STATEMENT OF THE MILITARY COALITION

on

HEALTH CARE CONCERNS OF
THE UNIFORMED SERVICES COMMUNITY

provided to the

SENATE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON PERSONNEL

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Presented by

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The Retired Officers Association

And

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National Military Family Association

Biography of Virginia Torsch, CDR, MSC, USNR
Assistant Director, Government Relations
The Retired Officers Association

CDR Virginia Torsch received her Bachelor of Science degree in Zoology from the University of Maryland in 1978, and completed her Master's of Health Science in International Health at Johns Hopkins School of Public Health and Hygiene, Baltimore, MD in 1982.

A year later, in 1983, CDR Torsch became a commissioned officer in the U.S. Navy's Medical Service Corps. She was sent to the Naval Hospital, Pensacola, FL where she served eleven months as the Assistant Comptroller. She then transferred to the Armed Forces Medical Intelligence Center, Fort Detrick, MD as a medical intelligence research specialist, writing medical studies on countries in Southeast Asia. Three years later in 1987, CDR Torsch transferred to the Pentagon where she served on the Navy Surgeon General's staff as the Assistant for Fleet Support in the Medical Operations and Planning Division. During this tour, CDR Torsch also completed the Naval War College's seminar program, graduating with distinction in 1989. In November 1990, CDR Torsch affiliated with the Navy Reserves where she is currently Officer in Charge of a reserve unit at the Portsmouth Naval Hospital, Portsmouth, VA

In December, 1990, after leaving active duty, CDR Torsch joined the Strategy 2000 staff at the Paralyzed Veterans of America where she assisted with the development and publication of Strategy 2000: The VA Responsibility in Tomorrow's National Health Care System, which analyzed the potential impact of national health care reform on the VA medical care system. While at PVA, CDR Torsch followed and analyzed health care reform legislation and initiatives, both at the national level and at the state level. In October, 1992, CDR Torsch joined the staff at The Retired Officers' Association as the Assistant Director of Government Relations, Health Affairs, where she continues to follow health care reform legislation and its potential impact on the military health services system. CDR Torsch has also assisted with the development and publication of TROA's Principles and Recommendations for Health Care Reform and serves as co-chairman of the Military Coalition's Health Care Committee.

CDR Torsch's military awards include the Defense Meritorious Service Medal and two Navy Commendation Medals. She currently resides in Annandale, Virginia.

The Retired Officers Association does not and has not received any federal grants, and does not have nor has had any contracts with the federal government.

Biography of Mrs. Sydney Tally Hickey
Associate Director, Government Relations Department, National Military Family Association

As the spouse of a retired Naval officer and an Air Force daughter, Mrs. Hickey has been a military family member for most of her life. She attended Florida State University and was graduated from Johns Hopkins University in 1961 with a B.S. in Nursing. She pursued her chosen specialty of Public Health Nursing in the states of Washington and Florida - and several in between. "Retiring" from remunerated work on the birth of her first daughter, she became a full time wife and mother and part time volunteer.

Her volunteer positions included: Navy Relief interviewer, teaching assistant, Brownie and Girl Scout Leader, Red Cross pediatric nurse, Commissary, Exchange and Hospital Board member, and President of four Naval Officers' Wives' Clubs. She continues her commitment to volunteer activities as a member of the Ecumenical Commission of the Episcopal Diocese of Virginia.

In 1983 she joined the Government Relations Staff of the National Military Family Association and served as the Director of the Department from 1987 to 1990. On January 1, 1990, she was competitively selected to become the Association's first paid professional staff member and currently serves as Associate Director, Government Relations. Mrs. Hickey supervises the preparation and delivery of the Association's dozen or so yearly Congressional testimonies, and travels extensively promoting the Association's mission of educating military family members about their rights and benefits.

The Military Chaplains Association of the United States of America selected Mrs. Hickey as the recipient of their 1992 National Citizenship Award. The University of Central Florida presented Mrs. Hickey with their 1993 Defense Transition Services Award for support to military families in transition. In 1998 Mrs. Hickey was presented the Champion for Children award by the Military Impacted Schools Association.

The National Military Family Association does not and has not received any federal grants, and does not have nor has had any contracts with the federal government.

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE

On behalf of The Military Coalition, we would like to express appreciation to the Chairman and distinguished members of the Senate Armed Services Committee's Subcommittee on Personnel for holding this important hearing. This testimony provides the collective views of the following military and veterans organizations which represent approximately 5 million members of the seven uniformed services, officer and enlisted, active, reserve, veterans and retired plus their families and survivors.

- Air Force Association
- Air Force Sergeants Association
- Army Aviation Association of America
- Association of Military Surgeons of the United States
- Association of the United States Army
- Chief Warrant Officer and Warrant Officer Association, United States Coast Guard
- Commissioned Officers Association of the United States Public Health Service, Inc.
- Enlisted Association of the National Guard of the United States
- Fleet Reserve Association
- Gold Star Wives of America, Inc.
- Jewish War Veterans of the United States of America
- Marine Corps League
- Marine Corps Reserve Officers Association
- National Guard Association of the United States
- National Military Family Association
- National Order of Battlefield Commissions
- Naval Enlisted Reserve Association
- Naval Reserve Association
- Navy League of the United States
- Reserve Officers Association
- Society of Medical Consultants to the Armed Forces
- The Military Chaplains Association of the United States of America
- The Retired Enlisted Association
- The Retired Officers Association
- United Armed Forces Association
- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- Veterans of Foreign Wars
- Veterans'Widows International Network, Inc.

The Military Coalition does not and has not received any federal grants, and does not have nor has had any contracts with the federal government.

INTRODUCTION

The Military Coalition is very grateful that through this Subcommittee's efforts, the last two years have seen significant breakthroughs in our mutual efforts to secure health care equity for all uniformed services beneficiaries, particularly with respect to the Medicare-eligibles who have been increasingly locked out of the military health care system. This subcommittee's efforts to upgrade the overall TRICARE program, redesign and expand the pharmacy system, and provide a substantially expanded test of enrolling Medicare-eligibles in the Federal Employees Health Benefits Program (FEHBP-65) were a major highlight of the 105th Congress.

But all of us appreciate that many of these initiatives are only the first steps, albeit crucial ones, on the road to providing the kind of health care coverage service beneficiaries need and deserve. Much remains to be done, both to ensure demonstration programs already approved are implemented fairly and successfully and to take the further steps that will be necessary to achieve our mutual goals in this extremely important area. In addition it is important to note that despite the progress in fixing some of the problems with TRICARE, to be addressed shortly, there are still significant issues that must be resolved. These issues include a lack of a uniform health care benefit, slow claims processing and others that will be detailed later in this statement.

DEMONSTRATION PROGRAMS

Before we turn our attention to the problems with TRICARE, we would first like to thank the Subcommittee profusely for its role in enacting legislation in the last two years for two demonstration programs aimed at restoring equity to health care benefits for Medicare-eligible uniformed services beneficiaries. These two tests – TRICARE Senior Prime, and FEHBP-65 – will go a long way toward restoring the promise of lifetime health care given to these older individuals when they entered the service as young recruits, and reiterated time and again as an inducement to serve until retirement. We would like to address each test in greater detail.

TRICARE Senior Prime: The Budget Reconciliation Act of 1997 provided for a demonstration program to test the concept of Medicare subvention, now called TRICARE Senior Prime. Under this test, Medicare-eligible uniformed services beneficiaries in six demonstration areas have the opportunity to enroll in a health maintenance organization (HMO) type plan, similar to TRICARE Prime, with the cost of their care being reimbursed to DoD by Medicare.

This test has been successfully implemented in all of the demonstration sites and, by all accounts, has been very well received by eligible beneficiaries at each site. The Department of Defense has expressed a strong desire to expand this program to other sites across the country as soon as feasible. The Military Coalition supports expansion of this test, and would like to take the additional step of making TRICARE Senior Prime permanent program as soon as possible. To this end, Representative Joel Hefley (R-CO) is preparing to introduce legislation that would make the TRICARE Senior Prime program permanent on a phased-in basis. His bill would expand Senior Prime to ten (10) additional locations with full-service military hospitals by January 1, 2001 and then across the remaining TRICARE Prime catchment areas not later than October 1, 2002.

The Military Coalition urges the Subcommittee to support legislation to expand TRICARE Senior Prime to an additional 10 sites by January 1, 2001 and pursue nationwide implementation upon receipt of the expected favorable test results.

One concern that has been inhibiting many older retirees from participating in TRICARE Senior Prime is their perception that the temporary nature of the demonstration program could place participants at financial risk. Beneficiaries need assurance that this program will not disappear after three years as so many of their other health care benefits have, especially since TRICARE Senior Prime is an integral part of the fulfillment of the promise of health care for life for uniformed services beneficiaries. At some tests sites, eligible beneficiaries have been reluctant to enroll in TRICARE Senior Prime because they are afraid the program will not be made permanent, and they do not want to get used to care in military hospitals again, only to be shut out if the test should end. Many are reluctant to drop their existing Medigap policies, lest they may be unable to regain these policies (in the event the demonstration is terminated) without incurring pre-existing condition limitations.

The Military Coalition urges this Subcommittee to support legislation that would make TRICARE Senior Prime a permanent program. The Coalition further recommends amending the TRICARE Senior Prime legislative authority to provide TRICARE Senior Prime enrollees the same Medigap reinstatement protections afforded participants in the FEHBP-65 demonstration test.

Rep. Hefley's legislation also would authorize non-enrollees to use TRICARE Senior Prime services on a fee-for-service basis. The Military Coalition believes this would be particularly useful, for the Department of Defense as well as beneficiaries, especially at some of the smaller facilities with little or no inpatient capabilities where it might be difficult to implement a Medicare HMO program.

The Military Coalition urges this Subcommittee to support legislation to authorize non-enrollees to use TRICARE Senior Prime services on a fee-for-service basis.

As TRICARE Senior Prime is expanded and made permanent, there is a particularly restrictive aspect of this program that must be corrected. Only those TRICARE Prime enrollees assigned to a military primary care manager (PCM) are currently allowed to "age into" TRICARE Senior Prime when they reach the age of 65. Prime enrollees assigned to civilian PCMs cannot "age into" Senior Prime immediately, but must wait for the next enrollment period to apply for enrollment. The Coalition firmly believes that all TRICARE Prime enrollees residing in the catchment area of the military hospital should be allowed to immediately "age into" TRICARE Senior Prime, regardless of whether their primary care manager is military or civilian. The Coalition is pleased that Rep. Hefley's planned bill would lift this restriction.

The Military Coalition urges this Subcommittee to support legislation that would promote equity by allowing all TRICARE Prime enrollees to "age-into" TRICARE Senior Prime upon attaining age 65, rather than just those enrollees with a military PCM.

FEHBP-65 Demonstration Threatened: The Coalition is pleased with the Department of Defense's efforts to ensure a fair process for the selection of FEHBP-65 test sites, and that sites have been identified in a timely manner so that the Office of Personnel Management (OPM) will not experience any delays in the contracting process. However, the Coalition is deeply concerned that Congress' efforts to conduct an equitable test of FEHBP-65 will be derailed by an aberration in the premium-setting process.

The problem stems from the Office of Personnel Management's (OPM) strict interpretation of the law and a DoD General Counsel opinion that the law authorizing the demonstration does not allow the Secretary to intercede with a premium safeguard. At the root of the problem is OPM's guidance that all FEHBP plans at each site, no matter how small, must participate in the demonstration. Further, because of what seems to be an overly strict interpretation of the requirement for separate risk pools, OPM will not allow the various plans to use any of their reserves to compensate for possible financial risk of enrolling service retirees (even though this is the usual practice under FEHBP for federal civilian beneficiaries). In some cases, substantial reserves exist. For example, the Coalition has been advised that the existing reserves for Blue Cross/Blue Shield approximate one billion dollars.

The small numbers of beneficiaries at each site, the requirement for a separate risk pool and the restrictions on the use of current reserves will almost certainly force FEHBP plans (especially the smaller plans) to set premiums very high, at least initially, until they can gather some claims experience for this new group of beneficiaries. The Coalition is very concerned that high premiums will dampen participation in the test, thus skewing the results. Far worse, high premiums may also create a significant backlash of negative publicity about the test, since beneficiaries have been led to believe they will be participating in FEHBP under the same rules, and with the same (or nearly equivalent) premiums as other federal employees and retirees. If they find they have to pay higher premiums than their federal counterparts, they will feel that an unfair double standard has been applied to them once again.

To ensure a reasonable opportunity for the test to succeed, the Coalition urged the Assistant Secretary of Defense (Health Affairs) to use part of the $78 million allocated to the FEHBP-65 demonstration in calendar year 2000 to create a reserve fund for FEHBP plans at each test site. This would assure the smaller plans that they will not be at unacceptable financial risk should they set premiums similar to premiums for federal employees and retirees. Since the number of actual enrollees in the FEHBP-65 demonstration will be far less than the 66,000 pool of potential eligibles (the Coalition believes that at best 30 percent may participate), there should be ample funds to permit DoD to assume the liability for any excess costs that may materialize. (Title 5 requires only 3% of the total premiums be set aside as a contingency reserve – this would translate to about $2.5 million for the FEHBP-65 test -- although some insurance carriers may require more. A member of the Blue Cross - Blue Shield Association expressed similar convictions that a relatively small amount of reserves would be needed). If (as the Coalition believes) the claims experience for uniformed services beneficiaries proves no different than that for federal civilian retirees, there would be no risk for DoD in subsequent years.

Regrettably, in a meeting with the Assistant Secretary of Defense (Health Affairs) on March 3, the Coalition was advised that an OSD legal opinion indicated that the law does not provide sufficient flexibility to establish a "reserve fund" to ensure premium parity. This is a major setback for the demonstration. Unless assurances are given quickly to the FEHBP plan managers at each test site that reserves are available to help ease the uncertainty of financial risk, OPM will be at a serious disadvantage when negotiating premiums this spring.

The Military Coalition strongly urges the Subcommittee to direct DoD to use part of the appropriation for the test as a reserve for the purpose of ensuring FEHBP-65 premiums are initially established at rates comparable to those for other FEHBP enrollees.

IMPROVEMENTS IN TRICARE

Although great strides continue to be made by DoD and Congress in fixing some of the more egregious problems with TRICARE, the Coalition remains concerned about other problems that continue to crop up on a consistent basis. Some of these problems are unique to TRICARE Prime, others to Standard, and some problems are common to both options. Before addressing the problems unique to each option, the Coalition would like to address some of the concerns we have about TRICARE that affect the functioning of the entire program.

Adequate Funding for TRICARE: The Military Coalition continues to hear each year of funding shortfalls in the overall Defense Health Program which are passed down to each of the Services'health care budgets. Although the Coalition was heartened to hear that DoD added $445 million in FY '99, and another $2 billion across the next five years, to its health care budget, the Coalition remains concerned this is not enough to address future funding shortfalls that might occur as a result of unanticipated medical readiness operations. Congress, and the Comptroller for the Department of Defense must be willing to budget adequate resources for the Defense Health Program, not just for medical readiness operations, but also for the peacetime health care component. The Coalition believes that an adequately funded health care benefit, not just for the servicemember, but his/her family as well, is just as important to recruitment and retention of qualified uniformed services personnel as is pay and retirement benefits. Further, the promise of this health care benefit into retirement must be kept if servicemembers are to be convinced that serving 20 or more years in uniform is in their best interests.

The Military Coalition recommends, therefore, that this Subcommittee set the standard for the Appropriations Committee to provide sufficient funding for the Defense Health Program, not just for military medical readiness, but also for DoD peacetime health care operations, including the TRICARE program. The Coalition recommends that funding for the TRICARE program more accurately reflect the number of uniformed services beneficiaries eligible for the military health care benefit rather than being based on the number of beneficiaries who actually used the military health care system the previous year.

TRICARE Claims Processing: A primary cause of frustration for both beneficiaries and civilian TRICARE providers participating in both Prime and Standard is the cumbersome and unresponsive TRICARE claims process.

Providers often experience months of delays in receiving payments and encounter great difficulties in even contacting TRICARE claims processors to resolve processing difficulties. This is the single most frequently mentioned reason why providers opt out of TRICARE participation or decline to accept TRICARE patients in the first place. This was also one of the reasons cited by the withdrawal from the Prime network of a 200 man provider group in the TRICARE Central region two years ago, and the most recent withdrawal of Group Health Cooperative (GH) of Puget Sound, Washington as a network provider in TRICARE Region 11. The loss of Group Health is particularly troublesome since GH has over 23,000 enrollees in TRICARE Prime, and moving these enrollees to other providers is no small task.

For beneficiaries, claims processing delays often result in dunning notices from providers or even having their accounts turned over to collection agencies -- jeopardizing their credit ratings if they fail to pay the claims out of their own pockets. In fact, TMC associations have been informed that

beneficiaries are routinely paying bills sent by providers rather spend the hours, and sometimes days, necessary to fight the TRICARE claims process.

As the Chief of Staff of the Army noted recently, a claims system that requires only 75 percent of claims to be paid within 30 days is inadequate protection for uniformed services members and their families.

Part of the problem is that only two financial intermediaries nationwide are familiar with TRICARE claims processing procedures. With a virtual monopoly, these intermediaries have little incentive to improve procedures or to invest in adopting up-to-date best business practices, such as electronic claims processing. Further, adoption of such practices would likely save the government $300 million per year, because the $9 TRICARE per-claim processing cost vastly exceeds the $2-per-claim cost of best private practices.

The Military Coalition has become convinced that fixing this fundamental TRICARE flaw will require a complete redesign and upgrade of the system, to encourage bids from more responsive potential intermediaries for TRICARE claims contracts and create incentives to meet acceptable customer service standards.

The Military Coalition recommends a complete redesign of the TRICARE claims processing and fiscal intermediary system, aimed at streamlining information flow and decisionmaking and using best private industry practices, including electronic claims processing, to be tested in at least the next two TRICARE regions to have their managed care contracts renewed next year.

Preauthorization Requirements: The requirements for preauthorization for care for both Prime and Standard beneficiaries vary widely from TRICARE region to region. For example, in Region 1, the managed care contractor requires preauthorization for all inpatient care regardless of the beneficiary's enrollment status (Prime or Standard) or residence (in or out of the catchment area of a military treatment facility). The Coalition is also very dismayed that pre-authorization is even required for TRICARE beneficiaries with other health insurance that pays first. This blanket requirement for preauthorization is creating havoc among beneficiaries in this Region. For example, The Coalition just heard of a case where a TRICARE Standard beneficiary residing in a noncatchment area in Region 1 almost had to cancel his wife's surgery because he was unable to obtain pre-authorization in time. If a staff member from one of the Coalition's Associations had not stepped in and asked a representative from the managed care contractor in this region to look into this situation, the surgery would have had to have been cancelled. Another Standard beneficiary in Region 1 received care from her local VA hospital (under contract as a TRICARE provider) which did not get preauthorization, so now they are trying to charge her $3,000 for her inpatient care. Although we have been assured she will not have to pay this bill, both of these cases point to a breakdown in communication to providers about the requirement for pre-authorization, especially outside catchment areas. And further, it appears that even when providers are aware of the need for preauthorization, they are having a hard time getting through to the managed care contractor to get authorization in a timely manner.

It was exactly for some of these same reasons, that the managed care contractor in the TRICARE Central Region has decided to relax its preauthorization requirements. This contractor has adopted the more efficient approach of pinpointing certain procedures that should be more closely scrutinized for preauthorization, and eliminating preauthorization requirements for the rest. The contractor does

not want to cause unnecessary delays and create unnecessary hassles for procedures that are going to be authorized 99% of the time anyway.

The Military Coalition strongly recommends that preauthorization requirements for both inpatient and outpatient care be limited only to those procedures where there is some doubt about their medical necessity. Further, the Coalition believes that DoD, and NOT the contractor, should set a standard policy for preauthorization requirements, and this policy must be clearly explained to both the beneficiary and to the provider.

The Coalition believes that increasing the overall funding for TRICARE, revamping the claims processing system and relaxing or even eliminating preauthorization requirements will go a long way toward addressing some of the fundamental problems with TRICARE. To this end the Coalition was gratified to see the Senate unanimously voted to add Senator Hutchisonś (R-TX) amendment to S. 4 that addresses these major problems with TRICARE. The Coalition believes that addition of this amendment sends a strong signal to DoD that a viable health care benefit is just as important to recruitment and retention of qualified uniformed servicemembers as pay and retirement benefits.

The Coalition would now like to address some very specific problems associated with each of the two main options under TRICARE which are unique to each program, starting with some of the problems specific to TRICARE Prime and then following with issues specific to TRICARE Standard.

TRICARE Prime: The Coalition is very concerned that, as currently structured, TRICARE Prime more closely represents a "managed cost" program than a "managed care" program.

Hardly a month passes without a news story highlighting the departure of another major group of health care providers from participation in TRICARE Prime. Most frequently, the reasons given for such departures are extended delays in claims payments, low reimbursements, and administrative difficulties in even contacting TRICARE contractors to resolve billing problems.

But many civilian and military providers alike voice even more significant concerns from the standpoint of ensuring continuity of care for TRICARE Prime beneficiaries. Depending on the services available in military treatment facilities (MTF), patients are frequently shuffled back and forth between providers in the MTF and those in the civilian network for different kinds of care. In civilian HMOs, the enrollee's primary care manager (PCM) is kept informed of all treatments, medications and other services provided to the patient from any source. That is, the patient's care is, in fact, managed by the PCM -- including oversight of all medications prescribed by different sources to ensure against adverse drug interaction.

Under TRICARE Prime, there is no such central oversight to protect the patient's welfare, as there is no communication between the civilian network providers and those in the MTF. In effect, the burden of ensuring there is some overall coordination of the patient's care is imposed on the patient, not the PCM.

This lack of coordinated care is a primary objection of civilian network providers and is a significant reason why many have chosen not to participate, or terminated participation, as TRICARE Prime providers.

The Military Coalition strongly recommends that the Subcommittee pursue action to ensure TRICARE Prime delivers "managed care" rather than "managed cost" by requiring information systems that allow PCMs to oversee <u>all</u> care and medical services provided to their assigned beneficiaries, regardless of the source of the care or services.

Portability and Reciprocity: Although DoD has issued a policy memorandum stating that TRICARE Prime enrollees in one region will be able to receive services from Prime in another region (reciprocity) and will be able to transfer their enrollment when they move (portability), this policy has yet to be fully implemented in all existing TRICARE regions. Enrollees are still experiencing a disruption in enrollment when they move between regions and are still not able to receive services from another TRICARE Region. The lack of reciprocity is presenting particular difficulties to TRICARE beneficiaries living in "border" areas where two TRICARE regions intersect. In some of the more rural areas, the closest provider or pharmacy may actually be located in another TRICARE region, and yet due to the lack of reciprocity, these beneficiaries cannot use these providers or pharmacies. This situation must be rectified immediately. TRICARE must become a seamless system to truly serve a beneficiary population that is probably the most mobile in the country.

The Coalition urges immediate implementation of portability and reciprocity so as to minimize the disruption in TRICARE Prime services for beneficiaries.

Uneven Benefit under TRICARE Prime: Sometimes TRICARE Prime enrollees, particularly those enrolled in the Exceptional Family Member program, or those with complicated health care problems, moving from one TRICARE region to another find that care authorized or covered in one Region is not authorized or covered in the new Region. Often specific specialty care is promised in the new Region, and then upon arrival, the family is told to disenroll the beneficiary from Prime in order to continue with that care. Although this affects perhaps only a small number of beneficiaries, these are the very same beneficiaries who most need continuity of care, and who cannot afford higher costs under TRICARE Standard.

The Coalition strongly recommends that care for these exceptional cases be effectively managed in an integrated manner across all TRICARE regions. Beneficiaries requiring specific specialty care should not be shunted into Standard simply because the managed care contractor is not able to provide that particular specialty within the Prime network.

TRICARE Prime Remote: The Coalition continues to hear from families of servicemembers assigned to remote areas where there is no TRICARE Prime option. These families are being unfairly burdened by having to pay much higher copayments for care than their counterparts assigned to areas where they can enroll in TRICARE Prime if they so choose. Although this problem was addressed two years ago in the FY 1998 Defense Authorization Act which authorized the Secretary of Defense to waive deductibles and copayments for active duty personnel assigned to duty locations more than 50 miles from a military hospital, this provision did not address health care costs for family members. DoD has attempted to implement a program called TRICARE Prime Remote to meet the needs of these families, but by all accounts, this program appears to be failing for a lack of sufficient providers. If DoD is unable to fully implement TRICARE Prime Remote, then the Secretary of Defense must be willing to waive TRICARE Standard copayments and deductibles for these family members as was done for the servicemembers in 1998.

The Military Coalition urges this Subcommittee to enact legislation directing DoD to ensure that health care costs for family members of active duty personnel assigned to an area that is not served by TRICARE Prime do not exceed the co-payments of family members who do participate in TRICARE Prime.

Access standards for TRICARE Prime: The Coalition continues to document numerous instances in most TRICARE Regions where access standards for time and for distance have not been met. Interestingly enough, these reports now seem to be focused on military hospitals not meeting access standards rather the managed care support contractor. While the Coalition applauds the progress made by the civilian contractors in addressing this problem, this is only half of the story. Military hospitals must also be held accountable to the very same access standards that civilian contractors must adhere to.

The Coalition strongly recommends that this Subcommittee hold military hospitals accountable to the same access standards that are now being met, apparently successfully, by managed care contractors, particularly if DoD is to be allowed to continue to bring as much health care as possible back into military treatment facilities.

Point of Service Charges under TRICARE Prime: The Coalition also continues to hear of a problem that it raised in last years'testimony to this committee – the issue of Prime enrollees being unknowingly referred to an out-of-network provider and thus incurring point-of-service charges, which are much higher than Prime copayments. Again, this problem now appears to originate from military providers referring Prime enrollees to out-of-network providers, not the civilian contractors. The civilian managed care contractors appear to have set up mechanisms to help eliminate any mistaken referral to an out-of-network provider. However, military hospitals have failed to implement any such procedures. In fact, the Coalition recently heard about a Congressional staff member who incurred major health care costs while still on active duty from an erroneous referral by a military physician to an out-of-network provider. This individual happened to be a base commander, and asked the very obvious question that if a base commander has such trouble with unplanned, and unrequested, point-of-service charges, how does the enlisted servicemember prevent this from happening?

The Military Coalition strongly recommends that any Prime enrollee, whether enrolled with a military or civilian primary care manager, be asked to sign a form documenting that her/she is requesting a referral to an out-of-network provider, and understand the charges he/she will incur as a result. Such documentation will eliminate situations where the TRICARE Prime primary care manager mistakenly refers enrollee to a non-network provider, thus invoking point of service charges.

115% Billing Limit Under TRICARE Standard: In 1995, DoD unilaterally reinterpreted the 115% billing limit in cases of third party insurance so as to substantially reduce TRICARE's reimbursement to beneficiaries. While providers may charge any amount, TRICARE only recognizes amounts up to 115% of the TRICARE "allowable charge" for a given procedure. Under DoD's previous interpretation, any third party insurer would pay first, then TRICARE (then CHAMPUS) would pay any balance up to 75% of the allowable charge (80% for active duty dependents).

Since the reinterpretation, TRICARE will not pay anything at all if the third party insurer paid an amount equal to or higher than the 115% billing limit. (Example: a physician bills $500 for a

procedure with a TRICARE-allowable charge of $300, and third-party insurance pays $400, while assessing a $50 copayment on the beneficiary. Previously, TRICARE would have paid the full $50 difference, because that is less than the $345 TRICARE would have paid if there were no other insurance. Under DoD's new rules, TRICARE pays nothing, since the other insurance paid more than 115% of the TRICARE-allowable charge.)

DoD's shift in policy unfairly penalizes beneficiaries with other health insurance plans, by making them pay out of pocket what TRICARE previously covered. In other words, they save TRICARE funds, but are denied any TRICARE benefit because of private sector employment or some other factor that provides them private health insurance.

The Military Coalition urges elimination of the 115% billing limit when TRICARE Standard is second payer to other health insurance.

Requirements for Non Availability Statements under TRICARE Standard: The Military Coalition continues to believe that all requirements for a Non Availability Statement (NAS) should be removed for those beneficiaries choosing to participate in TRICARE Standard. By choosing to remain in Standard, beneficiaries are voluntarily accepting higher copayments and deductibles in return for having the freedom to choose their own provider. The Coalition appreciates that the intent of NAS system when CHAMPUS was an evolving program was to maximize the use of military treatment facilities. However, when TRICARE was created, it offered beneficiaries a choice in how to exercise their health care benefit. DoD should allow beneficiaries this choice, and not insist that Standard beneficiaries jump through hoops to exercise this choice, particularly since most care in military hospitals and clinics is being given on a first priority basis to Prime enrollees anyway.

The Coalition strongly recommends that all requirements for Non Availability Statements be removed from the TRICARE Standard option.

Catastrophic Cap under Standard: The TRICARE Standard (CHAMPUS) catastrophic cap out of pockets is still $7,500 for retirees, which is much higher than other civilian fee-for-service plans which traditionally set limits between $2,000 and $3,000.

The Coalition strongly recommends that as a matter of equity, this cap be reduced to $3,000.

OTHER HEALTH CARE CONCERNS

Pharmacy Redesign: The FY 1999 Defense Authorization Act mandated that DoD submit to Congress by March 1, 1999, a plan for a system-wide redesign of its pharmacy programs. One of the goals of this redesign is to expand the retail and mail-order pharmacy benefit to all Medicare-eligible uniformed services beneficiaries regardless of where they reside. The Military Coalition has worked closely with DoD in the past year on this redesign, and has had the opportunity to provide input into how the pharmacy benefit should be structured, particularly expansion of the benefit to those who are Medicare-eligible. The Coalition applauds DoD's efforts in this regard and realizes this has not been an easy task.

The Coalition is concerned however, that Congress may have bound the hands of DoD in this redesign by mandating that no additional dollars be allocated to expand the pharmacy benefit to Medicare-eligible beneficiaries. Although DoD had great hopes that incorporating best industry

practices would generate enough savings to achieve the expansion, these hopes have fallen short. To generate the dollars to expand this benefit, DoD is apparently considering other more onerous measures such as charging a copay for prescriptions filled at military pharmacies or charging a monthly premium for a pharmacy benefit for Medicare-eligible beneficiaries who do not reside in BRAC areas. The Coalition is particularly concerned about copays for prescriptions filled in a military pharmacy since this would be viewed not only as one more violation of the health care promise, would escalate concerns that this is a "nose under the tent" play for extending copays to other health care services provided by military treatment facilities.

The Coalition believes that if after best business practices are adopted, if additional funds are needed to expand the pharmacy benefit to all Medicare-eligible uniformed services beneficiaries, then Congress should provide these funds, not the beneficiary. Therefore, the Coalition requests this Committee to support additional funding for the Defense Health Program to be used specifically for the purposes of expanding the retail and mail-order pharmacy benefit to Medicare-eligible beneficiaries.

Waiver of Medicare Part B Late Enrollment Penalties: The Military Coalition continues to be concerned by the small number of military retirees eligible for Medicare by virtue of age or disability who delayed enrollment in Medicare Part B because they thought they could receive all of their care from a military hospital, and thus are now paying a late enrollment penalty. The Coalition is particularly concerned about those who are under the age of 65 but Medicare-eligible due to disability. In order to maintain eligibility for TRICARE, they must be enrolled in Medicare Part B. The Coalition would like to thank this Committee for its part in ensuring temporary TRICARE eligibility until July 1, 1999, for those who were missed the window of enrollment opportunity last year, and we would hope that these individuals have now all had the chance to enroll in Part B. However, many did incur late enrollment penalties as a result. The number of beneficiaries who are now faced with late enrollment penalties is not large (only 12,000 in 1998) and waiving the penalties for these individuals would at most cost about $60 million.

The Coalition, therefore, requests your Committee support legislation to waive the Medicare Part B late enrollment penalties for uniformed services beneficiaries eligible for Medicare by virtue of age or disability who delayed enrollment in Medicare Part .

Long-Term Health Care Insurance: The Military Coalition notes with great interest that the President's Budget proposes legislation (S. 36 and S. 57) to authorize federal group long-term health insurance coverage for current and retired federal civilian employees and their families. This insurance would have no federal subsidy, and employee/retiree premiums would be set to cover the full cost of expected long-term care benefits.

The Military Coalition believes strongly that such a "win-win" program makes sense and, as a matter of equity, should also authorize equal participation by current and retired members of the uniformed services. Discussions with DoD officials and organizations representing federal civilian employees indicate support for inclusion of uniformed services beneficiaries in any such legislation, not only to provide them equal and much-needed coverage, but also to expand the participation pool to further reduce premiums.

The Military Coalition urges this Subcommittee to coordinate with the Civil Service Subcommittee to pursue expeditious enactment of group long-term health care coverage for both federal civilian and uniformed services beneficiaries.

CONCLUSION

The Military Coalition would like to reiterate its profound gratitude for all of the hard work this Subcommittee has done in the last two years to secure health care equity for all uniformed services beneficiaries. The Subcommitteeś efforts to authorize the implementation of the Medicare subvention and the FEHBP-65 tests are important steps toward restoring the promise of a lifetime health care benefit.

Much work remains to be done, particularly with the TRICARE program. Immediate efforts must be undertaken, both by Congress, and by DoD, to attract and retain quality health care providers. Ensuring adequate funding for TRICARE, fixing the claims processing system, reducing or eliminating preauthorization requirements and allowing increased reimbursements to providers, where necessary, are steps that can be taken immediately to make TRICARE a more viable health care program. The Military Coalition urges this Subcommittee to devote its attention toward correcting more of the more egregious problems with TRICARE detailed in this testimony.

Mr. Chairman, in closing, we wish to express our sincere appreciation to you and this Subcommittee for the opportunity to present our views on these critically important topics. We will be glad to answer any questions you may have.