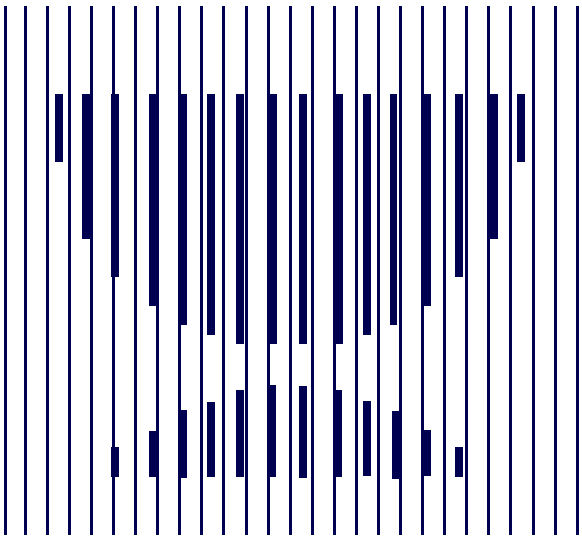
CBO MEMORANDUM

EVALUATING THE UNIFORMED SERVICES TREATMENT FACILITIES

June 1994



CONGRESSIONAL BUDGET OFFICE

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

The participation agreements between the Department of Defense (DoD) and the Uniformed Services Treatment Facilities (USTFs) outline the features of the managed care plans offered to eligible military beneficiaries by the USTFs. This Congressional Budget Office (CBO) memorandum has been prepared to comply with the provisions of the National Defense Authorization Act for Fiscal Year 1994 requiring CBO and the General Accounting Office to evaluate those agreements. The memorandum summarizes CBO's findings, which focus on two specific issues: the cost-effectiveness of the USTF managed care programs compared with other components of the military health care delivery system and the impact of the agreements on DoD's budget and expenditures.

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SUMMARY AND INTRODUCTION

The National Defense Authorization Act for Fiscal Year 1994 required the Congressional Budget Office (CBO) and the General Accounting Office to evaluate the participation agreements between the Uniformed Services Treatment Facilities (USTFs) and the Department of Defense (DoD). CBO conducted part of that evaluation by addressing two specific questions posed by the authorization act:

- Are the USTF managed care programs that the agreements address more or less cost-effective as a provider of care to military beneficiaries than the Military Health Services System (MHSS)?

- What is the impact of the USTF managed care programs on DoD's budget and expenditures for health care?

Because of limitations in the available data and differences between the benefit packages and cost-sharing requirements of the USTF managed care programs and the MHSS, CBO cannot answer either of those questions definitively. Moreover, the USTF managed care programs have been operating only since October 1, 1993--perhaps long enough to be considered "up and running" but not long enough to generate the data necessary to examine differences in the effectiveness of the two systems of care.

CBO has, however, examined the differences in DoD's cost for providing care in the USTF managed care programs and in the MHSS for a uniform population of beneficiaries. The results of that analysis suggest that the cost to DoD is higher for the USTFs compared with the MHSS in areas where beneficiaries have poor access to care at Military Treatment Facilities. Conversely, the cost to DoD is lower for the USTFs compared with the MHSS in areas where beneficiaries have better access to care at Military Treatment Facilities. Yet the significant differences in health care coverage offered to eligible military beneficiaries through the MHSS and the USTF programs--compounded by certain inefficiencies in the delivery and financing of care through the MHSS--may make the MHSS by itself a questionable standard against which to measure the costs of the USTF programs. To provide a fuller assessment, CBO compared the cost to DoD of providing care in the USTF programs and in civilian health maintenance organizations (HMOs). That comparison also suggests that the cost to DoD is higher for the USTFs compared with civilian HMOs.

Because DoD does not know exactly how many eligible military beneficiaries use its health care system, CBO could not determine the precise impact of the USTF managed care programs on the department's budget. Still, one impact that CBO could estimate was the cost to DoD of providing care to military beneficiaries who are eligible for Medicare. CBO estimates

that cost to be eight times greater with the USTF managed care programs than without them. In addition, the budget for the USTF programs is likely to grow at a much faster rate than other parts of DoD's health care system. Faster growth could lead to inequitable patterns of spending in the USTF programs compared with the rest of the MHSS.

Finally, CBO's analysis underscores the financial risk to the federal government from the relatively large number of Medicare beneficiaries enrolled in the USTF managed care program. Although the programs specifically require enrollees to refrain from using their Medicare benefits for the duration of enrollment, currently no system is in place to identify those beneficiaries who use both the USTF programs and Medicare. As a result, the federal government may be making double payments.

BACKGROUND: THE UNIFORMED SERVICES TREATMENT FACILITIES

In 1981, the Congress transferred 10 Public Health Service hospitals and clinics to private ownership and designated them as USTFs. To the facilities, this designation meant a guaranteed patient base from which to begin operations as private-sector health care providers. To many eligible military beneficiaries, it meant greatly improved access to free care. (Eight of the

facilities are in areas where beneficiaries have poor access to other military treatment facilities.)[1]

Ever since 1981, the Congress has renewed the designation of these hospitals as USTFs--but not without reservations. Members have been particularly concerned about the method of reimbursing the USTFs: as originally conceived, the facilities received a full annual payment for any beneficiary who used the USTF, regardless of whether the facility provided care for only part of the year or the beneficiary used other sources of care within the MHSS. The Congress specifically addressed this issue in the report on the National Defense Authorization Act for Fiscal Years 1990 and 1991 prepared by the House Committee on Armed Services. It directed DoD to determine the "most appropriate and cost-effective method" of integrating the USTFs with the military health care system; it also required the department to develop a model of managed care for the USTFs that would include enrollment and capitation financing. In the National Defense Authorization Act for Fiscal Year 1991, the Congress again directed DoD to begin implementing a managed care model for the USTFs.

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1. In total, seven corporate entities operate the USTF managed care programs. The Sisters of Charity of the Incarnate Word operate four of the USTF managed care programs in Texas. Each of the remaining six USTF programs is operated by a separate organization.

THE PARTICIPATION AGREEMENTS

On October 1, 1993, the USTF managed care programs began in all 10 facilities across the country. (For a summary of the USTF programs, see Table 1.) In compliance with the authorization acts, DoD and the USTFs signed participation agreements specifying two major changes in the reimbursement of the facilities: a system of voluntary enrollment for the USTFs, in which enrollees agreed to receive all of their health care from the military through the USTF network of health care delivery, and a reimbursement methodology based on capitation, or a fixed payment per person reflecting the uniform set of benefits covered under the managed care programs. These changes go a long way toward addressing the major concern of the Congress about USTF reimbursement.

Voluntary Enrollment

By incorporating a system of voluntary enrollment, the new managed care program holds each USTF accountable for a specific population of beneficiaries. Enrollees must agree to receive all of the health care services that they seek from the military directly from the USTF and the network of providers with which the USTFs contract. All enrollees are offered a

TABLE 1. UNIFORMED SERVICES TREATMENT FACILITIES, FISCAL YEAR 1994

Facility and Location	Enrollees[a] Under Age 65	Enrollees[a] Age 65 or Older	Enrollees[a] Total	Budget[b] (In millions of dollars)
Wyman Park Baltimore, Maryland	14,149	3,170	17,319	40.3
Brighton Marine Boston, Massachusetts	7,707	2,882	10,589	33.5
Bayley Seton Staten Island, New York	7,518	2,173	9,691	27.0
Martin's Point Portland, Maine	15,113	2,274	17,387	38.6
Lutheran Medical Cleveland, Ohio	4,288	506	4,794	14.3
Sisters of Charity of the Incarnate Word[c]	19,844	5,349	25,193	66.3
Pacific Medical Seattle, Washington	11,418	5,283	16,701	45.2
Total	80,037	21,637	101,674	265.0

SOURCE: Congressional Budget Office.

NOTES: Numbers may not add to totals because of rounding. USTF = Uniformed Services Treatment Facility.

a. The number of enrollees in each USTF managed care program is based on data provided in May 1994 by KPMG Peat Marwick Management Consultants on behalf of the USTFs.

b. In fiscal year 1994, the federal government will spend roughly $291 million to support the USTF managed care programs. Of that $291 million, $265 million is provided by the Department of Defense. The remaining $26 million is provided by the Department of Health and Human Services and the Department of Transportation.

c. The participation agreement between the Sisters of Charity of the Incarnate Word and the Department of Defense covers four of the USTF managed care programs, all located in Texas--in Galveston, Houston, Nassau Bay, and Port Arthur.

comprehensive, uniform benefit package that includes all of the services covered by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the military's fee-for-service insurance program, in addition to a wide range of preventive services.

All military beneficiaries--with the exception of active-duty personnel--are eligible to enroll in the USTF managed care programs, although the total number of enrollees that a USTF can accept is tied to budget ceilings that DoD establishes for each program. Among non-active-duty beneficiaries, dependents of active-duty personnel receive first priority. Within each beneficiary category, however, enrollment proceeds on a first-come, first-served basis. Once participants enroll in the USTF program, they are "locked out" of all other parts of the military health care system for the period of enrollment. In addition, enrollees aged 65 or older must agree not to use their benefits under Medicare. As with other military health care programs, enrollment in the USTF program does not in any way prevent enrollees from using any private insurance they might have.

Overall, this system of enrollment improves coordination between the USTFs and DoD by requiring beneficiaries to refrain from using Medicare and the MHSS, thus helping the USTFs better manage the total use of health care by their enrolled populations.

Reimbursement Through Capitation Rates

Equally significant is the new reimbursement methodology for the USTFs on the basis of capitation. Under this system, the USTF managed care programs receive a fixed amount per enrollee, based on the uniform benefit package offered to enrollees and the age and sex of the person. In this way, capitation directly links reimbursement from DoD to the number of persons enrolled in the USTF programs. The USTFs have an incentive to manage the use of care by beneficiaries because they are reimbursed a fixed amount per enrollee per month. Monthly reimbursement also offers DoD the added financial benefit of paying for no more than the actual number of beneficiaries enrolled each month.

Congressional Reporting Requirement

Given the history of concerns over the cost-effectiveness of the USTFs, the Congress, as noted earlier, directed the General Accounting Office (GAO) and CBO to evaluate the participation agreements between the USTFs and DoD. Specifically, Section 717 of the National Defense Authorization Act for Fiscal Year 1994 called for the evaluation of five aspects of those agreements: (1) the cost-effectiveness of the USTFs compared with other components of

the military health care delivery system; (2) the impact of the agreements on DoD's budget and expenditures for health care; (3) the costs and other implications of terminating the agreements before their expiration; (4) the health care services available through the USTFs compared with the health care services available through other components of the MHSS; and (5) the cost sharing required of beneficiaries enrolled in the USTF managed care programs compared with the cost sharing required for other components of the MHSS. This memorandum is CBO's response to questions 1 and 2. GAO is reporting separately on questions 3 through 5.

ARE THE USTFs COST-EFFECTIVE?

Addressing the question of whether the USTFs are cost-effective involves comparing not just the costs but also the effectiveness of the USTF and the broader military health care systems. Yet because of a lack of data on the provision of and access to health care in the USTF managed care programs, CBO could not compare the relative effectiveness of the two systems in providing care. Information on access and quality at the USTFs is limited because the programs began operating on October 1, 1993, and their short period of operation does not permit a fair evaluation of their performance. In addition, some of the information CBO received from the USTFs was not comparable to information on the same topic from the MHSS.

In comparing the costs of the USTF programs and the MHSS, problems stem from differences in the designs of the two systems. Because of significant differences in their benefit packages and cost-sharing requirements, the two systems of care are not fully comparable. In particular, enrollees in the USTF managed care programs benefit from enhanced coverage and lower out-of-pocket costs compared with beneficiaries who rely on the MHSS.

Beyond the differences in benefit design, the MHSS and the USTF programs have vastly different systems of health care delivery and financing. For instance, the USTF programs are based on principles of managed care. As such, they incorporate a system of enrollment in tandem with a system of payment rates that reflect the population being served by the program as well as the uniform benefit package that enrollees are offered. Despite DoD's future plans to develop the MHSS as a system of managed care, today's MHSS lacks most of the features of managed care, such as enrollment, that would make the two systems more comparable.

In view of the differences between the USTFs and the MHSS, CBO broadened its evaluation of costs by developing two standards of comparison: the MHSS, as required by the authorization act; and civilian HMO plans offered under the Federal Employees Health Benefits program. CBO chose

those plans because of their similarity--in cost-sharing requirements and benefit coverage--to the USTF managed care programs.

In making those comparisons, however, CBO was not able to compare the cost of providing care to enrollees in the USTF programs with the cost of caring for those same enrollees through the MHSS or in a civilian HMO plan because available costs for the MHSS and the civilian HMOs were not stratified by age and sex. Instead, CBO compared the cost of providing care in the USTF programs with the other two settings based on the population eligible for the MHSS in the first instance and the population enrolled in HMOs nationwide in the second instance (see Table 2).

In the first analysis, CBO compared the cost of providing care through the MHSS to beneficiaries under age 65 with the cost to DoD for those same beneficiaries enrolled in the USTF managed care programs. In this analysis, the cost of providing care through the MHSS represents the sum of costs for providing care at Military Treatment Facilities (MTFs) and through CHAMPUS. Because the costs of care through the MHSS were not stratified by age and sex, the capitation rates for each USTF were adjusted to make costs comparable--first, to reflect the age and sex distribution of the military population, and then by geographic location to reflect national rates.

Comparing only the costs of providing care for beneficiaries under age 65 fails to present a complete picture of the relative costs of providing care in the MHSS and the USTF managed care programs. For instance, that comparison ignores the costs of providing care to more than 20 percent of the total population of USTF enrollees--those over the age of 65. But benefici-

TABLE 2. DISTRIBUTION OF POPULATIONS BY SEX AND AGE (In percent)

Sex and Age	Total USTF Enrolled[a]	Eligible Military[b]		Total HMO Enrolled[c]
		Catchment	Noncatchment	
Men				
Under 15	9.2	14.5	8.4	13.4
15 to 44	7.1	8.0	8.2	22.4
45 to 64	18.8	12.2	18.4	8.5
65 and Older	10.8	7.2	13.3	2.8
All	45.9	41.9	48.3	47.1
Women				
Under 15	8.7	13.9	8.1	12.9
15 to 44	15.7	23.8	15.6	27.2
45 to 64	19.6	12.9	17.7	9.2
65 and Older	10.1	7.5	10.3	3.6
All	54.1	58.1	51.7	52.9

SOURCE: Congressional Budget Office.

NOTE: USTF = Uniformed Services Treatment Facility; HMO = health maintenance organization.

a. Distribution of population by sex and age for all USTF managed care programs based on data provided by the Department of Defense as of February 1994. CBO's cost analysis was based on these data.

b. Active-duty personnel excluded.

c. Distribution of population by sex and age for HMO enrollment nationwide based on data reported by the Group Health Insurance Association of America, Inc., *HMO Industry Profile, 1993 Edition* (Washington, D.C.: Group Health Insurance Association of America, Inc., 1993).

aries over age 65 affect MHSS costs negligibly. (This applies particularly to beneficiaries who reside in noncatchment areas where 8 out of 10 of the USTF programs are located.) As a result, CBO could not compare the costs for providing care to this age group in the two settings.

The second analysis compared the cost of providing care under HMO plans offered through the Federal Employees Health Benefits program to enrollees of all ages, including those over 65 years of age, and the costs for a similar population enrolled in the USTF managed care programs. Again, CBO compared per capita costs by adjusting the capitation rates for each USTF for the age and sex distribution of the underlying population enrolled in HMOs nationwide.

Comparing the Costs of the USTF Programs with Those of the MHSS

CBO compared the costs of the USTF managed care programs and the MHSS using two separate standards of comparison based on the location of the USTF. Location is important to DoD because the cost of providing care to eligible military beneficiaries through the MHSS depends heavily on where they live. Beneficiaries who live in "catchment areas"--that is, within about 40 miles of a military hospital--tend to receive more care through the MHSS than

beneficiaries living in noncatchment areas, where (by definition) there are no military hospitals but only CHAMPUS. Thus, beneficiaries in catchment areas tend to cost the government more.

To show the effect of location, CBO compared USTF costs with those for catchment and noncatchment areas. That analysis suggests the relative differences in the costs of providing care in the USTF programs and through the MHSS. However, it ignores any other differences in the provision of and access to health care in the two systems, particularly for those beneficiaries residing in noncatchment areas.

The USTF Programs Provide Care at a Lower Cost than the MHSS in Catchment Areas. Of the 10 USTFs, only 2 (Baltimore and Seattle) are located within catchment areas. For fiscal year 1994, CBO estimated that the average per capita cost to the government would be $1,850 to provide care to non-active-duty beneficiaries under the age of 65 who lived in catchment areas and who used the MHSS as their primary source of care.[2] To the extent possible, CBO excluded those beneficiaries who did not rely on the MHSS as their primary source of care. In Baltimore and Seattle, CBO adjusted the USTF rates for the age and sex distribution of the eligible catchment area population and for geographic differences between costs for the nation as a

2. CBO based its estimates of the costs for such beneficiaries in both catchment and noncatchment areas on data from CHAMPUS and the MTFs for fiscal year 1992.

whole and the two USTFs. CBO's estimate of the average capitation payment per enrollee for those USTF programs was approximately 4 percent lower than the per capita cost of the MHSS for catchment areas.

The USTF Programs Provide Care at a Higher Cost than the MHSS in Noncatchment Areas. All of the other USTFs are located in noncatchment areas, where costs to the government are generally lower. For fiscal year 1994, CBO estimated that the average per capita cost to the government would be $1,600 to provide care to non-active-duty beneficiaries under the age of 65 who lived in noncatchment areas and who used the MHSS as their primary source of care. Adjusting the USTF rates for the age and sex distribution of this eligible noncatchment area population--and for geographic differences between costs overall for the nation and for the USTFs--results in an average capitation rate for these USTF programs that is between 16 percent and 18 percent higher than the per capita cost of the MHSS for noncatchment areas. Because the USTF managed care programs are tantamount to an increase in benefits for noncatchment area beneficiaries, these results again seem consistent.

Diverse Problems Underlie the Comparison Between the USTFs and the MHSS. Comparing the costs of providing care to a uniform population of military beneficiaries through the USTF managed care programs and the

MHSS raises several different problems. The most significant limitation is that DoD does not know exactly how many people actually rely on the military health care system. That means that the per capita costs of providing care through the MHSS could very well be higher or lower than CBO has estimated.

Apart from the problems presented by the major differences in the designs of the two systems, the MHSS is a poor standard against which to compare the costs of the USTF managed care programs. Today's costs for care through the MHSS reflect past inefficiencies in health care delivery.[3] Any conclusions about the USTFs compared with the MHSS cannot offer a sound basis for judging whether USTF costs are too high. In addition, there are other possible differences between the USTF and MHSS populations that cannot be accounted for by the age and sex adjustment alone. Differences in health status and private insurance coverage are just two such examples.

Even more important, the difference between MHSS costs for catchment and noncatchment areas ($1,850 and $1,600) raises the question of which standard of comparison has more merit--the costs of MHSS care in catchment or noncatchment areas. If the per capita cost for catchment areas ($1,850)

3. For evidence on the high rates of health care use by military beneficiaries, see the following CBO publications: "Evaluating the Costs of Expanding Military Health Care Benefits into Lead Agent Region 6," CBO Memorandum (February 1994); and *Reducing the Deficit: Spending and Revenue Options* (March 1994).

were used as the standard against which the USTF managed care programs should be measured, then all of the USTF programs would be less costly than the MHSS. That conclusion is based on adjusting the USTF costs for the age and sex distribution of the eligible catchment area population and for the geographic differences in costs for the nation overall and the USTFs. Because of limitations in the data, however, the source of the relative advantage of the USTFs is difficult to pinpoint; it might stem from differences in the sets of benefits or the relative effectiveness of the two systems in providing care to military beneficiaries.

Comparing the Costs of the USTF Programs with Those of Civilian HMOs

Although the USTF managed care programs are not certified as HMOs, they incorporate many of the concepts of comparable managed care organizations. Like HMOs, the USTF managed care programs receive a fixed amount per enrollee. The USTF programs and HMOs also operate similarly, requiring people to enroll in their plans in exchange for lower out-of-pocket costs when enrollees use their designated network of providers. (Enrollment, in turn, makes it easier for the organizations to manage the provision of health care.)

Because of differences among the USTF managed care programs, no one model characterizes their system of health care delivery and financing. An independent practice association (IPA), which is a type of HMO, comes fairly close to most of the USTF programs, however. IPA plans contract with individual fee-for-service physicians or groups to provide services to enrollees of the IPA in physicians' private offices; those physicians may also continue to treat their other patients. Similarly, enrollees of the USTF managed care plans typically receive their services either in the USTFs or through a network of providers established by the USTFs to bolster the services available at the facilities.

To examine the costs of the USTF capitation rates compared with costs in the civilian sector, CBO used the premiums from the most comprehensive HMO plans offered under the Federal Employees Health Benefits (FEHB) program as a proxy for the health care costs of enrollees under those programs. The FEHB plans selected for this comparison represent all types of HMOs including IPAs. For all seven states in which the USTF managed care programs were available, CBO calculated an average HMO premium for that state based on a weighted average of single and family premiums for "high-option" HMO plans.[4] Although most such plans provide mental health

4. In contrast to the comparison between the MHSS and the USTFs in which CBO used a geographic factor to adjust the costs for each USTF, CBO made no such additional geographic adjustment in this comparison between civilian HMOs and USTFs in the same state.

coverage, it is not comparable to the coverage offered through the USTF managed care plans. Consequently, CBO added an allowance to each HMO plan's premium to take into account the typically more extensive mental health benefit offered through the USTF programs.

CBO then compared the capitation rates for each USTF with the FEHB premium for HMOs by adjusting USTF rates for the age and sex distribution of HMO enrollment nationwide. CBO found that the average weighted premium for the most comprehensive of the HMO packages offered under the FEHB program in each state was lower than the average capitation rates for every USTF managed care program, except for one in Maine. For the others, USTF rates ranged from as much as 25 percent higher to as little as 4 percent higher. Without the allowance added to the FEHB HMO premiums for the mental health benefit, the USTF rates would have been even higher--from 11 percent to more than 30 percent above the average of the FEHB premiums.

To examine the reliability of these results, CBO also looked at the 1992 per capita health care costs of the best-selling HMO package of benefits for those regions with USTFs. After adjusting those 1992 costs to 1994 and adding an allowance for the mental health benefit, CBO again found that the average capitation rates of the USTFs were higher than the per capita health

care costs for the best-selling HMO package. Specifically, USTF rates ranged from as much as 19 percent higher to as little as 3 percent higher.

Like the comparisons with MHSS costs, this comparison with HMO costs is subject to limitations and qualifications. First, the USTF managed care programs and civilian HMOs are not exact matches. Although comparability is somewhat less problematic than with the USTFs and the MHSS, differences in benefit packages and cost-sharing requirements mean that the USTF programs and the civilian HMOs are not fully comparable.

Second, CBO could not control for the health status of those people enrolling in USTF managed care programs. Civilian HMOs tend to attract a younger, healthier population of enrollees, whereas the USTF programs may be attracting an older group of enrollees with more health problems. This could be occurring in part because coverage by the military is limited to enrolling in the USTF managed care programs or using the MTFs based on space availability and priority status. (Those under age 65 can also use CHAMPUS.) To avoid that system of access to care, a military beneficiary whose health care needs were great would have an incentive to enroll in the USTF program.

In the absence of being able to control for the above factors (not to mention the selection process), this cost comparison can only suggest that the capitation rates for the USTF managed care programs--taking into account the rates for enrollees both under and over 65 years of age--are higher than the premiums for civilian HMOs. That conclusion agrees with CBO's findings about care provided through the MHSS in noncatchment areas compared with the USTF managed care programs.

IMPACT ON BUDGETS AND EXPENDITURES

The Congress also directed CBO to examine the impact of the USTF managed care programs on DoD's budget and expenditures. The previous analysis suggests that in noncatchment areas the costs to DoD are higher with the USTF managed care programs than without them. To address this question more fully, however, CBO focused on two other sets of issues, both of which suggest that DoD and the federal government are at risk of cost increases from the USTF programs. The first set of issues, which affects DoD's budget only, centers on the pressures arising from the rate-setting methodologies used to reimburse the USTFs in fiscal year 1994 and from DoD's assuming greater responsibility for the Medicare population. The second set of issues moves slightly beyond the Congressional request by discussing the possible impact on the federal budget of spending for

individuals who enroll in a USTF and also receive health care through Medicare.

How DoD Is Affected

As previously discussed, DoD has begun to reimburse the USTF managed care programs on the basis of capitation. Under the current reimbursement formula, DoD developed rates for fiscal year 1994 for two groups of enrollees: those under and those over 65 years of age. (Rates for these two groups had to be developed separately because of the major differences in the way that they use the MHSS.)

For beneficiaries under the age of 65, DoD developed rates for fiscal year 1994 based on the 1989 national average per capita cost of providing care through the MHSS to non-active-duty beneficiaries under the age of 65 who rely on the MHSS as their primary source of care. This approach was taken to ensure that the same amount would be spent on beneficiaries enrolled in a USTF managed care program or using the MHSS as their primary source of care. DoD then used the national average per capita cost to develop specific rates by age and sex for each USTF by adjusting the national cost for the geographic location of the facility and applying a set of

actuarial age and sex factors. To develop rates for fiscal year 1994, these base rates for 1989 were inflated each year by the annual rate of change in the medical services component of the consumer price index plus 3 percent to reflect additional cost growth arising from increased use and intensity of services, along with technological improvements. DoD then reduced these rates for 1994 by 1.25 percent to account for the potential recovery of third-party reimbursement by the USTFs.

For beneficiaries over the age of 65, DoD could not develop rates based on MHSS costs because, for a number of reasons, those beneficiaries rely primarily on non-DoD sources of coverage, including Medicare and private insurance. (Most important, military beneficiaries who are eligible for Medicare are not eligible for CHAMPUS and, like other retirees and their dependents, have the lowest priority access to MTFs.) Instead, DoD developed annual reimbursement rates for fiscal year 1994 using 1993 capitation rates for enrollees over age 65 in HMOs under contract to Medicare. DoD then used these rates to develop specific rates by age and sex for each USTF, adjusting the average per capita costs for the geographic location of the facility and applying a set of actuarial age and sex factors. These base rates were then inflated each year by the annual rate of change in the medical services component of the consumer price index (MCPI) plus 3 percent. To account for the more generous benefit package offered by the

USTFs relative to HMOs under contract to Medicare, DoD added an amount to the capitation rates to cover services included in the USTF benefit package but not covered by Medicare HMOs. The specific amount added was based on 1991 premium information about supplemental benefits, adjusted for geographic region and the MCPI.

Under these two rate-setting methodologies, the budget for the USTF managed care programs is likely to grow at a much faster rate than other parts of DoD's health care budget--for two reasons. The first, which applies only to rates developed for beneficiaries under age 65, is the use of 1989 as the base year for determining the 1994 rates--1989 costs are higher compared with more recent patterns of spending in the MHSS. A study by Lewin-VHI, Inc., showed that using the 1992 national average per capita cost of providing care through the MHSS to beneficiaries who relied on that system--rather than the 1989 levels--would result in capitation rates of almost 10 percent less in 1994. According to Lewin-VHI, this discrepancy was due, in part, to several factors: an inaccurate estimate that DoD made in adjusting the 1989 rates for higher CHAMPUS deductibles, a relative shift toward less expensive outpatient care, and the method of indexing the capitation rates.[5]

5. See Lewin-VHI, Inc., "Review of the USTF Managed Care Plan," submitted to the Assistant Secretary of Defense (Health Affairs) (Fairfax, Va.: Lewin-VHI, Inc., April 26, 1994).

That method--indexing the capitation rates paid to the USTFs by the MCPI plus 3 percent--is the second reason for the pressure on DoD's budget, which applies to rates for both groups of beneficiaries. Between 1989 and 1993, the rates for the USTFs increased by an average of 11 percent per year. Yet for that same period, DoD's health care budget rose by only about 7 percent--less than the average rate of inflation as measured by the MCPI and almost 4 percentage points less than the rise in rates for the USTF programs. DoD and the USTFs are currently negotiating capitation rates for 1995. Preliminary indications are that the base starting point will be moved to 1992, which would remove some of the budgetary pressure. At this time, however, it is unclear whether the 1992 base rates will continue to be adjusted each year by the MCPI plus 3 percent.

If DoD continues that method of indexing, the portion of its funding available for health care will shift toward the USTF managed care programs. Although they currently constitute only a small part of the total DoD health care budget ($265 million out of $15 billion in 1994), this imbalance will become more pronounced in the future. The actual inflation rates used by DoD for 1993 through 1995 are a composite of all medically related costs and not just those included in the MCPI. Those rates are even lower than the MCPI--5.3 percent for 1993 and 4.3 percent for 1994 and 1995--meaning that the USTF programs will receive greater increases than other parts of the

MHSS. That situation will lead either to increasingly inequitable patterns of spending for USTF enrollees at the expense of other military beneficiaries or to even larger profits for providers.

Apart from the pressures on the budget arising from the reimbursement methodologies, DoD will also feel some budgetary stress--absent any offsetting reimbursement by Medicare--from assuming greater responsibility for Medicare-eligible beneficiaries who enroll in the USTF managed care programs. DoD now spends very little on such beneficiaries because they rely on other forms of insurance coverage, such as Medicare. In fiscal year 1994, CBO estimates that DoD will spend less than $800 million--or about $700 per beneficiary--to provide health care to eligible military beneficiaries over the age of 65. The reimbursement formula for the USTF programs for enrollees who are eligible for Medicare, however, assumes that the USTFs are their primary source of care. As a result, the average annual rate of reimbursement for the USTF programs is approximately $5,600, or eight times more than the cost to DoD of providing care to Medicare-eligible people through the MHSS. Based on the estimated number of Medicare enrollees in the USTF managed care programs today (roughly 20,000), CBO estimates that DoD is spending close to $95 million more per year than it would otherwise have spent had enrollees continued to receive only some of their care from the military health care system.

Because CBO could not examine the effectiveness of the USTF managed care programs, it has no way to tell whether the benefits that enrollees receive are worth their higher cost to DoD. They may be; nevertheless, if the USTF programs expand--while continuing to attract Medicare beneficiaries--DoD may be forced to devote an increasingly disproportionate share of its resources to the USTF managed care programs for only a small segment of its overall eligible beneficiary population.

How the Federal Government Is Affected

CBO also considered the financial impact of the USTF managed care programs on the federal government as a whole, focusing on USTF enrollees over 65 years of age who are also eligible for Medicare. This group represents a potential risk of "double-dipping" from both sources of care. If this practice occurred, the government would be paying twice: once to the USTFs in the form of monthly enrollee payments and again to private providers who charge Medicare for services rendered.

USTF enrollees who are eligible for Medicare must agree not to use their Medicare benefits while they are covered under the USTF programs. If they use their Medicare benefits anyway and are caught, their enrollment

is terminated. To date, DoD has had no system in place to identify those individuals who use both health care systems. As a result, the federal government may be making double payments for a number of beneficiaries.

For the future, however, DoD hopes to be able to identify all Medicare beneficiaries who use both sources of care. By the end of fiscal year 1994, DoD may gain access to tapes from the Health Care Financing Administration that would allow identification of individuals who continue using their Medicare benefits after enrolling in the USTF managed care programs.

To lessen the effects of double-dipping, DoD can reduce future USTF capitation rates. Nonetheless, the terms of the participation agreements still place the federal government at some risk because DoD cannot reduce future rates by the full amount of possible Medicare leakage. The present methodology used to calculate reductions in capitation rates holds the USTFs responsible for as much as 100 percent of the amount of leakage up to 1 percent of capitation payments, but for as little as 25 percent if leakage is between 7 percent and 10 percent of capitation payments.