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DEFENSE HEALTH CARE

Management Attention Needed to Make TRICARE More Effective and User Friendly

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Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Defense's (DOD) implementation of TRICARE--its managed health care program. After years of testing alternative health care delivery systems, DOD began restructuring its system into TRICARE in 1993. Today, over 8.1 million active-duty personnel, their dependents, and retirees are eligible to receive care in this $15.6 billion-per-year health care system. TRICARE was designed to improve beneficiaries' access to health care while maintaining quality and controlling costs in a time of military downsizing and budgetary concerns.

Since TRICARE's inception, we have reported on the progress DOD has made in implementing TRICARE and the challenges that remain. Last June, TRICARE became a nationwide program when the last contract covering the Northeast became operational. As the program intended, many non-active-duty beneficiaries have opted to enroll in the managed care option called TRICARE Prime. As of the end of last year, 70 percent of eligible active-duty family members and 23 percent of retirees under age 65 had enrolled in TRICARE Prime. However, several concerns we have raised in the past about operational issues continue to affect TRICARE's progress.

My statement today will focus on four specific TRICARE issues: the extent to which (1) beneficiaries enrolled in TRICARE are getting timely access to health care, (2) claims for medical services are paid in a timely and accurate manner, (3) DOD and its contractors are identifying and mitigating fraud and abuse in TRICARE, and (4) DOD's pharmacy programs are cost-effective and consistently serve the needs of all beneficiaries. The information I am presenting is based on our completed and ongoing studies. This work includes visits to 29 military medical facilities to explore the issues at the hospital level, where care is provided. In addition, we obtained and analyzed nearly 20 million completed claims to determine whether they were processed in a timely manner. (A list of our products related to TRICARE appears at the end of this statement.)

We recognize that DOD has faced a huge undertaking in reforming its health care system. Balancing medical readiness needs with the perceived promise of peacetime care for beneficiaries who have come to rely on the military health care system has been challenging, and DOD has made strides in delivering health care to its beneficiaries, including those over age 65. However, issues surrounding the day-to-day operations of the health care system continue to surface, and much still remains to be done before TRICARE becomes the smoothly running, beneficiary-friendly endeavor envisioned by its developers.

In summary, DOD is not meeting its standards for scheduling beneficiary appointments, even for active-duty members. Also, even though contractors are meeting TRICARE claims processing timeliness standards, millions of claims are paid late, and claims processing continues to burden beneficiaries, civilian providers, and TRICARE contractors and managers. Additionally, although DOD has efforts under way to combat health care fraud, these efforts have not yet been effective, and additional opportunities exist to save hundreds of millions of dollars. Finally, to cost-effectively meet beneficiaries' needs for prescription drugs, a top-to-bottom redesign of the pharmacy programs of DOD and its contractors is needed. We have offered a number of recommendations regarding timely access to appointments and the pharmacy programs, which we believe, and DOD agrees, should help address these issues. Whether these operational difficulties will continue depends largely on the extent to which TRICARE management increases its attention and actions to fully resolve these problems.

BACKGROUND

DOD's primary medical mission is to maintain the health of active-duty service personnel and to provide health care during military operations. DOD also offers health care to non-active-duty beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees, if space and resources are available. Care for eligible beneficiaries is managed on a regional basis using primarily military hospitals and clinics supplemented by contracted civilian services. TRICARE is a triple-option benefit program designed to give beneficiaries a choice among a health maintenance organization (TRICARE Prime), a preferred provider organization (TRICARE Extra), and a fee-for-service benefit (TRICARE Standard). TRICARE Prime is the only option for which beneficiaries must enroll.

To better ensure timely access to health care, in 1994 DOD established access standards for appointment timeliness similar to those used by commercial managed care programs. For example, DOD's standards establish the maximum wait times between the day a Prime enrollee requests an appointment with his or her primary care physician and the actual date of the visit. The standards require that acute illness visits be scheduled within 1 day, routine visits within 1 week, and well (preventive) visits within 4 weeks. DOD also established a 4-week standard for referrals from a primary care physician to a specialist. These standards apply not only for appointments within the military medical facilities but also for appointments with physicians in the TRICARE civilian network who treat Prime enrollees. In

June 1998, DOD established a goal that at least 98 percent of the acute and routine primary care appointments for Prime enrollees fall within the standards.

During 1998, contractors processed about 28 million health care claims submitted by institutions, health care providers, and beneficiaries. DOD requires TRICARE contractors to process 75 percent of claims within 21 days and to maintain a 98-percent payment accuracy rate. In addition, DOD requires contractors to use ClaimCheck, a commercial off-the-shelf software program that analyzes the appropriateness of billing on professional claims. Timeliness and accuracy standards vary by private plans.

To help safeguard against health care fraud and abuse in its system, DOD established a Program Integrity unit in 1982 to coordinate its antifraud activities. This unit is responsible for developing policies and procedures regarding the prevention and detection of TRICARE fraud and abuse. The Defense Criminal Investigative Service within DOD's Office of Inspector General and the Department of Justice work in conjunction with this unit to investigate and prosecute alleged health care fraud and abuse. DOD's contracts with its five managed care support contractors also require them to perform antifraud activities to ensure that TRICARE dollars are used to pay only claims that are appropriate.

DOD's pharmacy benefits, which are available through military pharmacies, TRICARE contractors' retail pharmacies, and a national mail-order service, cost an estimated $1.3 billion in fiscal year 1997. The largest DOD pharmacy program is the outpatient pharmacies operated in military medical facilities, which dispensed about 55 million prescriptions in 1997, costing an estimated $1 billion. The military medical system is supplemented by five contractors' retail pharmacy programs and the national contractor's mail-order pharmacy program, which delivers 30- to 90-day supplies of certain medications. In the private sector, fee-for-service and managed care plans increasingly work with pharmacy benefit managers (PBM), who provide high-quality pharmaceutical care at the lowest possible cost. PBMs employ a number of best business practices, such as formulary development, therapeutic interchange, and drug utilization review.[1]

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[1]A formulary is a list of prescription drugs, grouped by therapeutic class, that a health plan prefers its physicians and beneficiaries use. Drugs are chosen for a formulary on the basis of medical value and price. Therapeutic interchange programs substitute formulary drugs for nonformulary medications, usually with physician consent. Such programs encourage patients to use, and physicians to prescribe, less expensive brand-name formulary drugs, which are considered to be as safe and effective as other, more expensive brand-name nonformulary drugs. Drug utilization review programs analyze patterns of drug use to prevent adverse drug reactions. PBMs use this information to make prescription substitution recommendations to physicians and to inform plans and physicians about physicians'

MANY BENEFICIARIES, INCLUDING THOSE ON ACTIVE DUTY, DO NOT HAVE TIMELY ACCESS TO APPOINTMENTS

Many Prime beneficiaries, including active-duty members, have not been able to obtain appointments at military facilities within DOD's established standards for appointment timeliness. DOD lacks data to determine if Prime beneficiaries have been able to obtain appointments with civilian providers within the required standards. Only recently has DOD measured the performance of its military medical facilities in meeting the access standards; consequently, DOD has not been in a position to take steps to address and improve access.

Many Appointments in Military Hospitals Are Not Made Within Standards

Our review of DOD data indicates that many Prime beneficiaries did not obtain acute and routine appointments with military providers within the access time standards established by DOD. Surprisingly, even active-duty members, for whom the military medical system was established, were not always able to obtain appointments within the standards. Although TRICARE is intended to give appointment priority to beneficiaries enrolled in Prime, they did not report better appointment timeliness than those who were not enrolled. According to data from DOD's Customer Satisfaction Survey,[2] the percentage of Prime beneficiaries obtaining appointments within the standards fell short of DOD's goal of 98 percent for acute and routine appointments. Some examples follow.

- About 80 percent of Prime beneficiaries requesting an acute appointment reported they obtained it within the 1-day standard.

- About 81 percent of Prime beneficiaries requesting a routine appointment reported they obtained it within the 1-week standard.

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prescribing patterns.

[2]DOD sends the Customer Satisfaction Survey to a sample of patients each month to obtain information on their access to and satisfaction with outpatient care provided in military medical facilities. We are currently reviewing DOD's survey methodology and data to determine what limitations, if any, exist.

- About 81 percent of active-duty members requesting an acute appointment reported they obtained it within the 1-day standard.

- About 79 percent of enrolled active-duty family members and retirees reported they obtained a routine appointment within the 1-week standard--the same percentage reported by those family members and retirees who were not enrolled.

Although DOD has not established a goal for preventive or specialty appointments, Prime beneficiaries who requested these appointments fared better than those requesting acute or routine appointments.

- About 96 percent of Prime beneficiaries requesting a preventive-care appointment reported they obtained it within the 4-week standard.

- About 93 percent of Prime beneficiaries requesting an appointment with a specialist reported they obtained it within the 4-week standard.

There are several reasons why beneficiaries may not obtain appointments within the access standards. DOD officials told us that beneficiaries calling for routine appointments might prefer a later appointment--one outside the standard--for their personal convenience. In other cases, appointment availability may be affected by the amount of care provided to non-enrolled beneficiaries by providers at military medical facilities. For example, at one military medical facility, our review of appointment data shows that about one-third of the acute and routine primary care appointments were booked by beneficiaries who were not enrolled in TRICARE. We could not determine specifically why appointments for Prime beneficiaries were not within the access standards because DOD's appointment data do not capture the reasons for noncompliance with the standard. Also, DOD officials could not provide estimates on the extent to which appointments not within the standards resulted from the patient's preference for a later appointment or from the nonavailability of appointments.

DOD's performance in meeting the access standards in the military medical facilities corresponds to the beneficiaries' ratings of various aspects of access. About 80 to 85 percent of the Prime beneficiaries rated their experience as "good," "very good," or "excellent" in terms of the length of time it took to get an appointment, the ease of making the appointment, and

overall access to medical care when they need it. However, non-enrolled beneficiaries reported similar ratings for the same aspects of access, which indicates enrolled beneficiaries did not report better experiences than those who were not enrolled.

DOD Lacks Data to Measure Civilian Provider Appointment Timeliness

DOD lacks data comparable to the data derived from its Customer Satisfaction Survey to determine if beneficiaries who visited TRICARE civilian providers obtained appointments within the required access standards. However, through its annual Health Care Survey of DOD Beneficiaries, DOD does collect information on beneficiaries' experiences with both civilian and military health care providers, including how long it took to obtain an appointment. The appointments described in the Health Care Survey, however, do not correspond to the appointments for which access standards were established, and, therefore, the survey cannot be used to measure whether appointments were obtained within the required time frames. The survey enables a comparison of the beneficiaries' access to civilian providers relative to military providers. Our review of the survey data indicates that enrolled beneficiaries who visited civilian providers reported getting appointments more quickly than those who received care from military providers. For example, about 70 percent of the beneficiaries enrolled in Prime reported getting an appointment with a civilian provider within 7 days, compared with 57 percent of those visiting a military provider for the same type of appointment. The survey also shows that Prime beneficiaries who visited civilian providers rated their access higher than those visiting military providers, with 84 percent considering their access to appointments as "good," "very good," or "excellent," compared with 63 percent of those who received care from military providers.

DOD Has Been Slow to Measure and Improve Access

DOD has been slow to take steps to improve access. In 1996, we recommended that DOD collect data on the timeliness of appointments to measure TRICARE's performance in improving beneficiary access.[3] Although DOD has collected some data through its surveys on beneficiaries' experience in obtaining appointments, in 1998 we reported that DOD was not measuring its performance in meeting TRICARE access standards.[4] Subsequently, the Strom Thurmond National Defense Authorization Act for Fiscal Year 1999 (P.L. 105-261) (the Defense Authorization Act) required DOD to establish a system to measure appointment timeliness. Rather than developing a new system, DOD plans to use its existing Customer Satisfaction Survey to meet the act's requirements for care provided in military medical facilities. Recently, DOD analyzed the Customer Satisfaction Survey data to identify which military facilities have not been meeting the standards; DOD now plans to enhance and use information from its military facility appointment systems to supplement the survey data. To measure its civilian providers' performance in meeting the appointment standards, DOD plans to develop a questionnaire modeled after the Customer Satisfaction Survey, as we recommended in 1998.[5] DOD estimates this survey will not be fully implemented before fiscal year 2000.

CONCERNS EXIST ABOUT THE TIMELINESS AND ACCURACY OF CLAIMS PROCESSING

Our analysis of a 1-year period of processed claims has shown that TRICARE's contractors met DOD's timeliness standards by paying over 75 percent of claims within 21 days.[6] Even though DOD paid the vast majority of claims on time, nearly 3 million were paid late. Moreover, DOD does not know whether contractors are paying claims accurately because less than half of the processed claims are subject to the audit and the methodology used to calculate payment error is statistically unsound. According to contractors, the principal reasons for claims processing problems are the complexity of the TRICARE program, frequent program changes, and DOD's delays in directing

[3]Defense Health Care: New Managed Care Plan Progressing, but Cost and Performance Issues Remain (GAO/HEHS-96-128, June 14, 1996).

[4]Defense Health Care: Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE (GAO/T-HEHS-98-100, Feb. 26, 1998).

[5]Defense Health Care: DOD Could Improve Its Beneficiary Feedback Approaches (GAO/HEHS-98-51, Feb. 6, 1998).

[6]The analysis includes claims from Foundation Health Federal Services, Inc.; Humana Military Healthcare Services, Inc.; and TriWest Healthcare Alliance, Inc., but not from Anthem Alliance for Health, Inc., or Sierra Military

them to implement identified changes. On average, 130 changes were made for each contract. Further, DOD's claims editing software is impeded by program changes and implementation delays. DOD has a number of initiatives under way to improve claims processing activities, but it remains to be seen how effective these actions will be.

Timeliness Standards Were Met Overall, but Some Impediments Exist

Our analysis showed that the three contractors responsible for 8 of the 11 TRICARE regions were meeting DOD's contractual timeliness standard of processing 75 percent of claims within 21 days. In fact, between July 1997 and June 1998, these contractors exceeded the standard by processing 86 percent of claims on time. However, nearly 3 million claims did not meet the timeliness standard, and more than 80 percent of these were from physicians and other professional providers. Furthermore, only 66 percent of claims from hospitals and other institutions were processed within 21 days. Hospital claims take longer to process for many reasons, such as their higher cost, their numerous line items, and the need for review by a medical professional. In contrast, 97 percent of pharmacy claims met the standard. Pharmacy claims were processed more quickly because they are usually simpler and because 90 percent are submitted electronically, which can speed processing.

Through discussions with contractors, DOD has identified changes that could improve claims processing timeliness as well as other aspects of the program. One of these proposed changes would eliminate unnecessarily prescriptive requirements for assessing the medical necessity of care provided and allow contractors to select and use a nationally accepted criterion. The current adjudication process is slowed because contractors must review and follow extensive criteria to determine whether payment should be allowed. A second initiative would adopt Medicare's timeliness standards, which differentiate between paper and electronic claims, and require contractors to pay interest on late claims. Medicare requires that 95 percent of complete electronic claims be paid in 14 days and that 95 percent of complete paper claims be paid in 30 days. Another initiative would adopt Medicare's practice of returning incomplete claims. By adopting Medicare's standards and practices, DOD would be mirroring a program that is more familiar to providers. These initiatives should help improve the completeness of claims initially received as well as provide incentives for contractors to process claims timely. In addition, they should increase the submission of electronic claims, which are paid faster and are less

expensive to process.

Claims Processing Accuracy Is Unknown; Program Complexity Affects Processing Accuracy

DOD uses external audits to assess contractors' compliance with payment accuracy standards by sampling processed claims and calculating the percentage of dollars paid in error. However, the method for these audits is statistically unsound and does not accurately represent the amount of overpayment and underpayment for two reasons. First, the sample excludes all claims under $100; consequently, only about 40 percent of processed claims are subject to the audit for payment accuracy. Second, the amount of inaccurate payments is calculated in such a way that the computed error rate is not representative of all claims subject to audit for that period. Therefore, the calculated error rate is not an accurate indicator of overall payment processing accuracy.

We applied appropriate statistical methods to the same data DOD used in its quarterly audit reports and recomputed error rates. Rates were generally higher, in one instance increasing from 5.5 percent to 10.5 percent. Another useful measure would be to calculate the number of claims processed accurately as a percentage of the total number of claims processed. When accuracy is calculated using this method, error rates for some of the contract periods we examined were as high as 25 percent.

Contractors told us that, of the many programs they administer--including Medicare as well as private plans--TRICARE is the most complicated and unique, which contributes to claims processing difficulties. The following features contribute to TRICARE's complexity.

- Each of TRICARE's three options has a different array of benefits, copayments, and deductibles. Claims require different adjudication procedures depending on which option is involved, and, even within each option, different claims processing rules apply.

- For the Prime and Extra options, provider reimbursement information is difficult to accurately maintain because payment agreements are complicated, and individual providers may belong to multiple practices with varying agreements.

- Claims submitted under the Standard option are also confusing to process because providers have the option of accepting TRICARE payment in full or

charging up to an additional 15 percent on a claim-by-claim basis.

- TRICARE is always the final payer when other health insurance is involved. Thus, contractors must understand the requirements of many other programs' benefit structures and obtain reimbursement information before the claim can be processed to completion.

Further compounding claims processing complexity are TRICARE's frequent program changes, which usually require contract modifications. According to contractors, their ability to process claims accurately is impeded because most changes require them to reprogram and test systems as well as retrain staff. In the future, DOD hopes to resolve some of these problems by consolidating changes and providing longer notification periods.

Providers and beneficiaries also contribute to problems with claims processing accuracy because they sometimes submit claims with inaccurate information. Subsequently, when the errors are identified, the claim must be resubmitted and reprocessed. Contractors told us that because TRICARE usually represents a small percentage of most providers' practices, providers have little incentive to educate themselves on its complex and frequently changing requirements.

DOD Management Problems Impede the Effectiveness of ClaimCheck

DOD's commercial claims editing software, ClaimCheck, is designed to ensure that providers are accurately reimbursed for services provided. During fiscal year 1998, ClaimCheck saved over $53 million and affected 3.5 percent of claims. ClaimCheck is a key player in the claim editing software industry, with over 200 customers nationwide, including over 60 percent of BlueCross BlueShield carriers and the Department of Veterans Affairs. In October 1998, the Health Care Financing Administration (HCFA) started using ClaimCheck to prevent overpayments in the Medicare program.

Despite ClaimCheck's general acceptance in the insurance industry, providers have expressed concerns about it, including its proprietary nature, doubts about its accuracy, the unavailability of edit explanations, and the lack of available recourse. While ClaimCheck edits are not published and available to providers, they are based upon industry standards, and TRICARE providers can request and receive information on specific edits. However, we identified a few instances in which DOD's version of ClaimCheck did not comply with industry standards because DOD was slow to implement policy changes that affected the software's outcomes.

Providers' frustrations have been compounded by DOD's poor communication with its contractors regarding the recourse available to providers and beneficiaries for questioning ClaimCheck determinations. DOD told contractors that ClaimCheck determinations could not be appealed but did not sufficiently communicate to contractors that an allowable charge review process could be used for reviewing ClaimCheck determinations. As a result, contractors improperly informed providers and beneficiaries that they had no recourse when ClaimCheck denied or modified a claim. After beneficiaries and providers complained that DOD and its contractors did not make a review process available to them, the Congress mandated in the Defense Authorization Act that DOD establish an appeals process for ClaimCheck denials.

DOD COULD SAVE HUNDREDS OF MILLIONS OF DOLLARS WITH A MORE EFFECTIVE ANTIFRAUD PROGRAM

While DOD does not know the precise extent of military health care fraud and abuse, it estimates the losses to its TRICARE program to be in the hundreds of millions of dollars annually. In addition to the financial loss, health care fraud also affects the quality of care provided and may cause serious harm to patients' health. Despite its responsibility to prevent and detect health care fraud, DOD has not been effective in doing so, recovering less than 3 percent of its estimated losses to fraud and abuse between 1996 and 1998. DOD has the opportunity to improve its antifraud efforts by developing clear and measurable goals and ensuring contractor compliance with these requirements. Moreover, DOD could benefit by increasing beneficiary awareness of fraud and abuse, ensuring that DOD knows the individual provider rendering medical care rather than the clinic or group practice, and including health care fraud in the agency's strategic plan with goals for program performance and measurable results.[7]

[7]The Government Performance and Results Act of 1993 (the Results Act) requires agencies to clearly define their missions, set goals, measure performance, and report on their accomplishments.

Hundreds of Millions Are Lost Annually to Fraud

DOD estimates that losses due to fraud and abuse account for 10 to 20 percent of military health care expenditures. These ranges are consistent with estimates of other public and private sector organizations, such as HCFA, the U.S. Chamber of Commerce, the Health Insurance Association of America, and the National Health Care Anti-Fraud Association. Given TRICARE's expenditure of about $2.5 billion for contracted civilian-provided care in fiscal year 1998, DOD could be losing between $250 million and $500 million annually to fraud and abuse.

Although anyone involved in health care can commit fraud, the primary perpetrator is the health care provider. Common types of provider fraud include billing for services not rendered, misrepresentation of services, and conducting unwarranted medical procedures or withholding necessary ones. For example, illegal practices such as "sink testing," which involves dumping patients' blood and urine specimens rather than actually performing the necessary tests, can result in incorrect diagnoses and inadequate medical treatment.

DOD's Efforts to Prevent and Detect Fraud and Abuse Need to Be More Effective

DOD officials told us they primarily focus on identifying high-dollar fraud cases and those involving patient harm. As shown in table 1, between 1996 and 1998, DOD recovered about $14 million in fraudulent payments. However, this amount is negligible when compared with DOD's estimated losses of between $570 million and $1.1 billion during the same period. Additionally, DOD participated in investigations, in conjunction with the Department of Justice and HCFA, of TRICARE and other government health care programs that resulted in penalties, fines, and other assessments totaling approximately $804 million; 199 criminal charges; and 150 civil settlements. DOD officials told us, however, that they could not identify what portion of these financial restitutions, criminal charges, and civil settlements was solely attributable to DOD efforts.

Table 1: Results of Antifraud and Abuse Efforts

Year	DOD estimates of fraud and abuse[a] (in millions)	Fraudulent payments recovered[b] (in millions)	Penalties, fines, and other assessments[b] (in millions)	Number of criminal charges[b]	Number of civil settlements[b]
1996	$130-260	$1.2	$23.5	53	24
1997	190-380	7.1	686.6	61	37

1998	250-500	6.1	93.7	85	89
Total	**$570 - 1,100**	**$14.4**	**$803.8**	**199**	**150**

[a]These figures represent DOD's estimate of 10 to 20 percent of program dollars lost to fraud and abuse.

[b]These figures could be related to cases identified in previous years.

Although DOD officials told us that TRICARE contractors play a critical role in combating fraud and abuse, the contractors have identified and referred relatively few potential fraud cases to DOD. Table 2 shows that, of approximately 50 million claims processed between 1996 and 1998, contractors referred only about 100 potential fraud cases to DOD for further development and investigation. Contractor officials told us that they have not been active in identifying potential fraud cases because their antifraud staff spend the majority of their time responding to DOD requests for information related to cases under investigation. TRICARE contractors also told us they were unclear about the types of potential fraud cases to refer to DOD for further development and were not adequately trained to identify fraud and abuse. In addition, DOD officials told us that, because two of the five contractors were relatively new to the TRICARE program, they had not yet compiled data to identify fraudulent behavior. DOD officials acknowledged that they could be more effective in combating fraud and abuse if their TRICARE contractors were more proactive in identifying and referring potential fraud cases.

Table 2: Claims Processed and Cases Referred by TRICARE Contractors, 1996-98

TRICARE contractor	Claims processed (in millions)	Referrals of potential fraud cases[a]
Foundation Health Federal Services, Inc.	25.7	92
Humana Military Healthcare Services, Inc.	14.5	4
TriWest Healthcare Alliance, Inc.	6.1	3
Anthem Alliance for Health, Inc.	2.7	2
Sierra Military Health Services	1.0	0
Total	**50.0**	**101**

[a]Potential fraud cases may involve multiple claims. These figures do not include balance billing and provider participation violations.

Source: DOD.

Opportunities Exist to Improve Antifraud Efforts

To reduce its vulnerability to fraud and abuse, DOD needs to develop and implement clear and measurable antifraud goals and objectives and ensure that contractors comply with these requirements. According to DOD officials, existing antifraud contract requirements are vague and do not require contractors to be proactive in their antifraud activities. DOD officials are in the process of implementing new antifraud program requirements for DOD contractors, such as requiring them to establish a corporate antifraud commitment, implement fraud identification software, and coordinate their antifraud efforts with one another. However, these new policy requirements still do not specify a level of effort or establish performance outcome measures. DOD officials stated that incorporating greater specificity and performance measurements into their managed care support contracts will improve the effectiveness of its antifraud program, and DOD is currently exploring ways to do so.

In addition, DOD has not adequately monitored its contractors' antifraud efforts. For example, since the inception of its managed care contracts, DOD has conducted only one performance evaluation of one contractor's antifraud activities. DOD officials told us that they have no plans to conduct any additional performance evaluations of contractors' antifraud activities.

DOD could also improve its antifraud efforts and increase beneficiary awareness of fraud and abuse by ensuring that its TRICARE contractors provide a fraud hot line number and address on the "Explanation of Benefits" sent to beneficiaries. Only one of the five TRICARE contractors is currently doing so. DOD and TRICARE contractor officials agree that this is an inexpensive and effective tool to use in combating health care fraud. DOD officials told us that they have directed all TRICARE contractors to provide a fraud contact on the "Explanation of Benefits" sent to beneficiaries.

Furthermore, DOD would benefit from knowing the individual provider rendering medical care rather than simply the clinic or group practice. Claims submitted by a clinic or group practice can mask individual provider fraudulent activity, such as overbilling and submitting duplicate bills. If claims do not identify individual providers, DOD lacks information to track and monitor whether a physician is engaged in fraudulent practices. Although TRICARE policy requires that claims be denied when submitted as part of a clinic or group practice, DOD waived this requirement in 1996. In the last 3 years, DOD has allowed payment on over 6 million claims totaling about $500 million that were submitted by a group or clinic. DOD officials acknowledged that information on individual providers is needed for fraud, abuse, and quality of care purposes and said that they are in the process of reinstating the requirement.

Finally, given the threat that health care fraud poses to program funds and patient well- being, DOD also needs to include in its strategic plan how it will address health care fraud and abuse. Specifically, officials at DOD agree that articulating its strategies, goals, and objectives in its strategic plan would help in combating health care fraud and abuse in the future.

NEED FOR TOP-TO-BOTTOM REDESIGN OF PHARMACY PROGRAMS

During the past several years, the Congress has grown concerned about the costs and quality of DOD's pharmacy benefit and, in 1998, mandated that we review DOD's pharmacy programs. We found that the problems DOD is experiencing delivering its pharmacy benefit stem largely from the way DOD manages its $1.3 billion pharmacy programs. Although the military and contractor retail and mail-order pharmacy programs share the same beneficiary population and are otherwise highly interrelated, DOD has adopted a program-by-program focus rather than a systemwide view of these operations. As a result, changes made to one program inevitably affect the others, and cross-program problems--such as nonintegrated databases and different formulary, eligibility, and copayment requirements--are having substantial, unintended cost and beneficiary consequences.

DOD and the Contractors Lack the Information Needed to Effectively Manage Pharmacy Programs

DOD lacks the comprehensive prescription drug cost and utilization data that PBMs and their health plan sponsors routinely track and analyze to manage pharmacy benefits and control costs. A root cause of the problem is that existing pharmacy patient databases at the military medical facilities, regional TRICARE contractors, and national mail-order pharmacy contractor are not integrated. Although most military beneficiaries regularly obtain prescription drugs from multiple dispensing outlets across DOD's three pharmacy programs, no centralized computer database exists with each patient's complete medication history. Millions of dollars in unneeded costs from overutilization as well as patient safety problems from adverse reactions to prescription drugs are likely occurring because DOD and its contractors lack the databases needed to support automated prospective drug utilization review systems to review prescriptions before they are dispensed. Moreover, the situation has allowed beneficiary prescription drug stockpiling to become so pervasive among military facility pharmacies that pharmacists commonly refer to the problem as "polypharmacy"--or the beneficiaries' practice of visiting multiple pharmacies to accumulate more prescription drugs than needed.

In contrast, automated review systems are widely employed by PBMs to reduce inappropriate prescription drug use, which can cause adverse reactions leading to illness, hospitalization, and even death. Since we issued our report, DOD has stepped up its efforts to plan for, acquire, and install an estimated $5 million pharmacy patient data system by March 2000 that will support automated drug utilization reviews on a limited basis.[8]

[8] Defense Health Care: Fully Integrated Pharmacy System Would Improve Service and Cost-Effectiveness (GAO/HEHS-98-176, June 12, 1998).

At the same time, DOD continues to study alternative information technology approaches to implement a comprehensive pharmacy patient management system. DOD may have a cost estimate and completion date for this system later this summer. Last year, DOD pharmacy officials estimated the 10-year cost of a similar system at $43 million. Such a system would save $424 million over the same period and substantially reduce patient safety risks.

Applying Commercial Best Practices Could Reduce Costs and Enhance Care Quality

In addition to integrated databases, PBMs use other practices to control costs and provide quality service. For example, PBMs offer health plan sponsors uniform formularies for beneficiaries as well as help in designing standard beneficiary eligibility criteria and cost-sharing to provide incentives for physicians to prescribe and beneficiaries to use formulary drugs. Features such as copayments for nonformulary drugs, for example, can create the incentives or disincentives crucial to balancing the health plan's financial soundness with beneficiaries' freedom to choose pharmacies and drugs.

While DOD's goal is to provide uniform pharmacy benefits, its programs operate under a complicated and confusing array of different policies, regulations, and contractual requirements governing such key benefit design elements as eligibility, drug coverage, and cost-sharing. For example, DOD's formularies vary depending on where the beneficiary gets the drugs. As a result, beneficiaries experience drug coverage and availability uncertainties and unnecessary costs. The lack of a uniform formulary drives up costs in other ways as well, such as by causing cost-shifting among military facilities because pharmacy patients have to "shop around" for prescriptions. Also, although all military beneficiaries obtain drugs from military medical facilities free of charge, the national mail-order and TRICARE contractors' programs require copayments regardless of whether the drugs are formulary or generic. Finally, most of DOD's 1.4 million Medicare-eligible beneficiaries lack a systemwide prescription drug benefit and thus have a serious coverage gap because Medicare does not cover outpatient prescriptions. Such problems prevent other PBM practices from being fully and systematically applied in DOD's pharmacy programs.

Establishing a uniform formulary with incentives for physicians to prescribe and beneficiaries to use formulary drugs could help reduce current benefit variability and increase cost-effectiveness. With an incentive-based formulary, DOD and its contractors could provide nonformulary drugs but require beneficiaries to make higher copayments than for formulary or generic drugs. Also, like private sector plans and PBMs, DOD could

negotiate deeper price discounts from drug companies seeking formulary approval for their products. But, for systemwide effectiveness, such a formulary may require military facility prescription drug copayments, which DOD believes it lacks authority to impose. Nonetheless, the existing pharmacy benefit variation, combined with nonintegrated databases, prevents DOD and its contractors from fully applying other PBM best practices, such as analyzing drug use to curb inappropriate use and to introduce less costly generic and therapeutic substitutes as well as identifying and, as appropriate, educating physicians who prescribe too many or nonformulary drugs. Such approaches have enabled private sector health plans to reduce their costs by an estimated 10 to 20 percent. On this basis, a uniform, incentive-based formulary could save an estimated $61 million to $107 million annually, and other PBM practices could save another $99 million to $197 million annually.

Mail-Order Program and Retail Pharmacy Proposal May Further Fragment Health Care Services and Raise Costs

In April 1998, DOD replaced the TRICARE contractors' mail-order pharmacy services with a separate national contract to help control the contractors' rising prescription drug costs. The purpose was to extend to contractors' mail-order services the discount drug prices previously available only to military facility pharmacies' prescription drug services.[9] Also, when the next round of TRICARE managed care support contracts phases in, DOD plans to carve out and provide under one national contract the TRICARE contractors' retail pharmacy services. These initiatives, however, may further fragment DOD's health care services and raise costs for TRICARE contractors, because the initiatives divorce contractors' medical care management from their pharmaceutical care, and this integration is important in maintaining the beneficiary population's good health.

An alternative would allow military medical facilities and TRICARE contractors to institute electronic billing and reimbursement once they integrated their pharmacy patient databases. With electronic billing and reimbursement, military facilities could continue, and possibly increase, the volume of pharmacy services they provide to TRICARE contractors' beneficiaries. By reimbursing military medical facilities, TRICARE contractors could potentially save money by directing their beneficiaries to these facilities to obtain medications at distribution and

[9]Military medical facilities get most of their prescription drug supplies through the Defense Supply Center in Philadelphia. This DOD agency negotiates discounted drug prices through distribution and pricing agreements with over 200 drug manufacturers. These prices are between 24 and 70 percent less than average wholesale prices.

pricing agreement costs, rather than using retail pharmacies. This approach would also keep pharmaceutical and medical care administration together under existing contracts.

Funding and Formulary Management Decisions Can Limit Access to Drugs and Affect Costs

Following DOD's downsizing efforts, which reduced the number of military facilities, the remaining military medical facilities began experiencing funding reductions that made the pharmacy benefit an attractive target for cost-cutting. At the same time, the demand for prescription drugs began increasing. Also, policy changes required that beneficiaries be treated alike in dispensing formulary drugs. To control costs, military medical facilities dropped certain prescription drugs from their formularies and did not add others. This prevented beneficiaries from obtaining certain drugs at military facilities.

According to TRICARE contractors, many beneficiaries responded by buying their prescription drugs at contractor pharmacies, thereby increasing the volume of prescription drug purchases beyond what the contractors had projected in their original bids. Blaming their cost overruns on military facility formulary changes, the contractors told us they intended to seek additional compensation from DOD. A DOD consultant concluded that the contractors' pharmacy use had risen at the same time the military pharmacies' use had dropped somewhat. DOD and the contractors disagreed about the cause of the contractors' cost increases and continue to study the matter. Of course, if DOD and the contractors had used integrated pharmacy patient databases during the periods in question, establishing cause and effect for the contractors' allegations could have been greatly facilitated.

Reported Recommendations and Agency Actions

In view of these problems, we have concluded that DOD needs a top-to-bottom redesign of its pharmacy programs that effectively involves the programs' major stakeholders. Also, we believe DOD needs to commit itself to managing pharmacy programs as a system and to bringing needed reforms to the system. Otherwise, DOD's pharmacy problems will continue and likely worsen.

To help DOD establish a more systemwide approach to managing its pharmacy benefit, we have suggested that the Congress consider directing DOD to establish a uniform, incentive-based formulary across its pharmacy programs and, as appropriate, to use non-active-duty beneficiary copayments at military facilities as incentives for physicians to prescribe and beneficiaries to use formulary drugs. Also, we have suggested that the Congress may wish to give

systemwide prescription drug eligibility to Medicare-eligible retirees not now eligible for such benefits. In response, language in the Defense Authorization Act directed DOD to submit a plan this month for a systemwide redesign of the military pharmacy system and to implement its planned redesigned pharmacy system at two sites for Medicare-eligible beneficiaries by October 1999.

We have also made a series of recommendations to DOD, recognizing that some changes may require additional legislative authorities and, as appropriate, DOD should seek such authorities from the Congress. The recommendations included the following:

- Expeditiously integrate the existing military, TRICARE retail, and national mail-order pharmacies' patient databases and provide for automated prospective drug utilization review.

- Establish a uniform, incentive-based formulary for military, TRICARE retail, and national mail-order pharmacies' programs. This should include using non-active-duty beneficiary copayments at military facilities to encourage the use of formulary drugs at military, TRICARE retail, and mail-order pharmacies.

- Extend systemwide prescription drug eligibility to Medicare-eligible retirees not entitled to prescription drug benefits under the Medicare subvention demonstration and pharmacy base closure programs.

- Upon integrating the existing pharmacy patient databases, institute electronic billing and claims reimbursement among military medical facilities and TRICARE contractors.

- Direct and ensure that military pharmacies and TRICARE contractors routinely apply accepted PBM practices, such as prior authorization and physician-approved therapeutic interchange.

- Postpone awarding a separate national retail pharmacy PBM contract until the subject reforms have been implemented for current TRICARE retail pharmacy programs and until cost savings from those reforms can be compared with potential cost savings under a separate retail pharmacy contract.

DOD and the TRICARE contractors agreed with each of the recommendations, but DOD stated that although military pharmacy copayments are valid and effective, beneficiaries will resist them and perceive benefit erosion.

We believe, however, that the military facility pharmacy benefit has already eroded because of medical facility funding reductions and formulary restrictions and that our collective recommendations will help reverse this troublesome course. Furthermore, beneficiaries' general acceptance of military medical facilities' pharmacy copayments will depend on DOD's bringing about and promoting marked improvements in its overall pharmacy efficiency, cost-effectiveness, and quality. DOD also stated that extending systemwide drug eligibility to Medicare-eligible retirees will require added funding, but we believe the savings from overhauling the pharmacy system will help offset such costs.

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Mr. Chairman, this concludes my prepared statement. I will be glad to respond to any questions you or other Subcommittee Members may have. We look forward to continuing to work with the Subcommittee as it exercises its oversight of the TRICARE program.

RELATED GAO PRODUCTS

Defense Health Care: Fully Integrated Pharmacy System Would Improve Service and Cost-Effectiveness (GAO/HEHS-98-176, June 12, 1998).

Defense Health Care: Offering Federal Employees' Health Benefits Program to DOD Beneficiaries (GAO/HEHS-98-68, Mar. 23, 1998).

Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians (GAO/HEHS-98-80, Feb. 26, 1998).

Defense Health Care: Operational Difficulties and System Uncertainties Pose Continuing Challenges for TRICARE (GAO/T-HEHS-98-100, Feb. 26, 1998).

Defense Health Care: DOD Could Improve Its Beneficiary Feedback Approaches (GAO/HEHS-98-51, Feb. 6, 1998).

Defense Health Care: TRICARE Resource Sharing Program Failing to Achieve Expected Savings (GAO/HEHS-97-130, Aug. 22, 1997).

Defense Health Care: Actions Under Way to Address Many TRICARE Contract Change Order Problems (GAO/HEHS-97-141, July 14, 1997).

Military Retirees' Health Care: Costs and Other Implications of Options to Enhance Older Retirees' Benefits (GAO/HEHS-97-134, June 20, 1997).

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

Defense Health Care: New Managed Care Plan Progressing, but Cost and Performance Issues Remain (GAO/HEHS-96-128, June 14, 1996).

Defense Health Care: TRICARE Progressing, but Some Cost and Performance Issues Remain (GAO/T-HEHS-96-100, Mar. 7, 1996).

Defense Health Care: Despite TRICARE Procurement Improvements, Problems Remain (GAO/HEHS-95-142, Aug. 3, 1995).

Defense Health Care: Issues and Challenges Confronting Military Medicine (GAO/HEHS-95-104, Mar. 22, 1995).

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