CBO TESTIMONY

Statement of
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on
Reforming the Military
Health Care System

before the
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Mr. Chairman, I appreciate the opportunity to appear before this Subcommittee to discuss the future of the military health care system. My testimony focuses on the plans of the Department of Defense (DoD) to reform that system and covers a range of issues, including:

- An overview of the military health care system;
- The obstacles to reforming the military health care system;
- DoD's plan to implement its Tricare managed care program nationwide; and finally,
- Modifications to the Tricare program and other strategies to improve the cost-effectiveness of the military health care system.

THE MILITARY HEALTH CARE SYSTEM

The Department of Defense operates one of the largest health care systems in the nation. Together, the Army, Navy, and Air Force operate about 135 medical centers and regional and community hospitals and more than 500 clinics worldwide. This substantial military medical establishment has a twofold mission: wartime readiness, which means having the capability to meet the armed services' wartime medical needs; and the provision of medical

care during peacetime to uniformed personnel and other eligible beneficiaries, including dependents of active-duty personnel, retirees, their dependents, and survivors.

Historically, the capacity of military hospitals and clinics (military treatment facilities, or MTFs) has fallen short of requirements for both missions. Wartime requirements during the Cold War, which reflected the scenario of an all-out conventional war in Europe, exceeded the services' ability to care for projected combat casualties and nonbattle disease and injury rates. DoD's plans during that period also included substantial backup hospital capacity for extended care through contingency agreements with the Department of Veterans Affairs and civilian hospitals under agreement with the National Disaster Medical System.

Peacetime demand has also exceeded the capacity of the military medical establishment, prompting the Congress in 1966 to establish the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), DoD's traditional fee-for-service insurance program that covers most of the cost of care that beneficiaries receive from civilian health care providers when care in military facilities is not available. By way of illustration, more than 8.5 million beneficiaries are eligible for military health care, though only 6.5 million actually choose to use the military health care

system. A substantial number of beneficiaries--2 million people--depend on sources outside the military for some or all of their health care. Some rely on Medicare. Others have private insurance, perhaps through their own employment or their spouse's employment, and use it to pay for health care in the civilian sector.

Military medical facilities provide the majority of care to those who use the military health care system; CHAMPUS provides the rest. Active-duty personnel, who have priority over all other potential users, receive almost all of their care in military hospitals and clinics. Their dependents are second in priority and receive care when space is available; in practice, military facilities provide the preponderance of dependents' medical care. Retirees and their dependents and survivors are also eligible to receive care in the MTFs, but they rank lowest in priority and actually receive the majority of their care in civilian settings, with reimbursement under CHAMPUS or other insurance policies.

In fiscal year 1994, DoD will spend about $15 billion to support the military health care system. In real terms, that amount is one-third greater than the budget for the system just 10 years ago. The total medical budget no longer consumes 3 percent, but rather 6 percent, of the total defense budget.

Besides the mounting pressure on the department to control costs, the hybrid nature of care at the MTFs and through CHAMPUS has been widely seen as unsatisfactory by beneficiaries, the services themselves, and the Congress. In response, the department has conducted a number of tests of alternative programs in recent years. The most recent of these tests, the CHAMPUS Reform Initiative (CRI), attempted to incorporate into military health care new approaches to managed care being used in the civilian sector. DoD's current plans for restructuring its health care system are an outgrowth of its experience with CRI.

PROBLEMS IN THE PROVISION OF MILITARY HEALTH CARE

Beneficiaries and providers in the military health care system face few incentives to economize on care. Two factors are largely responsible for this situation: a benefit structure with low cost-sharing requirements that encourages excessive use by patients, and a paucity of constraints on providers to curb the delivery of unnecessary and inappropriate health care. These problems are compounded by the interplay between the services' wartime and peacetime missions.

The Generosity of the Military Health Care Benefit

Compared with other health care plans, the military health care benefit is extremely generous. Care in the MTFs is virtually free to eligible beneficiaries. Beneficiaries face no deductible and virtually no copayments for outpatient care and prescription drugs. Even for inpatient care, some beneficiaries pay only nominal fees, while others pay nothing. Eligible military beneficiaries are not subject to any premium or requirements to enroll in a military health care plan, but instead are free to receive all, some, or none of their care from the military health care system.

The generosity of the benefit structure may help to explain why, compared with the U.S. population at large, military beneficiaries under the age of 65 make heavy use of health care. In 1992, civilians in the United States under the age of 65 consumed about 530 days of hospital care per 1,000 people and made 4.5 outpatient visits per person. Even after adjusting for differences in use associated with age and sex, comparable military beneficiaries consumed about 676 days of hospital care per 1,000 people and made 7.3 outpatient visits per person. Thus, military beneficiaries used hospital care at a rate about one-fifth higher, and outpatient care at a rate two-fifths higher, than the general population.

Despite these generous benefits, however, not all eligible military beneficiaries receive their care from the MTFs. Even among active-duty dependents, many are unable to gain access to care at the MTFs and instead rely on CHAMPUS. Some simply live too far away from the MTFs, and others prefer alternative coverage to what is available through CHAMPUS. About 10 percent of active-duty families have other health insurance coverage and may not rely on the military health care system at all for their care.

Similarly, many retirees and their families depend on sources outside the military for some or all of their care. Retirees and their dependents over the age of 65 receive care through Medicare. Many other retirees have private insurance through either their own or their spouse's employment and use it to pay for health care in the civilian sector. Based on the most recent survey by DoD, almost 60 percent of retirees are covered by private insurance policies.

Potential demand for health care by beneficiaries not now served by the MTFs poses both a problem and an opportunity for the military health care system. The problem is that if either additional capacity became available in the MTFs (for example, as a result of the defense drawdown) or alternative sources of care became more costly, the generosity of the military health care benefit might encourage use of military care by eligible military

beneficiaries who now use non-DoD sources. This risk is high considering that almost a quarter of DoD's total eligible population now relies on non-DoD sources for health care. But if additional demand by this so-called ghost population did not materialize, DoD might be able to reduce its overall costs of medical care by providing additional care at the MTFs to beneficiaries who currently are forced to rely on CHAMPUS. Even for this population, however, better access to the MTFs could also mean higher overall rates of health care use. In effect, beneficiaries who pay little out of pocket for their health care have almost no reason to economize.

Practice Patterns of Military Providers

Compounding the problems arising from the generosity of the military health care benefit are the incentives facing military providers to deliver more care to eligible military beneficiaries in the MTFs than the latter would receive under CHAMPUS. Among the most obvious factors influencing a physician's treatment of a patient are the supply of hospital beds and the economic incentives of the health care delivery and financing system. Based on the substantial hospital capacity of the military medical facilities, physicians thus can prescribe more and longer hospital stays than private-sector providers would offer.

Additional inefficiencies have arisen because budgets for the military health care system historically have been set on the basis of workload. Hospital commanders thus have had an economic incentive to fill their hospital beds. The policies of the specific services in treating patients also tend to create differences between the practice patterns of military and civilian physicians. Hospitalizing military beneficiaries for tooth extractions is just one example of the major differences in practice patterns between military and civilian physicians.

DOD'S CURRENT APPROACHES TO IMPROVING MILITARY HEALTH CARE

The Department of Defense has recently completed two major initiatives to improve the provision of health care to military beneficiaries. One is the so-called 733 study, mandated by the Congress in section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993, that analyzed peacetime and wartime requirements for health care. The second is the department's decision to move forward with the Tricare program and adopt a "triple option" benefit structure that would encourage beneficiaries to participate in more efficient managed care programs.

The 733 Study

The major objectives of the 733 analysis were to determine the wartime mission for military medical care in the post-Cold War era, and to determine how independently to provide cost-effective care in peacetime to eligible military beneficiaries. The wartime mission was adjusted to reflect current defense policy, which calls for the capability to fight two nearly simultaneous major regional conflicts. Although the study adopted a number of conservative assumptions, the resulting estimates of wartime requirements are substantially lower than those based on Cold War scenarios. Equally significant was the study's finding that MTF capacity is now well above projected wartime requirements, in contrast to the situation that existed during the Cold War. Had DoD taken into account the backup capacity provided by the Department of Veterans Affairs or even the National Disaster Medical System, wartime requirements would have been even lower and the excess capacity of the military health care system even higher.

The peacetime portion of the study examined the economics of sizing the military medical establishment. To determine if care provided in military treatment facilities is more cost-effective than care received under CHAMPUS, DoD simulated what would happen to total medical costs if the capacity of the MTFs expanded modestly to "recapture" the care provided in

the civilian sector under CHAMPUS. The analysis concluded that, for individual episodes of treatment, it costs less to provide care in the MTFs than through CHAMPUS. Recapturing CHAMPUS's workload, then, on a one-for-one basis would lower DoD's costs.

Nonetheless, the study found that improving access to care at the MTFs would increase total medical costs, because savings from recapturing individual cases would be more than offset by increases in the volume of care provided at the MTFs. The principal reason for this finding is that improved access would encourage some "ghost" beneficiaries to reenter the military health care system and forgo receiving care from other non-DoD sources, leaving DoD to pay for the care that third-party health plans would otherwise have paid. A secondary reason is that the rates of health care use among beneficiaries are higher when they receive care at the MTFs, because it is virtually free to beneficiaries and military providers tend to deliver more care than civilian practitioners.

Tricare

In December 1993, DoD submitted a plan to the Congress for establishing a managed care plan nationwide, referred to as Tricare. The goals of this plan

are to ensure that eligible military beneficiaries have access to stable, high-quality health care benefits and to improve the efficiency of the military health care system. To accomplish those goals, DoD proposes to establish a new approach to delivering and financing health care in the military on a regional level that will include both a system of capitated budgeting and a new triple option benefit package.

Triple Option Benefit Structure. The Tricare program would offer eligible military beneficiaries three options for health benefits. One choice would be to enroll in Tricare Prime, a plan modeled after approaches of private-sector health maintenance organizations (HMOs), but with a point-of-service option that would permit enrollees to retain the freedom to choose their own doctor. A second choice would be to continue using the standard CHAMPUS benefit plan, called Tricare Standard. A third choice for those using Tricare Standard would be to participate in Tricare Extra--a preferred provider option, or PPO --on a case-by-case basis. Neither Tricare Standard nor Tricare Extra requires beneficiaries to enroll. For all military beneficiaries, the MTFs would continue as the primary source of care, augmented by a network of civilian health care providers.

Each of the health benefit options will work somewhat differently. Similar to an HMO, Tricare Prime requires beneficiaries to enroll in the plan

and agree to obtain all of their care through a network of military and designated civilian providers. In return for surrendering some freedom to choose their doctors, enrollees in Tricare Prime benefit from less paperwork, enhanced coverage, and lower out-of-pocket charges than users of Tricare Standard when they obtain care from a civilian provider. The point-of-service feature of Tricare Prime, however, gives beneficiaries an additional option to obtain care from civilian doctors outside the network, albeit at higher out-of-pocket costs. Many of the features of Tricare Prime, such as the existence of a civilian or military primary care physician to manage the beneficiaries' use of health care, may make it more likely that enrollees will receive better access to the MTFs than nonenrollees. But by law access to the MTFs will continue to be granted on the basis of available space and priority status.

Beneficiaries wishing to enroll in Tricare Prime would have to pay an annual enrollment fee before they use any care at all, except dependents of junior enlisted personnel, who would pay nothing. As of this date, all other dependents of active-duty personnel would pay an annual enrollment fee of $35 for single coverage or $70 per family. Retirees and their family members would pay an annual enrollment fee of $50 for single coverage and $100 for families.

But by no means are the proposed enrollment fees for Tricare Prime--or, for that matter, the cost-sharing requirements--carved in stone. In fiscal year 1994, the Congress directed DoD to develop a uniform benefit option, modeled after civilian HMOs, that would reduce out-of-pocket costs for enrollees and be budget neutral. The DoD Comptroller has insisted that any such HMO option reduce the department's net costs. As currently designed, Tricare Prime would fail to meet both Congressional and Comptroller tests of budget neutrality.

The department has a number of options under consideration for its HMO-style program that would eventually replace Tricare Prime and attempt to reduce enrollees' out-of-pocket costs while achieving budget neutrality or perhaps even savings for DoD. All of the options are based on varying the cost-sharing requirements for care received under CHAMPUS and the MTFs, compared with those requirements under the present benefit structures and managed care demonstration programs. Some of the options consider only changes in requirements for care received under CHAMPUS; these would significantly reduce out-of-pocket costs for beneficiaries through removal of the deductible and some combination of lower inpatient and outpatient copayments. Other options would simply extend copayments to the use of certain types of care--such as outpatient care--at the MTFs.

Based on the cost-sharing requirements outlined for each benefit option, DoD apparently set the enrollment fee for each option to be budget neutral, holding constant the assumption that enrollees must have lower out-of-pocket costs. The results of DoD's analysis of these options have not yet been released, but preliminary indications are that few of the options can reduce out-of-pocket costs while resulting in budget neutrality or savings for DoD. Moreover, none of the options would hold beneficiaries liable for a premium comparable to those required to join a civilian HMO.

Of course, beneficiaries may elect to continue under Tricare Standard. In doing so, they will also continue to have access to the MTFs on a space-available basis and in order of their priority status. When care is not available at the MTFs, beneficiaries under Tricare Standard will retain the freedom to choose their own doctors, but they will pay higher out-of-pocket costs than under Tricare Prime. On a case-by-case basis, however, they may choose to use Tricare Extra. Under that program, beneficiaries who choose to use designated civilian providers for a particular episode of care pay less out of pocket and benefit from the lower prices accepted by network providers.

New Management Structure. In 1993, DoD established 12 health service regions across the country. Within each region, DoD has appointed a military medical "lead agent" (the commanding officer of the major military medical center in the region) with responsibility for carrying out the Tricare program. One of the major responsibilities of the lead agents will be to coordinate the delivery of health care within a region. Specifically, each lead agent will be responsible for developing a regional health services plan in conjunction with the hospital commanders of the military medical facilities within the region. Each plan is expected to outline how the region intends to meet the goals of managed care--and in particular its plans for both setting up a civilian provider network and adopting utilization management.

To supplement the capacity of the MTFs to meet the health care needs of each region's beneficiaries, DoD plans to extend fixed price, at-risk contracts for managed care support in all 12 regions. Under the overall authority of the lead agent, contractors will be responsible for developing networks of civilian health care providers and for providing other fiscal and administrative support to the lead agents in areas such as utilization management. The lead agent will be responsible for ensuring the integration of the civilian provider network and the MTFs, as well as ensuring that the three military departments are working together.

Capitated Budgeting. Capitated budgeting is another major feature of the Tricare program that attempts to improve the efficiency of the military health care system. To give hospital commanders a fiscal incentive to control costs, DoD introduced a system of capitated budgeting in 1994. Under capitated budgeting, each of the military departments, and in turn each commander, receives a fixed amount per beneficiary for providing all health care to the population within the hospital's defined service area.

By limiting future budgets to a fixed amount per person, DoD hopes to revise the current set of economic incentives facing military providers in the MTFs and encourage commanders to deliver only care that is both necessary and appropriate. This approach, if carried out effectively, would reverse a system of budgeting on the basis of historical patterns by MTFs in providing care and using resources. That budgetary process rewarded hospital commanders with larger budgets if they provided more health care. DoD's approach to capitation eliminates most of those incentives. The way that DoD plans to execute this method of budgeting, however, poses two major problems--both of which could undermine the effectiveness of capitation. Specifically, the method could lock in inefficiencies and could create conflicting financial incentives for MTF commanders.

Given that inefficiencies are part of the current medical system, setting per capita amounts on past levels of military spending will "lock in" the inefficiencies of the military health care system. DoD's systemwide approach to capitation, which projects resource requirements on the basis of historical spending patterns, is likely to do just that. Evidence of above-average use of medical care by military beneficiaries strongly suggests that capitation carried out in this way would tend to perpetuate inefficiencies. The lack of a clearly defined population against which per capita budgets are set could increase the risk that this occurs.

A much larger problem is to ensure that the financial incentives facing the hospital commander of the MTF do not unravel when DoD introduces the contracts for managed care support under Tricare. Under Tricare, DoD plans to hold a single contractor accountable for delivering all civilian care to beneficiaries who are eligible for CHAMPUS. MTF commanders, however, will be responsible for all care delivered to all eligible beneficiaries, even including the civilian care provided to CHAMPUS beneficiaries under the contractor's management. The budgets of MTF commanders will be based on the population of beneficiaries living within each hospital's service area; contractors will receive their payments on a similar basis, net of the costs of the care provided to military beneficiaries at the MTFs. During the course of the contract period, price adjustments will

be made on the basis of changes in three factors--population, the rate of reimbursement for providers under CHAMPUS, and the amount of care delivered at the MTFs.

The major problem with this approach is that adjusting prices on the basis of the amount of care delivered at the MTFs creates a set of contradictory incentives for the MTF commanders. Capitation will encourage the commander to curb the use of unnecessary care at the MTF. But the process of adjusting the bid would encourage the commander to deliver more care, thereby undermining the basic incentive of capitation to use resources more efficiently. This problem arises because a decrease in the amount of care delivered at the MTF would reduce the hospital commander's budget and in turn increase payments to the contractor. This shift would occur even if the reduction in the amount of care delivered at the MTF was attributable to improvements in efficiency at the facility. MTF commanders would have little incentive to find more cost-effective methods of delivering care, but quite the contrary would have a strong incentive to increase the amount of care at the MTF without regard to the level that is appropriate for the population being served.

For inpatient care, DoD has attempted to address this problem by proposing to adjust payments to the contractor for care that is authorized by

the MTF commander. But on the outpatient side, MTF commanders would still face the incentive to deliver additional visits at the MTFs, which without copayment requirements might result in beneficiaries increasing their use of MTF outpatient services. A more fundamental solution to this problem could require a restructuring of the financial arrangement between the MTF commander and the contractor. Delineating clearer lines of responsibility, such as assigning beneficiaries to either the MTF commander or contractor, would reinforce the incentives created by capitation. That solution, however, could have the effect of reducing access to the MTFs for beneficiaries assigned to care through the contractor, thereby causing those beneficiaries to have higher out-of-pocket costs than those assigned to the MTF commander.

Tricare Phase-In. DoD plans to put the Tricare program in place over the next three fiscal years. Based on the major changes that DoD intends to make--as well as numerous problems DoD has had in awarding its managed care contracts--that schedule may prove impossible. Nonetheless, by the end of fiscal year 1996, DoD plans to award all 12 regional contracts for managed care support. Operationally, that means by May 1997, in every region, beneficiaries will be offered the triple option benefit package, with the exception of certain areas of the country where DoD will not be able to offer

beneficiaries a health maintenance organization because of insufficient population.

To move Tricare along, lead agents have started to develop the required regional health services plans. A major part of that planning process will involve determining how much support the managed care contracts will provide to the MTFs to meet the health care needs of the region's population. To date, DoD has received plans from about half of the regions, though these plans--certainly subject to change--will not take effect until a contract for managed care support has been introduced. Until that time, lead agents will have other challenges, such as bringing the three military departments together for the planning process.

EVALUATING TRICARE

Several elements of the Tricare program will improve the incentives facing beneficiaries and providers alike--but only partially. Because Tricare fails to require universal enrollment--with premiums that would minimize the risk of ghosts reentering the military health care system--the department may find it difficult to establish a well-managed health care delivery system and implement capitated budgeting effectively. So far, Tricare also lacks the adoption of copayments at the MTFs that would encourage beneficiaries to

restrict their use of outpatient health care, although some of the program's administrative features will permit hospital commanders to control utilization rates.

Universal Enrollment

A requirement that all eligible military beneficiaries who plan to use the military health care system enroll in a military health care plan would offer DoD many advantages. Military providers could begin to plan for the health care needs of a defined population around which per capita budgets could be developed and cost-effective health care delivery networks built. Both of those strategies require an accurate count of the population against which medical resources could be capitated and health care plans developed. They can be carried out only if DoD is able to force all eligible military beneficiaries to choose between a military plan and civilian sources of care.

Tricare, however, fails to require universal enrollment and merely gives beneficiaries an opportunity to enroll in a program of managed care akin to a private-sector health maintenance organization. About two-thirds of the beneficiaries will probably decide not to enroll and instead will continue to seek care either at the MTFs or under CHAMPUS. At the same time, all

beneficiaries--enrollees and nonenrollees alike--may continue to use many other non-DoD sources of care and payment, including Medicare and private insurance. Hence, even if the enrollment requirements under Tricare Prime were extended to the entire population, DoD might not have any firmer grasp on the number of people actually relying on its system of care than it does today.

The existence of ghost beneficiaries makes it even more problematic to adopt a system of universal enrollment as a precondition to using the military health care system. For instance, if DoD required beneficiaries to enroll with the military--or face the possibility of "lockout" from the virtually free care at the MTFs and care under CHAMPUS--more beneficiaries could actually end up using the military's health care system. In tandem with a policy that required beneficiaries to forgo other health insurance options, many more beneficiaries would be likely to drop their other private insurance policies, driving up total military medical costs.

The low enrollment fees proposed as part of Tricare Prime would create this risk to DoD of ghosts reentering the military health care system. Most eligible beneficiaries--regardless of how much they may actually rely on the system today--would enroll in the military plan for a low annual fee in order to receive the extra security of coverage through the military system.

Premiums and Copayments

If enacted, the Clinton Administration's proposal for national health care reform would require beneficiaries to choose between a military plan and a civilian health plan. But short of a national consensus to restructure the provision of health care, active-duty and retired beneficiaries would view a unilateral action by DoD along these lines as a breach of faith.

An alternative, for which some precedent exists, would simply be to narrow the relative price disparities between the military health care plan and civilian plans. That could be achieved by requiring a substantial premium for eligible military beneficiaries to use the military health care system. Incentives could be improved even more if the premiums were accompanied by copayments--applied uniformly across the military and civilian settings--at levels approaching those in civilian plans.

Adopting a premium--or higher enrollment fee--for the military health care benefit would offer many advantages. Most important, a higher enrollment fee or premium for the military would reduce the risk of ghosts reentering the system, facilitating both regional management of the military health care system and capitated budgeting. It would also provide DoD with greater flexibility in reducing its cost-sharing requirements to resemble the

structure of most civilian HMOs--in particular for inpatient care received by retirees under CHAMPUS--without increasing its overall costs.

The best example of such an approach at work in the military health care system is the Uniformed Services Active Duty Dependents Dental Plan. Delta Dental (as it is known) is a comprehensive dental plan that is available only to dependents of active-duty personnel--individuals and families alike. Enrollment is voluntary.

Like many employers, DoD has unbundled its dental plan from other medical benefits, and Delta Dental operates on a par with many plans offered by civilian employers. To receive coverage, dependents of active-duty personnel must pay a premium--in 1993, around $265 for a single policy and roughly $530 for a family policy. DoD paid about 55 percent of the premium in that year regardless of the type of policy purchased. Hence, the net cost to the beneficiary enrolled was about $120 for an individual policy, and roughly $230 for a family policy. Depending on the type of service needed, copayments are also required.

Delta Dental offers a sharp contrast with the fee structure that DoD has proposed for Tricare Prime. The premium for Delta Dental, which covers only a portion of beneficiaries' health care, is more than triple the fee for

enrolling in Tricare Prime. More than half of all active-duty family members, however, pay the Delta Dental fees because they apparently are satisfied with the benefits that they receive. The rate of disenrollment has been falling steadily and is currently very low. Moreover, enrollment increased between 1992 and 1993 even though the level of premiums facing beneficiaries grew by 50 percent to 100 percent as a result of moving from a plan with basic coverage to one with comprehensive coverage, and even though enrollees became responsible for paying a greater share of the premium.

Collectively, the experience of the Delta Dental Plan offers several lessons. For one, military beneficiaries are willing to pay a premium as long as they are guaranteed a uniform, comprehensive health care benefit. In addition, the willingness to pay for dental insurance apparently reflects the perception of beneficiaries that the coverage is generous enough to justify its cost.

It is difficult to require a premium from beneficiaries when the availability of military health care is governed by available space and resources at the MTFs and beneficiary group status. Tricare loosens these space and resource constraints through its requirement that lead agents develop a regional health care delivery network, with the help of the contracts for wraparound managed care support. But the other major impediment to

setting a premium for the military health care benefit would still exist. That is, military beneficiaries will continue to receive care at the MTFs based on their priority status.

If DoD is able to develop a benefit structure that removes all such impediments, then perhaps it could establish a premium based on the costs of providing care to enrollees. Unless the benefit was perceived as more generous, however, military beneficiaries would probably view a premium as an erosion of their benefit package. That was less a problem with the Delta Dental program because dependents of active-duty personnel received virtually no dental coverage at the MTFs before enrolling in the dental plan. But dependents of active-duty personnel were willing to pay a substantially higher premium when their basic dental coverage became comprehensive. If military beneficiaries perceived the military health care benefit as sufficiently generous, they too might be willing to pay a premium.

Offsetting Beneficiaries' Costs of Health Care

The evidence from the Delta Dental Plan strongly indicates that eligible military beneficiaries are willing to pay for a quality health care plan. To determine how to set premiums for the military health care system, DoD

could consider what premiums are for comparable benefit packages in the civilian sector. In 1992, the premium for the best selling HMO package was around $3,300. Individuals paid between $1,500 and $1,700 per year for a single policy, while a family policy cost between $4,000 and $4,700 per year. Those premium costs, however, are about 45 and 65 times higher than the enrollment fees proposed for individuals and families, respectively, under DoD's Tricare Prime program.

Holding beneficiaries liable for a premium might require DoD to consider ways to offset the cost of medical care to active-duty families. Because medical care is only one important part of the military compensation package for active-duty families, other parts of that package could be used to offset any increases in beneficiaries' out-of-pocket costs imposed by a premium or copayments at the MTFs. For instance, along the lines suggested by the National Military Family Association, active-duty members could be provided an allowance or other forms of compensation to make up for what they would pay in premiums. Assigning civilian employers financial responsibility for sharing in these premiums--a feature of the Administration's health care proposal--would also help to defray any increases in medical costs as a result of this new financing arrangement.

Compensating active-duty members in the form of pay would also provide their families with greater economic empowerment to choose between the military health care system and civilian health care plans. This approach would be consistent with the President's proposal to reform the national health care system if premiums were raised to rough parity with those in civilian plans. Under the President's plan for military health care, however, beneficiaries would face strong economic incentives to enroll in the military plan rather than civilian alternatives.

A requirement to pay a premium to receive care through the military health care system would not necessarily lead to downsizing the military medical establishment. The important question is how differences between the costs of military and civilian health care plans would affect behavior.

As one might expect, the results of DoD's latest survey of beneficiaries' attitudes, choices, and knowledge--performed as part of the 733 study--suggest that differences between civilian and military premiums matter to beneficiaries. For example, if eligible military beneficiaries were given the choice of enrolling in either a military plan or a civilian plan, and assuming monthly civilian premiums were higher by $20 per individual or $50 per family than military premiums, roughly 6.2 million eligible military beneficiaries say they would enroll in the military health care plan, about the number using the

system today. If the difference in costs to the beneficiary between the military health care system and the civilian health care plan was even larger, it would drive enrollment rates up even higher--prompting many of the ghosts among the retiree population to reenter the military health care system. The net costs to DoD would depend on how financial responsibility was assigned among DoD, beneficiaries, and other employers.

MODIFICATIONS BEYOND TRICARE

As the 733 study indicates, the present size of the military medical establishment is more than adequate to meet the requirements of the wartime mission. Instead, it is the demand for health care by eligible military beneficiaries during peacetime that drives the size of today's military medical establishment. The question framed by the 733 study is how DoD should size its military medical establishment to meet its peacetime demands. The Tricare program would preserve the size of the military medical establishment.

The reduction in wartime requirements means that the decision to change the size of the military medical establishment should be based on the cost-effectiveness of that system to meet peacetime demand. Two choices are emphasized here, although there are many more choices along the continuum.

If DoD can provide care to its beneficiaries during peacetime more efficiently than the private sector can, then clearly DoD should preserve and possibly even expand the size of its military medical system. But if DoD is a less cost-effective provider of care than civilian providers, then its military medical infrastructure should only be adequate to meet wartime requirements. Peacetime requirements above that capacity should be met through arrangements with civilian health care plans.

The results of the 733 study show that DoD cannot provide care more cost-effectively in the MTFs than through CHAMPUS or other civilian plans. This conclusion applies unless DoD can control the effects of demand, particularly from those eligible military beneficiaries who do not rely on the system today. Tricare may help the department limit demand, especially through the role of gatekeepers. But the Tricare program fails to include other strategies to improve efficiency of the system, such as extending copayments to the MTFs, instituting an adequate capitation method of budgeting, and most important, implementing a system of enrollment with premiums that would help with regional health care planning without substantially increasing total medical costs.

Sizing the Military Medical System to Wartime Requirements

Downsizing the military health care system to wartime requirements might raise concerns about preparedness in the event of larger requirements in the future. The substantial hospital capacity for extended care through the contingency agreements with the Department of Veterans Affairs and the National Disaster Medical System should help to allay some of those fears. Reliance on the civilian hospital system could be increased if DoD was to institute improvements such as a tracking system for patients evacuated from the combat theater.

Aside from the availability of this additional capacity, there are other reasons why sizing the military medical system to wartime requirements need not jeopardize the medical readiness mission. The lessons learned from medical operations in Operations Desert Shield and Desert Storm strongly indicate that the size of the military medical infrastructure is only one factor in determining the wartime readiness of the military health care system. Just as important, if not more so, are the medical readiness training that medical personnel receive during peacetime to fulfill their wartime mission and the capability of the medical units to provide noncombat medical care and support the evacuation of casualties from theater.

Partly in response to the experience of Desert Shield and Desert Storm, DoD is developing a new strategic plan for medical readiness for the year 2001 and beyond. Both the results of the 733 study and plans for the military under national health care reform will guide DoD's process of determining medical force and resource requirements to fulfill the medical readiness mission. One way to improve medical readiness considered by DoD during this process is to create a unified medical command to manage all aspects of health care, including the readiness and the peacetime missions.

A related approach, based in part on the Canadian military health care system, would require DoD to provide health care only to active-duty personnel. This option has several advantages. As Canada has done, DoD could create a unified medical command--by consolidating its medical resources and administration of its three separate medical departments--with the sole purpose of meeting the medical readiness mission. As a by-product of separating the wartime and peacetime missions, DoD would face a stronger incentive to define how much it spends today on readiness alone and what resources are needed to support wartime requirements in the future.

However, because the workload generated by active-duty personnel would not provide surgeons with sufficient "on the job" training to handle wartime casualties, DoD would have to consider other ways to provide its

surgeons with adequate training. To accomplish that goal, DoD could expand its role as a referral center for trauma injuries and surgeries. Similarly, DoD could require its physicians to work in civilian emergency rooms where their skills would be both used and improved. These options to ensure proper training for physicians could be considered even if DoD is permitted to maintain the size of the military medical infrastructure.

Sizing to Peacetime Health Care Requirements

If DoD decides that its current medical system must be retained because of peacetime requirements, its ability to perform the wartime mission could be compromised. Although the overall number of physicians in the system today is nearly twice what is needed to meet wartime requirements, the composition of the medical force in peacetime differs from that required for wartime. One of the most obvious differences is in the types of physicians required to offer an HMO-like benefit centered around the MTFs, as Tricare Prime would create.

Delivering peacetime health care cost-effectively would require a greater reliance on specialists in fields such as internal medicine and obstetrics and gynecology, and less on general surgeons and other physicians

with specialties needed to serve the wartime mission. Even more than in the past, the total number of diagnoses during peacetime that would contribute to the training of military physicians for war would represent a very small percentage of the patient diagnoses treated at the MTFs.

CONCLUSION

Solutions proposed in the past to the problems plaguing the military health care system involve modifying the military health care benefit, requiring beneficiaries to enroll in the military health care system, and improving the economic incentives of the delivery system. Military health care planners have discussed these approaches for many years. However, fears of reducing the generosity of the military health care benefit and the effect that doing so would have on personnel retention and recruitment, wartime requirements, and promises made to past generations of service members have precluded many of the solutions from serious consideration.

What has changed is that wartime requirements are lower today than at any time in recent history. DoD is on the brink of reforming its medical system to improve the health care benefit available to eligible military beneficiaries and to make the system more efficient. Plans to reform its system, however, are based on retaining the size of the current military

medical establishment. Without modifications to those plans, several of the economic incentives facing beneficiaries and providers--and risks of cost increases arising from that incentive structure--could carry over into the new system. Unless DoD is able to improve the cost-effectiveness of its system for delivering health care, the Congress should consider downsizing the medical system as a way of holding down total medical costs. Any such change would have to be accompanied by improved programs for giving active-duty dependents and other beneficiaries access to civilian health care.