. CHAMPUS covers most out-of-pocket costs; under the standard CHAMPUS program, there is a 25-percent copayment for prescriptions.
FEHBP as a Medicare supplement	DOD pays part of the premium for the participants' choice of FEHBP plans, which typically cover Medicare deductibles and coinsurance, prescription drugs, and some dental care. Offered to all Medicare-eligible retirees, but we assumed 83-percent participation.	$1.6 billion per year; $1,571 per participant.	The participant pays about 29 percent of the plan premium—single annuitant average is about $680—just as a federal employee does. Copayments and deductibles vary but are close to $0 if the participant also has optional Medicare part B.
Mail-order pharmacy plan	DOD provides mail-order plan for prescription drugs, primarily for recurring medications, to all Medicare-eligible beneficiaries not living near a military pharmacy and not having mail-order service under a base closure plan (about 408,000 retirees).	$229 million per year; $561 per participant.	$8 per 90-day prescription.

The three proposals to have DOD fund Medicare supplemental coverage would cover all older retirees, and estimated additional DOD costs would range from $1.6 billion to $2.2 billion per year, in 1996 dollars, after they were fully implemented. Costs would be likely to rise over time as health care costs rose and greater numbers of Medicare-eligible retirees became

eligible for the programs. Specifically, the proposal to have DOD fund retirees' Medicare part B premiums and a private Medigap policy, including prescription coverage, would cost an estimated $2.2 billion per year. A second alternative—extending CHAMPUS coverage to older retirees as a Medicare supplement—could cost as much as $1.8 billion per year. The third option—offering older military retirees a Medicare supplement through enrollment in FEHBP—is attractive for its broad coverage and cost-sharing provisions, but it could cost as much as $1.6 billion per year. Moreover, all three of these options could inadvertently create a disparity in retirees' health care benefits by, in effect, providing older retirees with more comprehensive benefits than younger retirees. Further, while these options would provide retirees with enhanced benefits, none would increase retirees' access to care in military medical facilities.

Finally, the mail-order pharmacy option would address a significant gap in older retirees' health coverage—Medicare's lack of outpatient prescription drug coverage. This proposal is unlike the others, which involve many uncertainties or high potential costs. Under this proposal, for an estimated cost of $229 million per year, DOD could extend the current mail-order pharmacy program in base closure areas to Medicare-eligible retirees who live far from military facility pharmacies. This option would reduce prescription expenses for retirees living far from military pharmacies who have limited or no prescription coverage. And, because the approach could be implemented fairly easily as an extension of the current program, it would offer some relief to beneficiaries without major system changes.

Background

Today's DOD health care system provides coverage for about 8.2 million people, of whom over half are retirees and their dependents and survivors. (App. II includes more detailed information on military retirees, including population size and growth projections, demographics, use of DOD health care, and extent of other insurance coverage.) Under the terms of the 1956 Dependents' Medical Care Act, DOD has authority to provide retirees of any age health care in its medical facilities as long as space and resources are available. Retirees receive this care, referred to as "space-available" care, at little or no cost. The statute, however, does not entitle retirees to care in military facilities.

When DOD was given the authority to provide care to military retirees, retirees made up only 8 percent of the population eligible for military health care. At that time, the military health care system was sized for a large active-duty force, with enough capacity that retirees were almost

assured health care in military facilities on a space-available basis. Since then, however, downsizing of the military medical system, coupled with increases in the size of the retiree population, have contributed to a reduction in the availability of care for retirees in DOD facilities.

The introduction of TRICARE has also affected the amount of space-available care in medical facilities. The legislation authorizing TRICARE gives beneficiaries who enroll in its HMO benefit program called TRICARE Prime priority for care in military medical facilities. However, because retirees aged 65 and older are ineligible for TRICARE Prime, they can obtain care in military facilities only if space and resources remain after care is provided to enrolled beneficiaries. As TRICARE enrollment increases, the amount of space-available care will decline.

When space and resources are not available in DOD facilities, retirees not enrolled in TRICARE Prime must seek care from other providers. DOD pays most of the cost of the care of those under age 65 who receive care from private health care providers through CHAMPUS. CHAMPUS was established in part so that military members, once retired, could have health care coverage until eligible at age 65 for Medicare. Retirees lose their CHAMPUS coverage at age 65, and, when space and resources are not available within DOD facilities, these older retirees must depend on non-DOD sources, such as Medicare, Department of Veterans' Affairs facilities, and other government-sponsored or private health insurance, for their health care.

As we reported in our February 1997 testimony, using a blend of military facilities and other sources has created a patchwork system that Medicare-eligible retirees must learn to navigate to receive care. Space-available care is episodic and lacks the regularity and continuity that are often important to older retirees, who have more frequent and chronic medical problems than younger ones. And, although retirees may also access care through Medicare and private supplemental health insurance, many retirees experience coverage gaps and high out-of-pocket costs. Even older military retirees with more generous coverage through private or other government employer-sponsored insurance that acts as a Medicare supplement could experience relatively high costs depending on the extent to which their former employers share the costs. To address these availability, cost, and coverage issues, DOD and members of the Congress have developed several proposals with various health care program options for Medicare-eligible retirees.

Despite Cost-Neutral Intent, Medicare Subvention Poses Financial Risk to the Government

Under Medicare subvention, DOD's HMO option—TRICARE Prime—would be opened to Medicare-eligible retirees and would operate essentially as a Medicare HMO—that is, as HMOs that are currently operated by private companies under contract with HCFA and available to many of DOD's older retirees. DOD's subvention plan attempts to ensure cost-neutrality for both DOD and HCFA in two ways. First, it would require DOD to maintain its current spending, or "level of effort," on Medicare-eligible retirees treated in military medical facilities. Second, the plan would require that HCFA's payment rate be set lower than the per-person rate HCFA currently pays to private Medicare HMOs. If DOD's level of effort was accurately determined and the Medicare payment rate was appropriately set, neither DOD or HCFA would experience increased costs. However, DOD's lack of information with which to accurately determine its current level of effort raises questions about whether the program would actually be cost neutral. Furthermore, DOD's capacity and financing constraints could significantly limit the number of older retirees who would benefit from this program.

Accurately Determining DOD's Level-of-Effort Baseline Would Be Difficult

DOD's role in attaining cost-neutrality under the subvention plan would be to maintain its historic level of spending, or "level of effort," for care it provided to Medicare-eligible retirees. According to the proposal, once the level of effort in dollar terms was determined, it would be divided into two portions: one that would continue to fund space-available care for older retirees and one devoted to fund care for beneficiaries who enrolled in TRICARE Prime through subvention.[7] The dollars allocated for TRICARE enrollees' care would then be divided by HCFA's per-person payment, yielding the number of subvention enrollees that DOD remained responsible for funding. Once DOD's subvention enrollees reached that number, DOD would receive monthly per-enrollee payments from HCFA for each enrollee over the target. At the end of each year, a level-of-effort spending reconciliation would be conducted. If DOD had not spent all of its level-of-effort dollars, even if it had enrolled more than the target number of beneficiaries, it would have to reimburse HCFA for payments it made up to DOD's level-of-effort threshold.

After its review of Medicare subvention legislation, CBO reported that the program's potential cost-neutrality critically hinges on how accurately DOD would be able to establish its level-of-effort baseline spending on

[7]Under proposed legislation for a test of the subvention program, the proportions for space-available care and enrolled care would be 70 percent/30 percent in the first year of subvention, 60 percent/40 percent in the second year, and 50 percent/50 percent in the third year.

Medicare-eligibles.[8] The risk of establishing an inaccurate level-of-effort baseline would be great because of the limitations of DOD's cost and utilization data. DOD's current systems capture information on the types and costs of medical services provided by individual facilities but cannot attribute those facility costs to specific patients or groups of patients. If the current spending was overestimated, the level-of-effort baseline would be set too high, putting DOD at risk of guaranteeing care to enrolled retirees without having adequate funding to provide it. If DOD underestimated its current spending, the level-of-effort baseline would be set too low, and HCFA would pay for services that DOD now pays for. This would exacerbate the problems of the Medicare Hospital Insurance trust fund, which is expected to be depleted in 2001.

Even if the baseline was accurately set, DOD's historic level of spending might not reflect the actual costs of guaranteeing comprehensive health care coverage to retirees enrolled under subvention. That is, the level of effort reflects the past spending on space-available care for Medicare-eligible beneficiaries. If the costs to provide the full range of Medicare-covered services to the targeted number of enrollees were greater than the spending level established by the baseline, DOD would have to find funds to provide enrollees' care, possibly by taking funds from other DOD health programs, by reducing space-available care for nonenrollees, or by asking for supplemental appropriations.

Medicare Payment Level Is Critical to Proposal's Cost-Neutrality

HCFA's role in attaining cost-neutrality under this proposal would be to provide per-person payments for additional enrollees. These payments, which would be intended to reimburse DOD for the cost of the care provided to Medicare-eligible enrollees above the level of effort, are critical to the cost-neutrality of this proposal. HCFA currently pays Medicare HMOs a flat fee for each enrolled beneficiary that is equal to 95 percent of Medicare's estimated average cost of treating a similar beneficiary in the fee-for-service sector. Under this proposal, DOD has agreed to accept a payment rate from HCFA that would be at least 2 percentage points lower than the rate HCFA pays to private Medicare HMOs.[9] After the first year, HCFA's payment rate would be further reduced by excluding allocations for graduate medical education, indigent care, and capital costs—costs that DOD does not incur or for which it is separately funded. DOD has estimated that, because of these adjustments,

[8]CBO, memorandum for the record, Feb. 21, 1996, and cost estimate on H.R. 3142, Sept. 17, 1996.

[9]Current proposals for Medicare subvention contain payment rates ranging from 90.25 percent to 93 percent.

the resulting payment rate could be 7 to 13 percent less than the rates HCFA pays private Medicare HMOs.

It is uncertain whether the proposed payment rates would be appropriate to ensure that neither DOD nor HCFA incurred costs greater than it would otherwise have incurred to care for this population. For example, DOD could incur additional costs if the payment rate was lower than the actual cost of providing the full range of care that Medicare subvention promises to the newly enrolled beneficiaries, both at military facilities and through civilian providers. DOD believes that it can provide care to older retirees in military medical facilities at a lower cost than Medicare HMOs can. This contention is based on the "733 study," which compared the cost of providing care to DOD beneficiaries in military medical facilities with the cost of providing care in the civilian sector.[10] The study compared military medical facilities only with the CHAMPUS fee-for-service program, however, and not with Medicare fee-for-service or HMO providers. Moreover, the study developed average costs of care as they pertain to the overall military community, not to older retirees as a separate population. Therefore, the cost advantage attributed to military medical facilities by the 733 study may not accurately reflect DOD's costs in comparison with private sector HMOs or be generalizable to older retirees treated in DOD facilities.[11]

Even if DOD did not incur additional costs in delivering medical facility care, it could incur additional costs if the cost of using civilian providers was higher than the payment rate. Although DOD's intention under Medicare subvention is to enroll older retirees and provide most of their care in military medical facilities, not all facilities have the resources to provide the full range of enrollees' care. To meet its obligation, therefore, DOD would supplement facility care with care purchased from private providers. To ensure that it did not incur additional costs, DOD would need to purchase this care at rates commensurate with the rates HCFA would pay DOD. It is uncertain whether DOD could find providers who would accept these lower rates. If DOD could not find providers who would accept the lower rates, it would either incur additional costs by buying those services guaranteed under subvention at the higher rates or be unable to offer subvention at some facilities.

[10]Office of Program Analysis and Evaluation, "The Economics of Sizing the Military Medical Establishment," Executive Report of the Comprehensive Study of the Military Medical Care System (Washington, D.C.: DOD, Apr. 1994).

[11]DOD officials told us that they are in the process of developing patient-level accounting systems that may provide better information on the cost of providing care to specific groups of patients, such as older retirees.

On the other hand, because many enrollees in a Medicare subvention program would presumably be diverted from civilian fee-for-service Medicare providers, HCFA could incur additional costs if its payments to DOD were higher than what HCFA would have paid under standard fee-for-service Medicare. In April 1997, we reported that HCFA's method for establishing HMO payment rates overstates the average cost of all Medicare beneficiaries and leads to excess payments because it does not fully correct for HMOs enrolling a less costly—more favorable—selection of beneficiaries.[12] Thus, it would remain to be seen whether the proposed payment rates for DOD would result in excess payments.

Comparatively Few Retirees Would Benefit From Subvention

Under DOD's current proposal, subvention would only be offered to Medicare-eligible beneficiaries who live near military medical facilities.[13] Moreover, for the reasons described above, subvention would be less financially feasible for facilities that had to purchase significant amounts of care from private providers. DOD officials told us that each medical facility would have to carry out a financial analysis before starting a subvention program to determine the amount and cost of care it would have to purchase. They told us that, from a financial perspective, many smaller facilities would not be able to afford to offer enrollment under subvention. It appears, then, that a smaller number of retirees than is now being served—approximately 300,000—would be likely to benefit from subvention. In its plan for a test of the subvention program at seven facilities, the number of enrollees that DOD estimated it could accommodate equated to about 20 percent of the Medicare-eligible beneficiaries in those areas, and DOD expected that a similar proportion could be accommodated under a nationwide implementation. On the basis of the numbers of retirees living near military facilities with sufficient capacity to operate a subvention program, we estimated that about 75,000 older retirees could participate nationwide if the subvention program was offered at all but DOD's smallest hospitals.[14]

[12]Medicare HMOs: HCFA Can Promptly Eliminate Hundreds of Millions in Excess Payments (GAO/HEHS-97-16, Apr. 25, 1997).

[13]According to DOD officials, over the longer term DOD would seek to offer subvention outside of military medical facilities using civilian providers, if the program proved feasible once tested.

[14]We defined "smallest hospitals" as those with fewer than 50 beds. According to DOD population data for 1996, 381,788 Medicare-eligible retirees lived within the DOD-designated 40-mile catchment area of a military hospital with 50 beds or more. DOD defines "catchment area" as the area within a 40-mile radius surrounding a military medical facility. In addition, we removed from consideration any facilities that were currently in operation but scheduled to close because of base closure actions.

Uncertainties about DOD's ability to establish a reliable level-of-effort baseline and otherwise estimate its costs under subvention point up the need for DOD to test this concept before nationwide implementation. DOD agrees and has already begun exploring within its system the possible financial and capacity limitations to subvention and planning for the administrative and reimbursement mechanisms needed to test the concept in limited areas.

Supplemental Insurance Would Fill Medicare Gaps but Be Expensive

Another option to improve older retirees' DOD-sponsored health benefits is for DOD to offer increased insurance coverage beyond that provided through the Medicare program, given the likelihood that many older retirees will be unable to access care from military facilities. As suggested in three proposals, if DOD funded the cost of supplemental insurance provided by private insurers, CHAMPUS, or FEHBP, many of the gaps in Medicare coverage could be filled, and some retirees could experience lower out-of-pocket costs. However, DOD's costs to provide this additional coverage could be substantial, from $1.6 billion to $2.2 billion per year, depending on the type of supplemental insurance plan offered. Moreover, the costs of these programs would probably rise with health care costs and as greater numbers of retirees reached age 65 and became eligible for the benefits. Providing this type of supplemental coverage would require some changes in the current administrative systems, but the administrative costs should be relatively minor for the CHAMPUS and FEHBP options, with somewhat higher administrative costs associated with the private supplemental insurance option.

Paying for Medicare Part B Premiums and Private Medigap Policies

Upon reaching age 65, retirees' eligibility for CHAMPUS ends, and Medicare becomes the primary insurer. Under Medicare part A, which is paid for through employer/employee payroll taxes, retirees receive coverage for inpatient hospital, skilled nursing facility, home health, and hospice care. Most retirees also purchase Medicare part B (which costs $525.60 per person in 1997) to receive coverage for services including physician visits, outpatient care, laboratory tests, and medical equipment needed in the home. However, requirements for copayments and deductibles and limitations in the Medicare benefit, such as no coverage for outpatient prescriptions and no cap on out-of-pocket costs, have led many retirees to purchase additional insurance policies—"Medigap" policies—specifically to fill the gaps in coverage. According to a 1995 survey of military beneficiaries, about 31 percent of those aged 65 and older reported having this supplemental insurance.

The cost of these supplemental policies can be significant to the retiree. The annual premiums of plans that include coverage for prescription drugs can range from $750 to almost $3,000, with the more expensive plans generally providing the greatest coverage and filling in more of the gaps in Medicare coverage. We calculated the 1996 average annual premium for a Medigap policy that included coverage for outpatient prescriptions to be approximately $1,307.[15]

Assuming financial responsibility for part B premiums as well as paying for Medigap policies for all Medicare-eligible retirees would cost DOD an estimated $2.2 billion, or about $1,833 per participant. This cost estimate is based on coverage under a Medigap policy that includes a prescription benefit.

The cost for this option could be even higher if DOD also paid the premium penalty assessed for late enrollment in Medicare part B. Retirees who do not enroll in Medicare part B during their initial enrollment period[16] are subject to a 10-percent surcharge on their monthly premiums for each year between the one in which they turned age 65 and the one in which they enrolled. Paying these additional surcharges could be a significant cost to DOD. In a report on a 1995 study related to base closure activities,[17] DOD estimated that the 11,000 Medicare-eligible beneficiaries living near military medical facilities who did not enroll in Medicare part B during their initial enrollment period would be subject to $10 million in surcharges over a 5-year period. According to a recent DOD survey of beneficiaries, about 10 percent of retirees aged 65 and older, or approximately 120,000, did not have Medicare part B.

To offer Medigap policies, DOD would need to establish some new administrative structures. Because Medigap policies' premiums and insurers vary across the states, DOD would need to establish a mechanism for coordinating and managing the program, such as OPM has for administering FEHBP. The cost to create this mechanism is unknown but could be considerable. An alternative would be to solicit bids on and

[15]We based our calculation on the premiums of plans offered through Blue Cross/Blue Shield and Prudential in most states, as presented in a study by the Families USA Foundation, a health care advocacy group, and weighted those premiums to reflect differences in plan costs by age relative to the age distribution of DOD retirees.

[16]The initial enrollment period is generally a 7-month period that begins 3 months before the retiree turns age 65.

[17]Office of the Assistant Secretary for Health Affairs, DOD, "Possible Financial Relief From Medicare Part B Late Enrollment Surcharges for Medicare-eligible Military Retirees Who Have Been Adversely Affected by a BRAC," Report to Congress (Washington, D.C.: DOD, 1996).

award a national contract for a Medigap policy, although this would not be without cost.

Extending CHAMPUS as a Medicare Supplemental Policy

Another option to increase insurance coverage of military retirees is to extend their coverage under the CHAMPUS program beyond age 64. Under this extension, the CHAMPUS benefit would serve as a supplemental policy to Medicare, covering most out-of-pocket costs as well as medical services included in CHAMPUS but not covered by Medicare, such as prescriptions. The extension of CHAMPUS would provide retirees continued coverage under a plan familiar to many of them. Additionally, even though current legislative proposals would require retirees to enroll in Medicare part B, retirees could experience lower out-of-pocket costs.

Providing CHAMPUS as a supplemental policy to all Medicare-eligible beneficiaries could cost DOD as much as $1.8 billion, or about $1,520 per participant. This estimate is based on the assumption that CHAMPUS would pay the costs remaining after Medicare paid its allowable amount for covered services and that CHAMPUS would pay for the services not covered by Medicare. As a result, retirees would generally have no out-of-pocket costs for Medicare-covered services. For example, if the cost of a medical procedure was $100 and the maximum amount allowed by Medicare and CHAMPUS was $100, Medicare would first pay its customary 80 percent of the allowable ($80) and CHAMPUS would pay the difference, up to its customary 75 percent of the allowable. In this example, the retiree would have no out-of-pocket costs. For those services covered by CHAMPUS but not by Medicare, such as prescription drugs, retirees would pay the customary CHAMPUS copayment of 25 percent.

Because CHAMPUS is an established program within DOD, the existing administrative structure could be used after modifications were made to various information and claims processing systems. According to DOD, these modifications would not significantly increase the costs of the program but could take between 6 and 12 months to implement.

Offering Enrollment in FEHBP to Older Retirees

Another option is to offer military retirees enrollment in FEHBP, the nationwide health care plan administered by OPM that is available to federal civil servants during employment and, as a supplement to Medicare, after retirement. Through FEHBP, military retirees could choose from at least a dozen plan options including fee-for-service plans such as Blue Cross/Blue Shield and the Government Employees Hospital

Association, regional HMOs, and point-of-service plans.[18] As with active and retired federal employees, military retirees who enrolled would be required to pay a premium. The amount of the premium would vary depending on which plan was chosen and the government and beneficiary share in the cost of the selected plan. In 1996, for example, the government paid, on average, 71 percent of the premium for non-Postal Service federal employees and retirees, and beneficiaries were responsible for the remaining 29 percent.

Offering Medicare-eligible retirees the opportunity to participate in FEHBP could provide additional coverage for services not covered under Medicare. For example, many of the plans provide coverage for prescriptions and have catastrophic limits on out-of-pocket costs, and some offer dental benefits, none of which is covered by Medicare. Additionally, even with the same cost-sharing provision as federal employees have, under FEHBP, retirees could pay a lower premium for increased coverage than they would under private Medigap policies, depending on the plan chosen. For example, in 1997 an enrollee's share of premiums for the five largest plans in FEHBP with comprehensive coverage, including prescription and dental coverage, ranges from about $370 to $1,750, compared with Medigap plans, which have premiums ranging from $750 to almost $3,000 but offer no dental benefits and have limits on prescription coverage.

Providing this additional coverage to Medicare-eligible retirees, however, could cost DOD as much as $1.6 billion, or about $1,571 per beneficiary. This estimate is based on our assumption that 83 percent of DOD's Medicare-eligible population would enroll in FEHBP.[19] Because the remaining 17 percent would have insurance paid in full or in part by their former employers, and most employer-sponsored plans require lower out-of-pocket costs than FEHBP, we assumed that very few of these retirees would opt for FEHBP coverage.

Premium amounts, and thus the government and beneficiary costs, are determined by such characteristics of the covered beneficiary population as gender mix, health status, and health care utilization. According to OPM, however, this information has not been developed for the military retiree population. Therefore, the legislative proposals for this option require that

[18]Point-of-service plans are HMOs that permit enrollees to use non-HMO providers if they pay higher copayments.

[19]This is based on our analysis of the 1994-95 Health Care Survey of DOD Beneficiaries, which indicates that 17 percent of military retirees have private health insurance for which the premiums are paid either in full or in part by their former employer.

the premiums for DOD retirees be determined separately from the premiums for the retired federal employee population covered through FEHBP. As a result, the cost for this option could be affected by the extent to which certain characteristics of the military retiree population are similar to or different from those of retired federal employees. If military retirees and other FEHBP participants, on average, used the same types and amounts of health care, then their premiums would be similar.[20]

Offering Medicare-eligible retirees enrollment in FEHBP would impose new administrative responsibilities and related costs on DOD and OPM, such as managing enrollments, withholding premiums from annuities, and preparing and distributing plan materials. Although the administrative costs associated with this option have not been determined, they should not be substantial, according to DOD and OPM.

Another consideration related to the supplemental coverage approach used in all these proposals is whether DOD would be creating a disparity between the benefits offered to its Medicare-eligible retirees and those offered to its other beneficiaries. For example, organizations representing military beneficiaries have reported that many retirees under the age of 65 would prefer FEHBP coverage to CHAMPUS because under FEHBP, for example, they would not have to pay for additional supplemental insurance, as some do under CHAMPUS. To the extent that DOD funds supplemental coverage for older retirees, younger retirees could view this as an inequity in benefits.

Mail-Order Pharmacy Benefit Would Fill a Major Coverage Gap

The Medicare program does not provide coverage for outpatient prescriptions, a major expense for older people, who tend to use more prescription drugs as they age. Military retirees can get prescriptions filled at military treatment facility pharmacies for free, but these facilities are not readily accessible to all older retirees. Retirees who live near facilities that have been closed through base closure actions can get prescription drug refills through the base closure mail-order benefit program. Further expanding this mail-order benefit to those who do not live near military facilities and do not currently have a mail-order benefit would fill an important health coverage gap. It would cost about $229 million per year and would not require major changes in the DOD medical program.

[20]A study by the Rand Corporation (Susan D. Hosek and others, The Demand for Health Care: Supporting Research for a Comprehensive Study of the Military Health-Care System (Santa Monica, CA: RAND Corporation, 1994)) provides evidence that military families tend to use more health care than comparable civilian families. However, it is not clear whether this pattern holds for older retirees, let alone whether it would persist under the conditions of the proposed FEHBP option.

Current Mail-Order Program Could Be Expanded at Relatively Modest Cost

DOD currently operates a mail-order prescription program in base closure areas for all beneficiaries affected by the closing of military medical facilities. Older retirees who live in these areas or who can demonstrate prior use of a now-closed military pharmacy are eligible to use this mail-order benefit. By expanding this mail-order program, this benefit could be provided to older retirees outside base closure areas who live too far from a military pharmacy to easily use that source for recurring prescriptions.

Expanding the current program would result in additional cost to DOD. We calculated the added annual cost of expanding the current mail-order benefit to older retirees who live outside the catchment area of a military facility, and who do not already have the benefit through the base closure medical program, at about $229 million, or about $561 per participant. The mail-order pharmacy proposal would allow these retirees to receive a 90-day supply of a drug for an $8 copayment. We assumed that all the beneficiaries eligible for the program would participate because there would be no premium and a small copayment. However, it is possible that fewer would actually participate. According to DOD officials, only about half of those eligible for the existing mail-order program in base closure areas have used it. Many choose not to participate either because they prefer to travel to a military facility to receive their prescriptions for free or because they are using other health insurance that they currently hold for their prescriptions. To the extent that beneficiaries chose to continue using other health care coverage, the added costs to DOD for this program would be less. And, if beneficiaries chose to no longer travel to military facilities to refill their prescriptions, the added cost of implementing this proposal would be somewhat offset by savings at those military facilities' pharmacies. We were not able to estimate this effect because DOD currently does not collect data on the amount or cost of prescriptions supplied to older retirees through its military pharmacies.

A Formulary and a Drug Utilization System Could Help DOD Manage Mail-Order Program Costs

A common method used by private sector payers to control prescription drug costs is a formulary—a list of prescription drugs that are preferred by a health plan sponsor for reasons of medical value and price.[21] The mail-order pharmacy programs now operating in base closure sites allow beneficiaries to obtain the broad selection of pharmaceuticals available under CHAMPUS. The one exception is that pharmacies that contract with

[21]For more information on formularies and their use in managing pharmacy costs, see Pharmacy Benefit Managers: Early Results on Ventures With Drug Manufacturers (GAO/HEHS-96-45, Nov. 9, 1995) and Pharmacy Benefit Managers: FEHBP Plans Satisfied With Savings and Services, but Retail Pharmacies Have Concerns (GAO/HEHS-97-47, Feb. 21, 1997).

DOD to carry out these programs are required to dispense the generic equivalent of a brand-name drug unless a doctor specifically requires that the brand-name item be dispensed as written for clinical reasons. The use of a formulary appropriate for older retirees would be one way for DOD to contain the costs of a mail-order program.

Carefully tracking the number of older retirees using pharmacy benefits—collecting data on where they receive their prescriptions, what types of medications they use, and what those prescriptions cost DOD—is another way to manage the cost of a pharmacy program. DOD could use this information to develop a cost-effective formulary and to adjust copayments to control costs. Although DOD currently has no drug utilization information system in place, we believe DOD could use a participant enrollment mechanism and point-of-service software to better track the use of a mail-order pharmacy benefit.

Medical System Size, Structure, and Mission Considerations

As we testified in February 1997, the military health system's current size and structure relative to its primary wartime mission are now being evaluated. Further downsizing and restructuring of the system in line with reduced wartime requirements are being predicted. It is important to factor the potential for such changes into the choices DOD makes about providing care for its aging population through major new benefit programs. Before deciding on proposals that either retain care for older beneficiaries in military facilities or provide for them entirely through civilian sources, the training needs of DOD physicians may have to be evaluated. Upholding the "medical readiness" tenet that military medical facilities have a mix of patients of all ages to keep physicians prepared for wartime may be difficult if more care for older beneficiaries is provided through civilian sources. Moreover, it is important to consider the broad issue of whether the physician mix of the military medical system is adequately equipped or trained for geriatric care, and whether it should be realigned to be so in light of its primary wartime mission.

Conclusions

Over the last decade, DOD health care system changes have included the introduction of managed care programs that altered access-to-care priorities, numerous facility closures, and significant downsizing of military medical staff. Older retirees, who cannot participate in TRICARE Prime, have grown concerned about their current, and even more so, their future ability to access space-available care in military facilities. The proposals made thus far to improve older retirees' health benefits and

access to DOD-sponsored health care to varying degrees increase either the number of retirees receiving such care or the amount of care that many now receive. The proposals' anticipated costs would vary markedly, from the Medicare subvention option, which is designed to be budget neutral, to the relatively moderately priced mail-order pharmacy option, to the high-price-tag options of using Medigap, CHAMPUS, or FEHBP as Medicare supplements. Each of the options would have differing effects on the military health system. All would introduce the need for such structural changes as new enrollment and reimbursement mechanisms, and some raise questions about the "military readiness" consequences of caring for all older retirees outside military facilities. Furthermore, the Medicare subvention option has generated concern about the system's ability to provide comprehensive geriatric care at its facilities. Given these considerations and the likelihood that the military medical system will undergo further downsizing, the mail-order pharmacy option appears comparatively attractive for the near term. The lack of a prescription benefit under Medicare is a major void in older retirees' coverage that could be filled at a comparatively modest cost and without major system change.

Agency Comments and Our Evaluation

In commenting on a draft of this report, DOD generally agreed with our representation of the issues. It did, however, have several concerns. First, DOD suggested that our mail-order pharmacy cost estimate be updated and provided us with more current prescription expenditure and usage data for the current base closure area program. As appropriate, we used these more recent data to recalculate our estimate.

Relatedly, DOD stated that our apparent assumption that catchment area retirees now have 100 percent of their prescription drug needs met by military facilities was incorrect. Also, DOD questioned the feasibility—from an operational and customer service standpoint—of offering the mail-order program only to retirees living outside catchment areas and thus denying it to those within such areas. We were asked to evaluate the pharmacy option only as it pertained to retirees outside catchment areas and not to all retirees regardless of their proximity to military facilities. In doing so, our evaluation did not assume that those within catchment areas now have all of their prescription drug needs met, nor did it assume that those who would receive the mail-order pharmacy benefit would have 100 percent of their prescription drug needs met. We do believe, however, that such a program would help fill a major Medicare coverage gap for those most needing such coverage. We are currently planning a review of

all of DOD's pharmacy operations that will include such issues as current benefit uniformity. Regarding the operational difficulties of establishing geographic eligibility for the mail-order program, we note that the existing base closure area program defines eligibility primarily by service area. Thus, we believe any such eligibility-related difficulties could be overcome for a limited expansion of this program to beneficiaries outside catchment areas.

DOD also commented that our report failed to mention that, under the Medicare subvention proposal, DOD's ultimate goal would be to offer enrollment in TRICARE Prime to Medicare-eligible beneficiaries wherever TRICARE Prime was offered. We agree, and have amended the text accordingly. DOD went on to say that such an expansion could be made by using the TRICARE contractors or existing Medicare HMOs. Regarding such an expansion, however, even if subvention was tested at military facilities and proved cost neutral, it would remain to be seen whether DOD could administer subvention using civilian providers and achieve the same cost-neutral result—that is, provide services costing less than or the same as services from other Medicare providers. We continue to question whether any government cost advantage would result from DOD's making such arrangements with civilian providers. Further, extending subvention this way could involve a rather complex financing arrangement whereby HCFA might provide payments to DOD for its use in paying civilian contractors or HMOs. These organizations might, in turn, reimburse DOD for any care DOD provided in its own facilities. And each year, DOD would attempt to reconcile these funding transfers with HCFA to ensure cost-neutrality. Moreover, DOD's use of civilian providers for this purpose could duplicate, and thus compete with, the existing Medicare HMO program administered by HCFA.

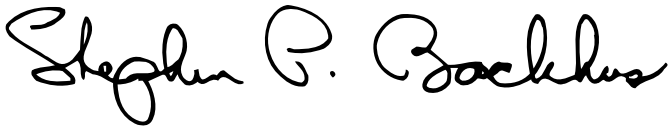
Finally, DOD stated that the option providing CHAMPUS as a Medicare supplement might enable beneficiaries to obtain prescription drugs with a lower copayment than the standard CHAMPUS copayment of 25 percent—the percentage we used to estimate costs—from retail pharmacies and mail-order programs operating under TRICARE. DOD said that, if beneficiaries were able to take advantage of these programs, their costs would be lower, but the cost to DOD would increase. While we agree that beneficiaries might avail themselves of TRICARE pharmacy programs under this option, we disagree that DOD's costs would necessarily increase. TRICARE programs are aimed at reducing DOD and beneficiary costs through negotiated discounts such that providing prescription benefits through these programs might not be more costly than under standard

CHAMPUS. For these reasons, and because DOD does not have data available on how many prescriptions retirees would obtain at various copayment amounts or what DOD's cost would be, we continue to believe that using the standard CHAMPUS copayment is a reasonable approach to estimating this option.

DOD also made several technical comments, which we incorporated as appropriate. DOD's comments in their entirety are included as appendix III.

We are sending copies of this report to the Secretary of Defense and will make copies available to others upon request.

Please contact me on (202) 512-7111 or Dan Brier, Assistant Director, on (202) 512-6803 if you or your staff have any questions concerning this report. Other contributors to this report include Catherine O'Hara, Evaluator-in-Charge; Timothy Carr; Sandra Davis; James Espinoza; Elsie Picyk; Mary Reich; Dayna Shah; and Nancy Toolan.



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Director, Veterans' Affairs and
Military Health Care Issues

Contents

Abbreviations

CBO	Congressional Budget Office
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CRS	Congressional Research Service
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
HCFA	Health Care Financing Administration
HMO	health maintenance organization
OPM	Office of Personnel Management

Scope and Methodology

In conducting our review, we examined, where available, the legislative history of each proposal under consideration. We interviewed Department of Defense (DOD) headquarters officials, military medical facility managers, and health care providers nationwide to gain perspective on the effects of system changes on retirees and to obtain cost data relevant to the different proposals. We analyzed DOD population and health care use data for the period between 1994 and 2004 and the results of the 1994-95 Health Care Survey of DOD Beneficiaries to obtain demographic characteristics and information about sources of care and insurance coverage relating to eligible retiree populations. We did not verify DOD's data for accuracy or consistency.

We also interviewed Department of Veterans Affairs officials regarding the Department's pharmacy program, and reviewed DOD contractor reports and studies of the military health system and interviewed their authors. These contractors included the Rand Corporation, the Institute for Defense Analyses, the Logistics Management Institute, and the Center for Naval Analysis. We also interviewed representatives of military retiree associations and advocacy groups to obtain their perceptions of problems Medicare-eligible retirees face and solutions to improve their health care benefits. In addition, we interviewed Health Care Financing Administration (HCFA) officials and reviewed agreements between HCFA and DOD regarding the Medicare subvention proposal. We also interviewed Congressional Budget Office (CBO) officials about CBO's efforts to estimate the budgetary effects of Medicare subvention and Office of Personnel Management (OPM) officials about the cost and structural implications of the Federal Employees Health Benefits Plan (FEHBP) option. In addition, we reviewed our reports on the military health care system and those of DOD, the Congressional Research Service (CRS), and CBO. We conducted our work from June 1996 through May 1997 in accordance with generally accepted government auditing standards.

Methodology for Estimating Costs of Proposals

The information and assumptions we used to estimate the cost of the various options were derived from studies and evaluations conducted by DOD, CBO, CRS, and private consultants as well as from DOD data systems. We made certain general assumptions, in addition to assumptions that are specific to the analysis of each of the options. First, we assumed that these options would be implemented in an environment in which very little or no space-available medical care could be provided to older retirees in military medical facilities, because virtually all available care would be devoted to TRICARE Prime enrollees. Thus, the cost of each option was evaluated

relative to a baseline scenario in which older retirees relied almost exclusively on civilian Medicare-funded care.

Also, we recognized that, to the extent that each of these options would lower beneficiaries' cost of health care, beneficiaries could use more health care, a phenomenon known as induced demand. However, we did not incorporate induced demand effects in our estimates because we lacked specific data on the behavior of DOD's Medicare-eligible population, its total health care use, and its current insurance coverage and cost. Further, we recognized that a change in the benefit options offered to older retirees might result in an increased use of Medicare-funded health care services by beneficiaries who previously were reliant on DOD for care. However, because of the lack of appropriate data, we have not estimated the potential increases in costs to the Medicare program. Neither did we assess the impact that these proposed changes might have on the future solvency of the Medicare Hospital Insurance trust fund.

Finally, we did not attempt to produce an estimate of the cost of implementing a Medicare subvention program because we determined that sufficient data are not available on certain crucial variables (for example, the cost of treating older retirees inside DOD facilities). Further, a substantial portion of the effect of implementing a subvention option would consist of the effect on the Medicare Hospital Insurance trust fund. But uncertainties related to DOD's ability to reliably set its level-of-effort baseline and price out its per-enrollee care, as well as other problems discussed in this text, seriously limit the reliability of estimates of subvention's potential effects on the Medicare Hospital Insurance trust fund.

Estimating the Population

To determine the population eligible for each option, we used DOD's Resource Analysis and Planning System, Version 10.0.1 (Feb. 1997). We limited the population for each proposal to the 1,196,346 Medicare-eligible retirees, their dependents, and survivors (referred to hereafter as "retirees") living in the continental United States. We excluded those living overseas (about 12,000) because their health care options differ significantly from those of retirees in the United States. For example, Medicare is not available overseas, and few military facilities are available.

Cost for DOD to Pay the Medicare Part B Premium and Purchase Medigap Policies for Older Retirees

Medigap policies are offered by private insurers under 10 standard plans, referred to as plans A through J, which provide progressively greater coverage at increasingly higher premiums. Only plans H, I, and J offer coverage for outpatient prescription drugs. We assumed that DOD would purchase the lowest cost plan providing prescription coverage: plan H. For our estimate, we used the 1996 average annual premium of $1,307 for plan H policies offered by Blue Cross/Blue Shield and Prudential. We obtained this figure from the Families USA Foundation, a national nonprofit consumer health care organization.

Further, to purchase a Medigap policy, beneficiaries are required to enroll in Medicare part B. The 1997 annual premium for Medicare part B is $525.60. We assumed that DOD would offer this benefit to the entire population of Medicare-eligible retirees. Although many retirees already have both Medicare part B and Medigap coverage, because DOD would pay the premiums for both the Medigap policy and the Medicare part B premium, unlike most employers, we assumed that all 1,196,346 beneficiaries would participate.[22]

Medicare Part B and Medigap Plan H Cost Estimate Calculation

$525.60 (annual Medicare part B premium) x 1,196,346 (Medicare-eligible beneficiaries) = $628,799,458.

$1,307 (average annual Medigap plan H premium) x 1,196,346 (Medicare-eligible beneficiaries) = $1,563,624,222.

$628,799,458 (for Medicare part B) + $1,563,624,222 (for Medigap plan H) = $2,192,423,680 (total estimated cost).

Cost for CHAMPUS as a Medicare Supplement

Under the proposal that would make the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) a Medicare supplement, DOD would pay beneficiaries' out-of-pocket costs for copayments and deductibles for services covered by Medicare parts A and B and a portion of the cost of outpatient prescription drugs, which are not covered by Medicare. HCFA estimates that aged Medicare-eligible beneficiaries' out-of-pocket costs for Medicare-covered services will be $877.44 in 1997. Annual prescription costs for Medicare-eligible beneficiaries in 1997 are estimated to be $819, according to HCFA. Under this proposal, beneficiaries would pay the standard CHAMPUS copayment of 25 percent for prescription drugs, with DOD paying the remaining 75 percent, or $614.25. Finally,

[22]Because some retirees would not have previously elected Medicare part B coverage, they would face penalties for late enrollment. If DOD paid the cost of these penalties, there would be an additional cost in the initial years of the program.

because physicians can charge more than the maximum amount Medicare allows—up to 115 percent—CHAMPUS, as supplementary coverage to Medicare, would pay these additional costs up to its allowed amount. DOD estimates that these additional physician charges would amount to about $34 million.

We assumed DOD would offer this benefit to the entire population of Medicare-eligible retirees. Because there are no premiums for CHAMPUS coverage and DOD would pay most of the out-of-pocket costs for retirees, we assumed that all 1,196,346 Medicare-eligible beneficiaries would participate.

CHAMPUS as a Medicare Supplement Cost Estimate Calculation

$877.44 (average Medicare beneficiary out-of-pocket cost per year) x 1,196,346 (Medicare-eligible beneficiaries) = $1,049,721,834 (for medical costs).

$819.00 (annual retail prescription cost for each Medicare-eligible beneficiary) - 25 percent (beneficiary copayment) = $614.25 (DOD annual prescription cost for each Medicare-eligible beneficiary).

$614.25 (DOD annual prescription cost for each Medicare-eligible beneficiary) x 1,196,346 (Medicare-eligible beneficiaries) = $734,855,531 (total annual cost of prescription coverage).

$1,049,721,834 (medical costs) + $734,855,531 (prescription coverage) + $34,000,000 (additional physician charges) = $1,818,577,365 (total estimated cost).

Cost to Enroll Older Retirees in FEHBP

For our estimate, we assumed DOD would pay an annual premium of $1,571 per person. This represents the government's portion of the fiscal year 1996 self-only premium for federal government retirees enrolled in FEHBP, of whom about 75 percent are aged 65 or older. We obtained this figure from OPM. This premium cost could be higher or lower for DOD, depending upon demographic and medical use characteristics as well as beneficiary plan choices. In the absence of a specific plan and beneficiary data, OPM could not provide us with an estimate of the actual premiums, so we assumed that the costs would be the same as for the federal retiree population.

We assumed that DOD would offer this benefit to the entire population of Medicare-eligible retirees. According to a DOD survey, 17 percent of

Medicare-eligible retirees have insurance coverage fully or partially paid by their post-military employers. Because FEHBP requires beneficiaries to pay a higher portion of the premium than most private employers do, it is likely that the 17 percent would not enroll in FEHBP. Therefore, we assumed that 992,967, or 83 percent of the 1,196,346 Medicare-eligible retirees, would participate.

FEHBP Cost Estimate Calculation

$1,571 (average annual premium cost to DOD) x 992,967 (83 percent of Medicare-eligible beneficiaries) = $1,559,951,157.

Cost for the Mail-Order Pharmacy Benefit

For our estimate, we used DOD's cost per prescription, dispensing fee, copayment, and prescription usage rates under the current base closure mail-order pharmacy benefit program. We assumed that the benefit would be provided to all Medicare-eligible beneficiaries aged 65 and older who live outside a DOD military treatment facility catchment area (568,885 of the total 1,196,346). But, 160,531 of these are already eligible for the benefit under the current base closure mail-order program. Therefore, we assumed that a maximum of 408,354 older retirees would participate in the program.

Mail-Order Pharmacy Benefit Cost Estimate Calculation

$35.00 (average cost per 90-day supply prescription) + $7.00 (dispensing fee) - $8.00 (copayment) = $34 (average cost per 90-day supply prescription).

$34.00 (average cost per 90-day supply prescription) x 16.5 (average number of 90-day supply prescriptions per person annually) = $561.00 (average annual prescription cost for each Medicare-eligible beneficiary).

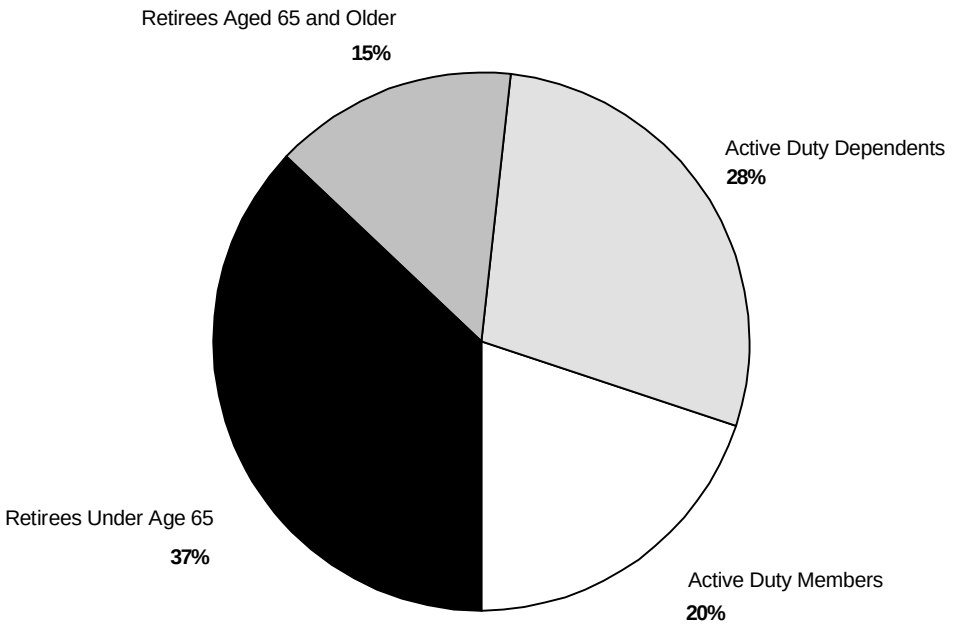
$561.00 (average annual prescription cost for each Medicare-eligible beneficiary) x 408,354 (Medicare-eligible beneficiaries) = $229,086,594 (total estimated cost).

Profile of the Military Retiree Population

Retiree Population, More Than Half of DOD Beneficiaries, Is Expected to Grow

In 1996, military retirees[23] made up over 50 percent of the population eligible for DOD health care (see fig. II.1). Since 1994, the number of retirees and their families has increased 5 percent, and the number of active duty members and their families has decreased about 12 percent; this trend is projected to continue (see fig. II.2). Most of the 1996 retiree population was younger than age 65 (see fig. II.3). However, the number of retirees aged 65 and older is expected to increase dramatically, while the number of those under age 65 remains essentially the same (see fig. II.4).

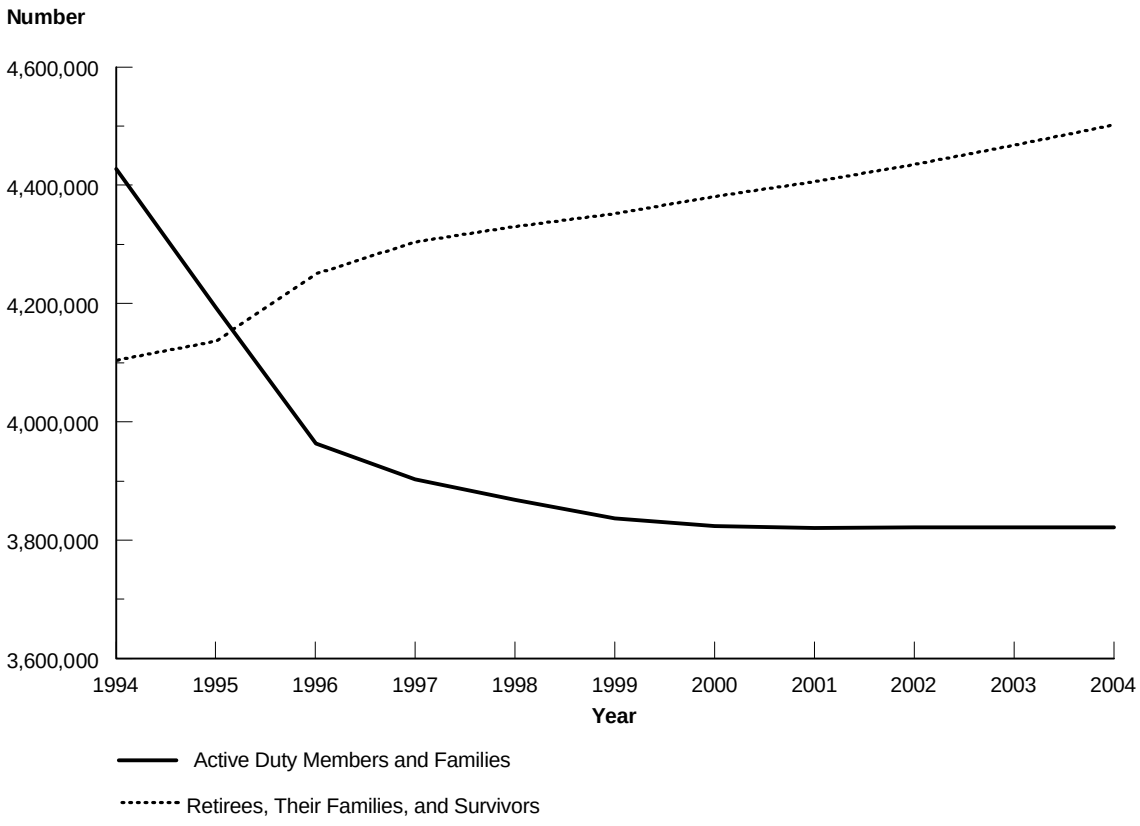
Figure II.1: Population Eligible for Military Health Care by Beneficiary Category, 1996



Source: Our analysis of DOD's Resource Analysis and Planning System data.

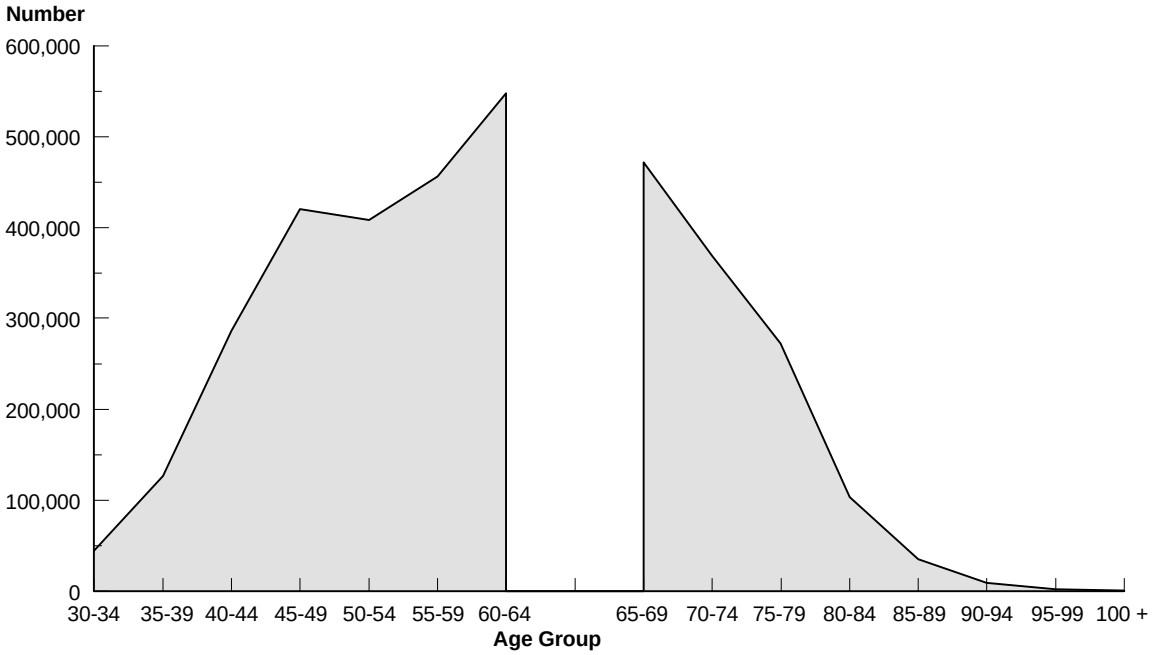
[23]We continue to use the term "retirees" to refer to retirees and their dependents and survivors.

Figure II.2: Active Duty and Retiree Population Trends, 1994-2004



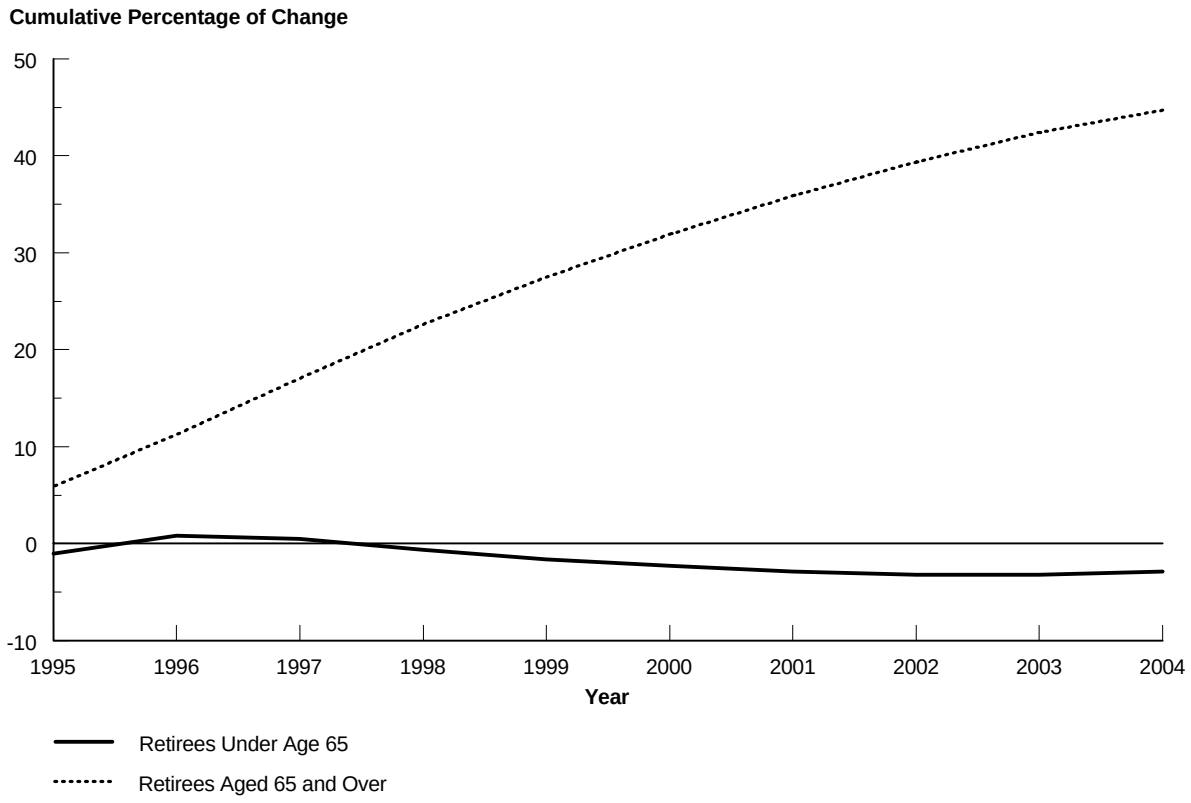
Source: Our analysis of DOD's Resource Analysis and Planning System data.

Figure II.3: Age Distribution of Retiree Population, 1996



Source: Our analysis of DOD's Defense Medical Information System data.

Figure II.4: Projected Change in Retiree Population Through 2004



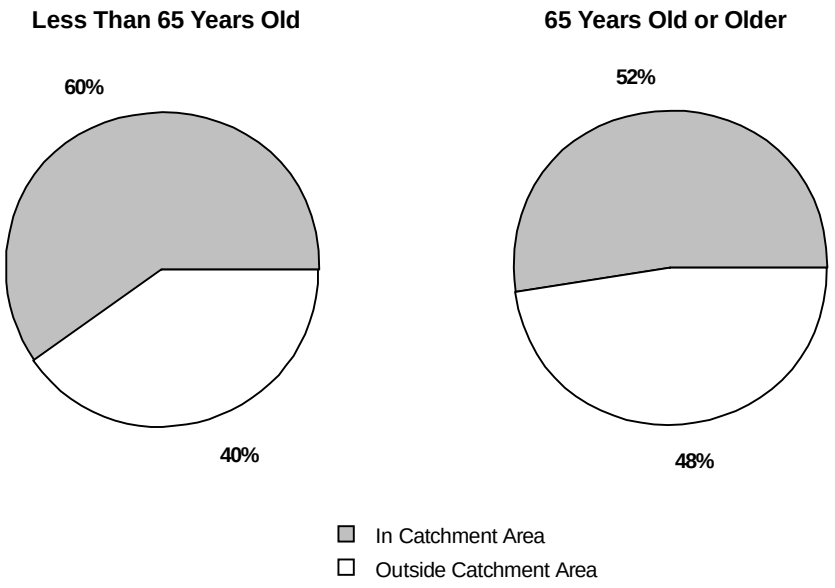
Source: Our analysis of DOD's Resource Analysis and Planning System data.

Most Older Retirees Do Not Live Near Large Military Medical Facilities

In 1996, about 60 percent of retirees under age 65 lived within the 40-mile catchment area[24] of a military medical facility, as compared with slightly more than half (52 percent) of the retirees aged 65 and older (see fig. II.5). Of the older retirees, about 14 percent lived near a large facility (200 beds or more) that offered a wide variety of specialty care services. About 10 percent lived near facilities with 100 to 199 beds, about 8 percent lived near facilities with 50 to 99 beds, and about 21 percent lived near small medical facilities of less than 50 beds that had little inpatient capacity. (See fig. II.6.)

[24]A catchment area is defined as the area within a 40-mile radius surrounding a military medical facility.

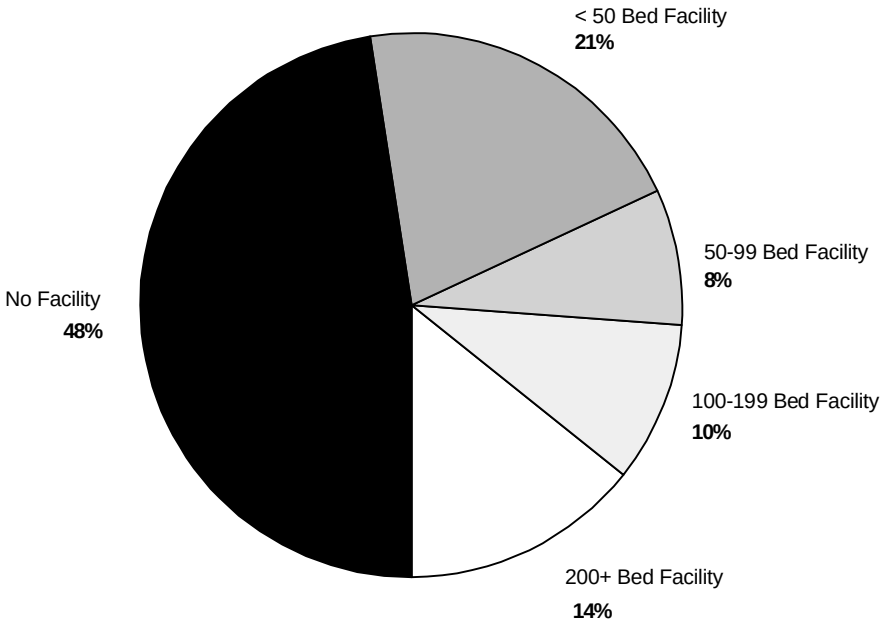
Figure II.5: Proximity of Retirees to Military Medical Facilities by Retirees' Age, 1996



Note: Retirees living outside the continental United States are not included.

Source: Our analysis of DOD's Resource Analysis and Planning System data.

Figure II.6: Percentage of Older Retirees Living Near a Military Medical Facility, by Facility Size, 1996

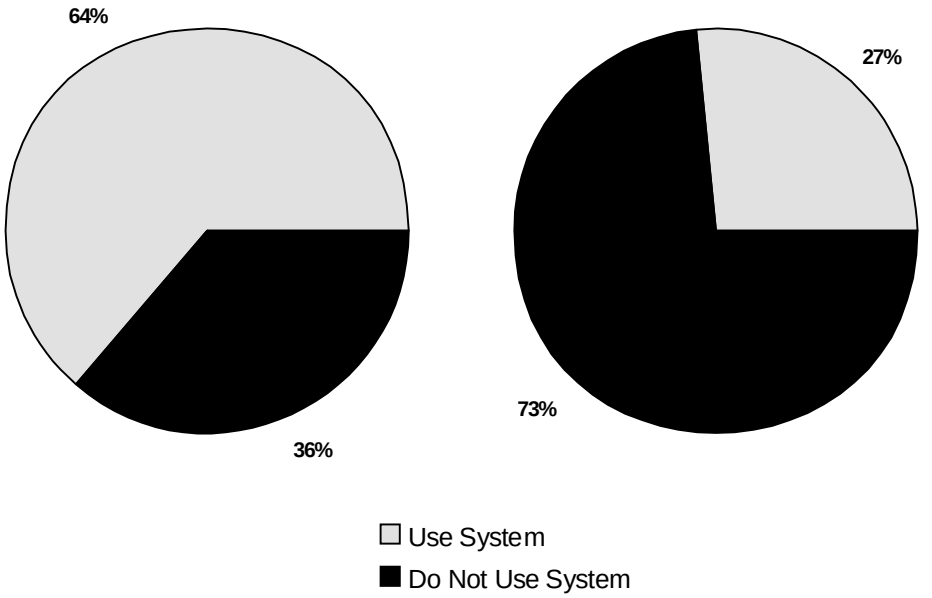


Source: Our analysis of DOD's Resource Analysis and Planning System and the Joint Cross Service Working Group on Military Medical Facilities of the Base Realignment and Closure Commission data.

Few Older Retirees Use the Military Medical System; Many Use Only Pharmacy Services

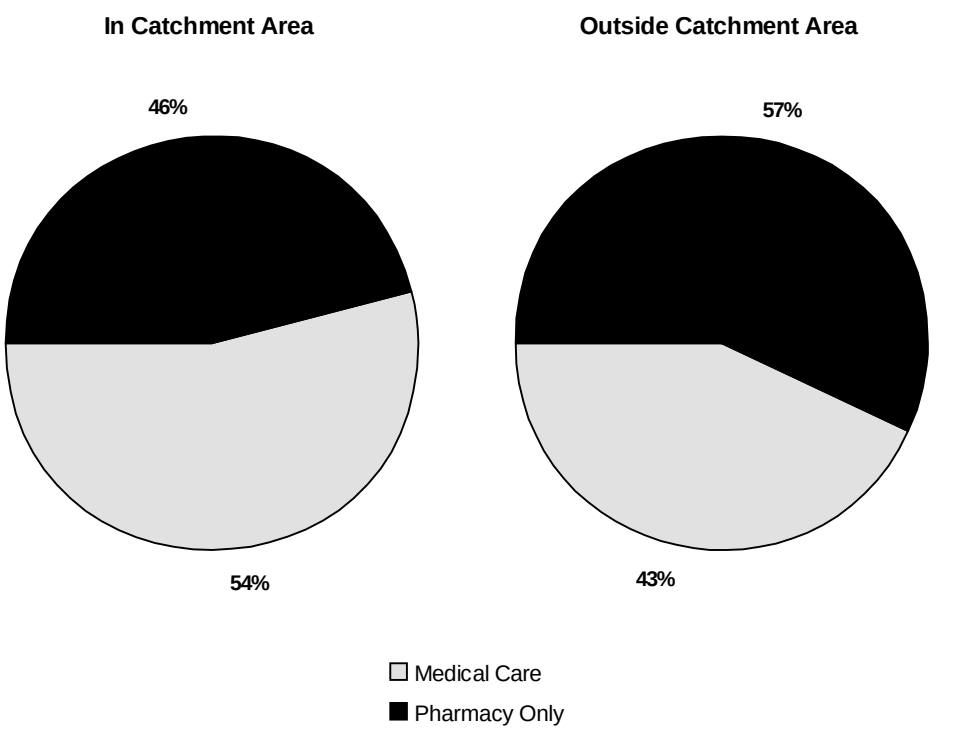
In 1996, about two thirds of retirees under age 65 used the military health system, including military medical facilities and the CHAMPUS program. In comparison, only about a quarter of the retirees aged 65 and older used military medical facilities for their care (CHAMPUS eligibility ends at age 65). (See fig. II.7.) For retirees aged 65 and older who did use the military medical system, a significant percentage used pharmacy services only, regardless of their proximity to a military medical facility (see fig. II.8).

Figure II.7: Retirees' Use of Military Health System by Retiree Age, 1996



Source: DOD's Resource Analysis and Planning System data.

Figure II.8: Type of Service Older Retirees Received at Military Medical Facilities by Retirees' Proximity to Facility, 1996

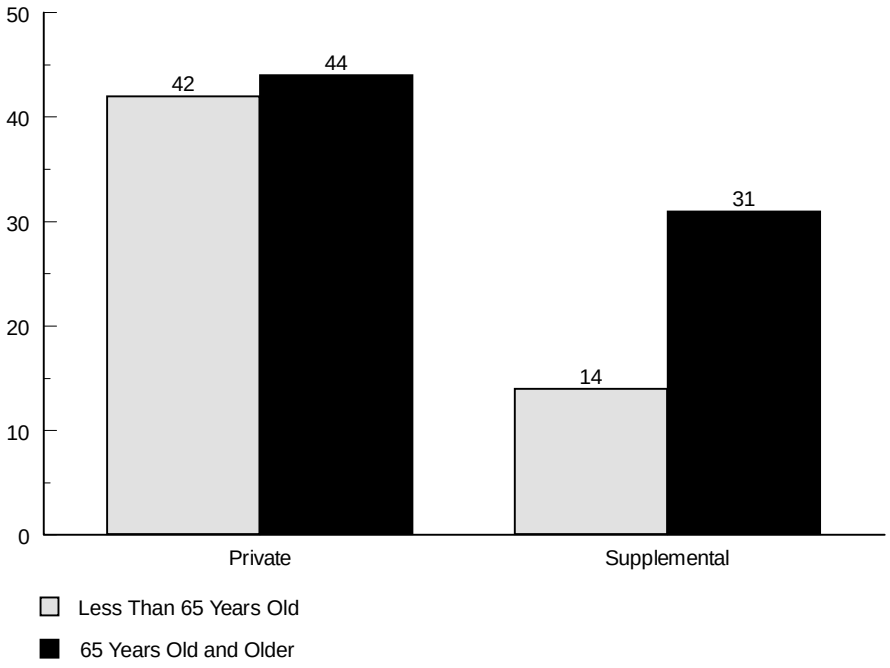


Source: Our analysis of DOD's Semi-Annual User Survey data.

Almost Half of Military Retirees Have Private Health Insurance

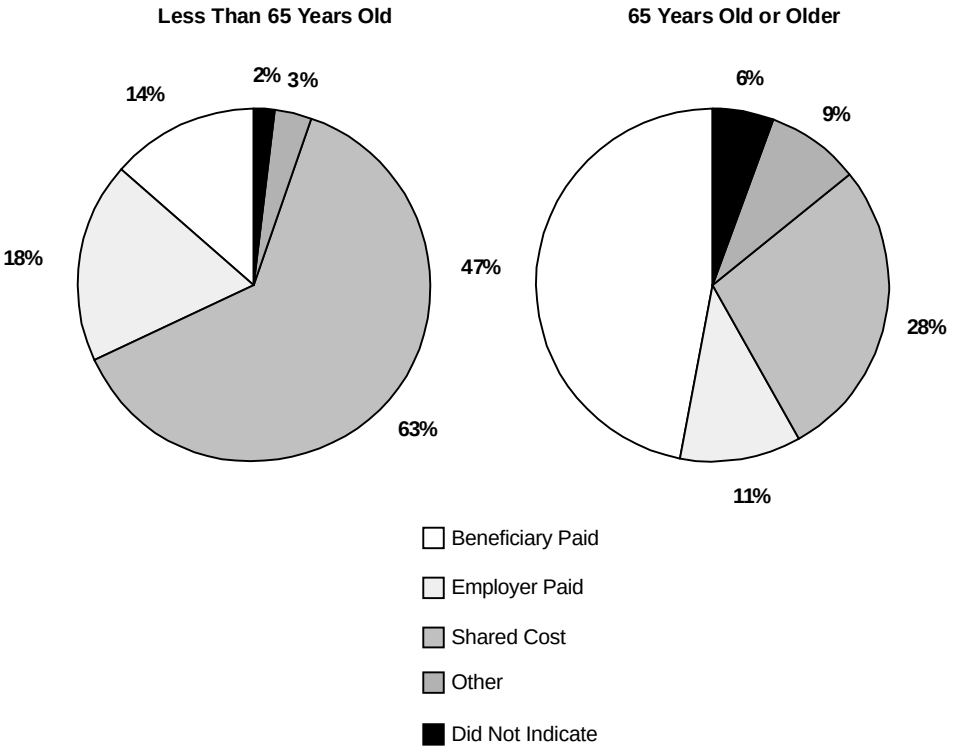
According to a 1994-95 survey of DOD beneficiaries, over 40 percent of military retirees, regardless of age, had private health insurance coverage. About a third of retirees aged 65 and older also reported having additional insurance coverage to supplement their Medicare benefits. A smaller proportion of retirees under age 65, about 14 percent, also had insurance to supplement their CHAMPUS coverage. (See fig. II.9.) For those retirees who had private health insurance, many had part or all of that coverage paid for by their current or former employer; however, many more older retirees paid the entire cost of that coverage themselves (see fig. II.10).

Figure II.9: Retiree Private and Supplemental Insurance Coverage by Age, 1994-95



Source: Our analysis of DOD's 1994-95 Survey of DOD Beneficiaries data.

Figure II.10: Retirees With Private Insurance by Age and by Who Paid the Premium, 1994-95



Source: Our analysis of DOD's 1994-95 Survey of DOD Beneficiaries data.

Comments From the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

JUN 6 1997

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Health, Education, and Human Services Division
U.S. General Accounting Office
Washington, D.C. 20548

This is the Department of Defense (DoD) response to the General Accounting Office (GAO) draft report, "MILITARY RETIREE HEALTH CARE: Costs and Other Implications of Options to Enhance Older Retirees Benefits", dated May 21, 1997 (GAO Code 101491/OSD Case 1366). The Department has reviewed the draft report and offers the following comments:

a. The Department believes the cost associated with the mail order pharmacy option for Medicare eligibles is understated. My staff has provided your analysts more current data on expenditure rates for the pharmacy program available to Medicare eligible military retirees around Base Realignment and Closure sites. This data should help make your projections for this option more accurate.

b. In addition, while the Department understands the GAO's tasking to examine the option to provide mail order pharmacy service to Medicare eligibles only in non-catchment areas, we do not feel that is a viable option from an operational or customer service standpoint. This option assumes that those beneficiaries residing within the 40 mile catchment area have 100% of their prescription needs met by a military pharmacy. This is not the case. Military pharmacies are not resourced nor expected to carry all the drugs available on the market today. The list of drugs that are available at military pharmacies (formularies) is tailored to meet the needs of the military population and the prescribing practices of the assigned medical staffs. Civilian physicians, however, who see DoD beneficiaries outside the military hospital are not obligated to prescribe only those drugs available at the military pharmacy. Therefore, beneficiaries with some civilian prescriptions may have to obtain the medications outside the military hospital. It would be very difficult to explain to these individuals that because they live within 40 miles of a military hospital, they could not use the mail order benefit to obtain the drugs not available at the military pharmacy, whereas those who lived 41 miles away could use the military hospital or the mail order program. We anticipate all Medicare eligible beneficiaries would use the military pharmacy for all items that they can obtain free and then the mail order program for those they could not obtain at the military facility.

c. The draft report indicates that "relatively few retirees (about 75,000) could be accommodated by subvention, due to military health facility and financial considerations." The Department's goal in its long-standing pursuit of Medicare subvention legislation, is to offer enrollment in TRICARE Prime to Medicare eligible military retirees wherever TRICARE Prime is offered. Our initial test of the subvention concept will focus on offering enrollment at a limited number of military facilities. However, once the concept of subvention is proven valid, the Department would seek to expand the program by offering Medicare eligibles the opportunity to enroll in Prime wherever TRICARE Prime is available. This could be done in a variety of ways, including modifying TRICARE Support contracts to allow enrollment of Medicare eligibles to civilian Primary Care Managers as well as to contract with existing Medicare HMOs and then be reimbursed by them when care is provided in military facilities to military beneficiaries enrolled with them.

d. Table 1, Comparison of Military Retiree Health Care Options, the CHAMPUS as a Second Payer option indicates that retirees would have a 25% copay for prescriptions. The probable effect of extending CHAMPUS as a second payer to Medicare eligibles is that such beneficiaries would likely use either the TRICARE mail order pharmacy service in each region or the local community retail pharmacy network. In such cases there would be no deductible and a nominal/reduced copayment, rather than the 25% copayment after deductible under standard CHAMPUS. The effect of this would be to reduce the individual beneficiary out-of-pocket costs and increase the government cost over standard CHAMPUS.

Thank you for the opportunity to comment on the draft report and to discuss its content with your staff members who assisted in its preparation. My point of contact for this report is Col Jerry Luby, Director of TRICARE Operations Policy. He can reached at 703-614-4705.

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