NATIONAL MILITARY AND VETERANS ALLIANCE

TELEPHONE (703) 750-2568 FAX (703) 354-4380

STATEMENT

BEFORE THE

SUBCOMMITTEE ON

PERSONNEL

COMMITTEE ON ARMED SERVICES

UNITED STATES SENATE

BY

COLONEL CHARLES C. PARTRIDGE, U.S. ARMY, RETIRED
NATIONAL ASSOCIATION FOR UNIFORMED SERVICES
5535 HEMPSTEAD WAY SPRINGFIELD, VA 22151

11 MARCH 1999

MILITARY HEALTH SYSTEM

Curriculum Vitae and Organizational Disclosure Statements

Charles C. Partridge
Legislative Counsel
National Association for Uniformed Services

Colonel Partridge, US Army, Retired, has been the legislative counsel for NAUS since May 1984.

Colonel Partridge's military career spanned 31 years of enlisted and commissioned services in the reserve and active forces. He served in Vietnam, Germany, Korea and in several installations in the United States. Colonel Partridge served three tours in the Pentagon as a staff officer dealing with personnel matters. He also served as the Chief of Staff of the Army Intelligence and Security Command, Arlington, Virginia and as the Executive, Office of the Chief, Legislation Liaison, Secretary of the Army, Pentagon. He is a graduate of the Army War College, the Army Command and General Staff College, and has a Masters in Public Administration from Pennsylvania State University.

Disclosure

Neither the National Association for Uniformed Services (NAUS) nor the National Military/Veterans Alliance have received a grant from (and/or subgrant) or a contract (and/or subcontract) with the federal government for the past three fiscal years.

INTRODUCTION

Mr. Chairman and distinguished members of the Committee, NAUS and the National Military and Veterans Alliance would like to express its appreciation to you for holding these important hearings. The testimony provided here represents the collective views of our members.

The Alliance includes 19 military and veterans organizations. These organizations represent over 3,500,000 members of the seven uniformed services, officer and enlisted, active duty, reserve, National Guard, retired and other veterans plus their families and survivors. These organizations whose top priority is a strong national defense are listed below:

Air Force Sergeants Association	**National Association for Uniformed Services**
American Military Retirees Association	**Naval Enlisted Reserve Association**
American Retirees Association	**Naval Reserve Association**
Class Act Group	**Non Commissioned Officers Association**
Catholic War Veterans	**The Retired Enlisted Association**
Gold Star Wives of America	**Society of Medical Consultants to the Armed Forces**
Korean War Veterans Association	**Society of Military Widows**
Military Order of the Purple Heart	**Tragedy Assistance Program for Survivors**
Legion of Valor	**Veterans of Foreign Wars**

Medical care along with adequate pay and inflation protected retired pay and commissaries are the top concerns of the military community. With base and hospital closures and reductions in medical personnel, the increasing lack of available health care continues to be a major concern to active and retired personnel alike.

We want to thank the committee for its long standing interest in Military Health Care and for its support for the Federal Employees Health Benefits Program for military retirees.

BACKGROUND

The military health system has several missions, first and foremost is caring for active duty troops and maintaining military medical care readiness, readiness training and contingency operations as well as providing care for active duty family members; continuing to provide promised, lifetime medical care to military retirees, and their family members. To carry out

these missions, top quality personnel to staff military medical units, hospitals and clinics are essential. These personnel are attracted to military medicine through the Uniformed Services University of the Health Sciences, the U.S. Health Profession Scholarship Program and quality graduate medical education programs sponsored by the various military medical services. Each is an important element of the system and are all linked together. Additionally, as we are seeing today with the recruiting shortages in all services except for the Marine Corps, keeping faith with the retirees by keeping the medical health care promise is vital to our strong all volunteer force and to our national defense. In a recent *Christian Science Monitor* article addressing recruitment problems, Major General Evan Gaddis, the commander of the Army's Recruiting Command headquartered in Fort Knox made special note of the fact that "military retirees, upset over a steady erosion of benefits like health care and pensions, aren't talking up military careers to young adults as they might once have."

A military medical system is necessary to support not only the present active forces but also to meet future requirements. To attract, maintain and properly certify highly qualified medical professionals requires assuring them that they will have a complete range of patients with varied health problems to include older retirees. They can't be adequately trained treating only young (average 23) service members and young family members. This means it is imperative to maintain a strong, vibrant, capable direct care system.

The Defense Health System has undergone a significant downsizing in the past 10 years and continues to shrink. The number of normal beds has decreased by 41 percent (12,000), expanded beds have decreased by 46 percent (20,000), the number of hospitals has decreased by 35 percent (58) and the number of medical centers has decreased by 33 percent (6). Additionally, military medical personnel have decreased by 13 percent while civilian medical personnel have decreased by 22 percent. Please contrast these reductions with the 10 percent reduction in the eligible serviced population (867,000) during the past 10 years. According to the Department of Defense "demand continues to exceed supply, especially among retirees" all the while, the "Medicare eligible population (is) growing 4 to 5 percent annually". And at the same time <u>today</u>, the Department of the Air Force is directing its Medical Command to eliminate 1,300 more uniformed officer medical personnel.

CURRENT

The direct care system coupled with TRICARE Prime, Extra and Standard along with

Medicare Subvention and increased cooperation between DoD and DVA should result in adequate care for all eligible beneficiaries. Unfortunately, military personnel are increasingly being disenfranchised and DoD has not yet developed a plan that will provide an adequate health care option for all DoD beneficiaries. In addition, the TRICARE system is flawed. Some of the problems and recommendations for solving them follow:

A DoD study found that TRICARE administrative costs are far too high. Each Managed Care support contract proposal costs millions of dollars, each winner can expect a protest from the losers costing more millions. More money is being spent on medical administration and less on the patient. We believe this committee should direct a review of alternative means of procuring private sector healthcare to supplement the Military healthcare system.

While we support expanding TRICARE Prime beyond catchment areas, some areas are too sparsely populated to create networks. If the TRICARE Standard benefit were adequate, beneficiaries in those areas could still be served. However, the CHAMPUS Maximum Allowance Charge (CMAC) is too low. The CMAC should be linked to the service benefit plan of the Federal Employees Benefits Program as Congress originally directed, rather than the Medicare rate. This point cannot be overstated especially in areas that are medically underserved.

DoD has also reduced the value of TRICARE Standard/CHAMPUS when it is used as second payer to other insurance. When CHAMPUS/TRICARE Standard is used as a second payer it is based on "benefits-less-benefits" rather than a "coordination of benefits" basis. As a result beneficiaries of the so-called benefit receive no benefits from CHAMPUS as second payer. The coordination of benefits method should be restored and legislative provisions put in place to keep it.

The TRICARE Point of Service (P.O.S.) option for enrollees in the Prime program is too expensive at $300/$600 deductibles and 50% copay. The P.O.S. option should be changed to the TRICARE Standard rate, $150/300 and 25% copay. We have seen no evidence of abuse of the P.O.S. option and believe that the standard deductible and copays are enough to prevent frivolous use. Further, there should be no requirement to obtain advance authorization to use the P.O.S. option.

The VA is a TRICARE subcontractor in some regions. Currently, copays are the same whether beneficiaries use the VA or civilian providers. Military personnel believe that VA

hospitals/clinics should be given the same status as MTFs for TRICARE purposes and that copays be waived if beneficiaries obtain their care at VA hospitals and clinics.

Everyone of these problems cited here has a common thread – save money by eliminating or reducing care provided. The fewer beneficiaries served means the fewer DoD dollars needed to provide health care. Regardless of the promises made and of all the intentions of this Congress, health care for military retirees is not treated as a benefit and it certainly is not treated as an entitlement. Health care for military retirees, their families and their survivors is merely a line item expense in the DoD budget to be squeezed for more pressing needs by comptrollers and budget analysts who do not rely on the Defense Health Program for their health care.

Unfortunately, the shortcomings in the Defense Health Program for retirees are spilling over to the active force as well. Two weeks ago the Army's 5th Recruiting Brigade held a Family Symposium in St. Louis, Missouri. This symposium was one step in the Army's Family Action Plan and it brought together spouses to discuss issues of concern to recruiters, their families and the US Army. At the close of the meeting the delegates voted on their top 5 issues. Issue #2 was "Timeliness of TRICARE Claims Payment". Issue #1 was "Lack of TRICARE Providers". Last fall, a member of the NAUS staff was attending the Chief of Staff, US Air Force's Retiree Council conducted at Randolph Air Force Base. While visiting the gymnasium, he met a young F-15 pilot who had just resigned his commission and accepted an appointment in the reserves. His reason for leaving the active force? Health care. While deployed in the Middle East, his spouse and their children could find no health care providers near his parents-in-law's home that would accept TRICARE Standard and, of course, there were no health care providers in a TRICARE Prime network. Their concerns in the US affected him every day while serving in Saudi. His new job with an airline offered him trouble free health care that he and his spouse could depend on. The young man said his decision to leave the active Air Force wasn't about money, and in fact, he would have paid to fly the F-15 Eagle. He said it was all in how you take care of your people and health care was the most important part of that for him.

There are other TRICARE and Defense Health Program "spill-overs" into the active force that you need to be aware of. Last month at a national TRICARE conference, the Under Secretary of Defense for Health Affairs, Dr. Sue Bailey, made a special point of talking about bringing more care into the MTF. There is a great irony here because Dr. Bailey's call for bringing more health care inside the MTF comes at a time when military hospitals are continually being downgraded to clinic status, military doctors are being eliminated (1,300 in the US Air Force alone by the year 2000), and skilled medical support personnel positions are being eliminated

(600 licensed practical nurse positions are being reclassified as infantrymen or truck drivers in the Army). To see the results of these conflicting policies you need go no further than right here in Washington, DC. Personnel shortages and staffing decisions make up inside of the Army's medical system have left Walter Reed Army Medical Center (WRAMC) no longer able to care for all of the seriously ill dependent children of our active duty service members in the National Capital Area. In February at least 10 children had to be referred to Children's Hospital because neither WRAMC nor Bethesda (the National Naval Medical Center) had the necessary beds and support personnel. Many of these costly referrals could have been avoided with the addition of just one more nurse on evening shift and one extra nurse on nights.

There is another ramification worth mentioning, especially to this Committee that has already devoted so much time and energy on the subject of pay and compensation issues for our uniformed personnel as well as this Committee's efforts in trying to fix the disincentives for military service. In the next 2 to 3 years, the vast majority of our enlisted personnel will be up for re-enlistment. One can imagine the frustration and anger that the active duty men and women will feel about the inability of the respective medical corps to take care of their children inside of the system. Because, not only does each referral to Children's Hospital add at least $10,000 to the cost of care for the government and the taxpayers, the families of these children are faced with copayments and deductibles that they otherwise would not have been required to pay had their children been admitted to WRAMC or Bethesda. If this is occurring at the Army and Navy's premier facilities, what must be going on in Colorado and Georgia? Additional medical expenses, especially for our more junior members, was not part of the recruiting pitch or re-enlistment talk and these expenses adversely impact on the overall compensation package for these young soldiers, sailors, airmen and marines.

One final, general point that is being made at WRAMC – every aspect of business is starting to revolve around the patient's TRICARE status. Non-Medicare eligible retirees are restricted from primary care except for space available. If they get in for one visit, they are told not to expect a follow up appointment. Therefore, even if a patient needs care for a continuing disease such as Diabetes, or other condition that would support the Graduate Medical Education (GME) program at WRAMC, they are told to go somewhere else or buy into Prime.

<u>MEDICARE REIMBURSEMENT (Subvention)</u>

We welcome the Medicare reimbursement demonstration project which is authorized at six sites in 10 locations. We hope that the program can be rapidly expanded to serve more beneficiaries at more sites and full implementation expedited. According to the GAO

(GAO/T/HEH5-97-84 Feb 97) no more than 75,000 of the 1.2 million Medicare eligible beneficiaries can be accommodated by military treatment facilities even after the program is fully expanded throughout the United States. DoD expects to care for additional Medicare eligibles in the TRICARE Networks; however, it is clear that all Medicare eligibles will not be served and that another option is needed. We will address this issue later.

MEDICARE SUBVENTION PPO OPTION

Last year Medicare reform legislation also provided for the first time for a Medicare Preferred Provider Option demonstration project. Unfortunately, the DoD/Medicare Subvention agreement allows only a test of an HMO option which DoD plans to do through the TRICARE Senior Prime program. We believe the PPO Option should be added to the DoD/Medicare demonstration project.

FEE-FOR-SERVICE MEDICARE SUBVENTION

We would like to see the fee-for service Medicare reimbursement option tested as well. This test would allow Medicare eligible military beneficiaries to keep their standard Medicare benefit, and when using the MTFs on a space available basis, present their Medicare Card to the MTF. The MTF would bill Medicare as other providers do, except that it would be on a discounted basis to reflect the lower cost of care provided by the MTFs.

This would save Medicare Trust funds while making more efficient use of MTFs and use capacity that otherwise would not be used. This also supports our contention that Medicare eligible military medical beneficiaries earned the promised lifetime medical care for themselves and their eligible family members in MTFs and they paid for Medicare Part A coverage through mandatory deductions from their military and civilian pay checks.

FEHBP OPTION

We appreciate the support of this Committee and the Senate for a demonstration of the Federal Employees Health Benefits Program (FEHP). While DoD still has not yet submitted a plan that would provide a health care option for all military beneficiaries, we believe this test, if properly

supported and executed, will provide them with the information they need to design an FEHBP plan for those military beneficiaries unable to gain access to an MTF or to a TRICARE Prime network. However, the program is not funded at the level initially planned; further, DoD has not solved the problem of ensuring that the cost to the military beneficiary in the demonstration is the same as comparable plans offered to federal civilians.

We believe funds should be earmarked for the purpose of guaranteeing the rates while ensuring that current FEHBP beneficiaries are protected. We also recommend that sufficient fund be added to the demonstration to establish a reserve fund to guarantee the rate structure and to increase the number of enrollees. Congress said that the test could involve a total of 66,000 participating beneficiaries but the test has been designed with a total of 66,000 eligible beneficiaries . In the absence of adequate funding, in our opinion, the issue of the separate risk pool is not being addressed aggressively and no assistance is being offered to OPM by DoD to resolve the question on insurance reserve funds. OPM appears to be proceeding on track to have the program ready to go on 1 January 2000, but our concerns remain.

There is a bill in the House that would remove the ceiling on eligible participants and permits Medicare-eligible retirees throughout the country to participate should they desire. The bill, H.R. 113, is sponsored by Representative Duke Cunningham who said in his Dear Colleague letter: "Military Health Care: If It Ain't Right, Fix It". Costs could be controlled if necessary by capping the program. Our estimates indicate that some 30% of retirees would select the FEHBP option. The death rate of older military retirees, especially those of WWII and Korea is close to 3,200 per month. They need access to health care now, not five to seven years from now when it would be too late. Now is the time to act. We must not continue to allow the decline in availability of medical care to disenfranchise military retirees and their families.

PHARMACY ISSUES

A uniform benefit with integrated pharmacy databases that serve all 8.2 million military health care beneficiaries is a benefit supported by the National Military Veterans Alliance. However the National Military Veterans Alliance has the strongest opposition to any pharmacy fee inside of the military treatment facility. Any proposal that includes MTF pharmacy fees would be a gross breach of faith and a violation of the military health care promise. The National Military

Veterans Alliance would urge that any proposed benefit would allow military healthcare beneficiaries access to all FDA approved drugs for all beneficiaries regardless of age or geographical location. Additionally, although we support the maximum use of generic drugs, if a particular brand or new drugs are needed, they should be made available. While management efficiencies and a centralized data base can provide some savings, the pharmacy redesign cannot be fully funded from within current resources without a reduction elsewhere in the DHP. Since the DHP is already not fully funded, this would create serious problems.

MEDICAL CORPS END STRENGTH

It is not cost-effective to include military health care personnel in the down-sizing efforts of DoD. Rising costs of health care maintenance organizations (HMOs) substantiate that the overall costs of the military health system (MHS) to the taxpayers will be significantly reduced if military beneficiaries (active duty, retirees and their family members) are treated, to the optimum capacity, in the military treatment facilities. Breaking out the health care billets from the overall force strength will ensure quality, cost-effective care by the MHS and eliminate the competition for billets as identified for both military and medical readiness.

UNIFORMED SERVICES UNIVERSITY OF THE HEALTH SCIENCES

The National Military/Veterans Alliance thanks this committee for its strong support for providing necessary funding for the continued operations of the Uniformed Services University of the Health Sciences. Study after study has shown that when all factors are considered USUHS is more cost effective that the US Health Profession Scholarship Program. We urge you to continue your support for this school which is a national resource.

RETIREE DENTAL PROGRAM

The unsubsidized Retiree Dental Program which recently began enrolling retirees has already signed up over 100,000 military families. The program should be reviewed as we obtain experience this year to determine what adjustments in benefits should be made to meet the needs of beneficiaries and remain cost effective to them.

UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

The National Military/Veterans Alliance wants to take a moment to support the USFHP program offered by the seven TRICARE Designated Providers, also known as USTFs. We see it as a choice for certain populations and a choice that is highly rated by beneficiaries. The USTFs have transitioned to TRICARE Prime and are doing great work educating beneficiaries on all options available to them, including those offered by the Managed Care Support Contractor in the region. Additionally, the nine Uniformed Services Treatment Facilities continue to treat military beneficiaries through their USFHP at a satisfaction rate of well over 90. They use the same fee structure as TRICARE providers. The Facilities offer the only DoD sponsored program that is keeping the military healthcare promise by guaranteeing care to Medicare eligible military beneficiaries fortunate enough to live near them and obtain care there. We thank this committee for its support for the USTFs in the past and urge you to continue to support their operation.

Both the Managed Care Support Contractors and the USTFs provide essentially the same benefit at essentially the same cost to the government. The programs differ in the local networks of doctors and hospitals available to beneficiaries. Some beneficiaries find one network more to their liking; others find it easier to access care in the competing network.

Since the benefit packages and costs are essentially the same, this should be purely an issue of beneficiary choice and ease of access to care. Yet, while retirees and their eligible family members may enroll in the TRICARE Prime networks offered by a Managed Care Support Contractor for a twelve month commitment at any time during the year, this opportunity is available only one month each year for the TRICARE Prime program offered by the USTFs. In the interest of beneficiary choice and improving access to care by retirees and family members, we encourage you to allow enrollment into both TRICARE Prime programs year round.

CLOSING

Mr. Chairman, the National Military/Veterans Alliance thanks you and this subcommittee for holding this hearing and we urge immediate action to expand the FEHBP test now, so that all retired military beneficiaries can begin enrolling and receiving care in the year 2000.