CBO TESTIMONY

Statement of
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on
Restructuring Military Medical Care

before the
Subcommittee on Civil Service
Committee on Government Reform and Oversight
U.S. House of Representatives

September 12, 1995

NOTICE

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Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss the option of letting military beneficiaries enroll in the Federal Employees Health Benefits (FEHB) program. As part of my testimony today, I would like to submit a paper--*Restructuring Military Medical Care*--that the Congressional Budget Office (CBO) published in July. That paper discusses in great detail the option of allowing military beneficiaries to enroll in the FEHB program. The paper also covers a range of other issues, including:

- A description of the military medical system, the composition of the military beneficiary population, and trends in the costs of military medical care;

- An analysis of the wartime military medical mission and the contribution of peacetime medical care to wartime readiness;

- CBO's assessment of the Department of Defense's (DoD's) plans to reform the military health care system; and

- The potential savings from downsizing the military medical system in the United States to its wartime requirements.

I would like to summarize some of the major points of the paper and then respond to your questions.

Today's extensive military medical system is the chief source of health care for more than 6 million people, including 1.7 million uniformed personnel. The number of people eligible for military health care worldwide is more than 8 million, but many of those eligible choose instead to rely on other insurance coverage. Beneficiaries do not have to enroll or otherwise commit themselves to use the military system; instead, they can elect to use military care on a case-by-case basis (see Tables 1 and 2 for information about the size and cost of the military health care system).

TABLE 1. NUMBER OF BENEFICIARIES ELIGIBLE FOR MILITARY HEALTH CARE IN FISCAL YEAR 1996 (In millions)

Active-Duty Personnel[a]	1.7
Dependents of Active-Duty Personnel[b]	2.3
Retirees and Dependents[c]	4.2
All	8.2

SOURCE: Congressional Budget Office estimates based on data provided by the Department of Defense.

a. Includes medically eligible personnel in the full-time Guard and Reserve, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration.

b. Includes all dependents of medically eligible personnel.

c. Includes survivors.

For fiscal year 1996, DoD requested more than $15 billion for health care. Most of that money represents the costs of the military's direct care system, which includes more than 120 hospitals and over 500 outpatient clinics around the world. A much smaller piece of the health care budget will be spent on CHAMPUS, the Civilian Health and Medical Program of the Uniformed Services. CHAMPUS is an insurance program that covers most of the cost of care that military beneficiaries receive from civilian providers when care in military facilities is not available. Of all the medical care received by military beneficiaries, about 70 percent is provided through the direct care system and only 30 percent through CHAMPUS. Care furnished in military facilities is virtually free to the beneficiary, whereas CHAMPUS users bear higher out-of-pocket costs for the care that they receive, although they are not required to pay a premium.

TABLE 2. DoD's TOTAL MEDICAL BUDGET, FISCAL YEAR 1996
(In billions of dollars of budget authority)

Operation and Maintenance	
CHAMPUS	3.8
Other medical activities	6.0
Procurement	0.3
Military Personnel	5.0
Construction	0.3
Total	15.5

SOURCE: Congressional Budget Office estimates based on data provided by the Department of Defense.

NOTES: Numbers may not add to total because of rounding.

DoD = Department of Defense; CHAMPUS = Civilian Health and Medical Program of the Uniformed Services.

The military health care system was created primarily to care for military personnel in wartime. Indeed, the nature of the direct care system today in large measure reflects the expansion of the system during World War II and the Cold War. In peacetime, military medical personnel train for their wartime mission and provide care for active-duty personnel, their dependents, and retirees and their families. According to DoD, providing peacetime care is an important element of training for wartime.

With the end of the Cold War, however, wartime requirements for medical care have declined dramatically. Policymakers in DoD and the Congress are now faced with the question of whether to maintain a medical establishment that is larger than needed to meet wartime medical requirements. DoD is currently reviewing those requirements. According to one study conducted for the department, however, the wartime mission does not require more than about 11 military hospitals in the United States.

Savings from downsizing the military's direct care system to its wartime requirements could be substantial. Under the definition of wartime readiness used by CBO, downsizing could eventually reduce military medical costs by about $9 billion each year. That estimate does not include the costs of closing military

treatment facilities. More important, those gross savings do not reflect the cost of providing another source of health care coverage to military dependents, retirees, and survivors.

Any significant reduction in the size of the direct care system would have a major impact on the way that DoD trains and prepares medical personnel for wartime, but not necessarily on the effectiveness of that training. CBO's analysis indicates that the care provided in military medical facilities in peacetime bears little relation to many of the diseases and injuries that medical personnel need to treat in wartime. Downsizing could actually lead to better training opportunities than DoD offers today. If the direct care system was downsized, DoD would have to find other ways to provide wartime training to medical personnel, keep them employed during peacetime, and furnish some of the care for active-duty personnel. Strengthening affiliations with the civilian sector could achieve many of those goals.

PEACETIME CARE

Beneficiary groups, DoD, and the Congress have all expressed concern about the performance of the military health care system in peacetime. Beneficiaries complain about limited access to the direct care system, the quality of care, and the administrative burdens imposed by CHAMPUS. In turn, DoD is concerned about the

system's rising cost during an era of constant or falling overall defense budgets. Hence, the Congress has mandated a number of experiments, demonstrations, and studies to improve the delivery of health care and hold down costs.

Out of those criticisms and analyses, DoD has developed a plan for reform called Tricare, which it is introducing into each of 12 service regions throughout the United States. The central element of Tricare, called Tricare Prime, offers lower costs for beneficiaries in return for enrollment in a loosely structured managed care program built around military treatment facilities. Tricare also includes a number of other features to improve the efficiency of the military health care system, such as a new method of budgeting and the use of civilian resources to supplement those of the direct care system. DoD believes it can improve the delivery of health care at no more cost than today's system.

Tricare is now offered in only a few of the 12 service regions; thus, a judgment on the program is premature. Nonetheless, CBO is skeptical about DoD's ability to achieve its stated objectives. Our analysis suggests that the most likely outcome of Tricare is an increase of about 3 percent from today's costs. (The range of possible outcomes stretches from a savings of 1 percent to added costs of 6 percent.) Perhaps of more concern, the administrative changes that DoD is introducing appear to fall short of what is needed to improve the delivery of peacetime health care.

Under a downsized military direct care system, DoD would not be able to provide as much care to military beneficiaries in its own facilities. Instead, the department would have to consider other ways to provide for the continuing health care of military beneficiaries. Part or all of the savings from downsizing could be used for that purpose.

One approach to giving military beneficiaries access to civilian health care would be to extend coverage to them through the Federal Employees Health Benefits program. FEHB is the source of health insurance for more than 9 million federal workers and retirees of the federal government and their dependents. Enrollment in the FEHB program is voluntary. Participants have a wide range of choices of types of plans and providers, with varying premiums and levels of benefits. On average, the government pays about 72 percent of premiums; beneficiaries pay the rest.

CBO looked at offering military beneficiaries coverage under the basic FEHB program and two variations. The basic option reflects current premium-sharing arrangements between the government and nonpostal employees. The other options were designed to show the effects of reducing FEHB premium costs for beneficiaries. As a result, both of those options would lead to increased enrollment levels and government costs above those expected under the basic option. All three alternatives

would let military beneficiaries, excluding active-duty personnel, enroll voluntarily in the FEHB program. Regardless of their decision about enrollment, however, dependents, retirees, and survivors would no longer be able to use the military health care system. But DoD would ensure that all of its beneficiaries over the age of 65 had full coverage under Medicare, whether or not they enrolled in an FEHB plan to receive wraparound coverage.

I will summarize the results of CBO's analysis briefly. The costs and participation rates for the basic option are shown in Tables 3 and 4. Detailed results for the other options are available in CBO's July paper.

Effect of FEHB on Enrollment

We found that the number of military beneficiaries who would enroll in the FEHB program would vary extensively among the three FEHB alternatives. Under the basic option, fewer people than the number using the military health care system today would enroll in an FEHB plan. But under either of the enhanced options, enrollment would be substantially higher than the number using the system today.

Effect of FEHB on Government Costs

The total cost to the government would differ under the three alternatives. The basic option would lead to a total cost to the government of $7.3 billion, or a net annual savings to the government of $1.7 billion after downsizing was completed. But the

TABLE 3. STEADY-STATE COSTS AND SAVINGS TO THE GOVERNMENT FROM OFFERING MILITARY BENEFICIARIES ENROLLMENT IN THE FEHB PROGRAM (In billions of dollars)

Category	Estimate
Government Costs	
To the Department of Defense[a]	5.9
To Medicare[b]	1.4
Total Costs	7.3
Savings in DoD's Medical Budget from Downsizing the Military Health Care System in the United States to its Wartime Requirements[c]	-9.0
Total Government Savings	-1.7

SOURCE: Congressional Budget Office based on budget estimates for fiscal year 1996.

NOTE: FEHB = Federal Employees Health Benefits; DoD = Department of Defense.

a. Includes increases in costs to DoD from making premium payments on behalf of military beneficiaries enrolling in the FEHB program and from paying enrollees' premiums under Medicare Part B (including fines for those beneficiaries who waived coverage when they first became eligible).

b. Includes increases in the costs of Part A and Part B coverage under the Medicare program.

c. Estimates exclude several additional costs, such as the cost of providing health care to military beneficiaries in the United States other than active-duty personnel and any implementation costs associated with downsizing, such as the costs of closing facilities.

costs of the more generous FEHB plans would exceed savings from downsizing the military health care system. Thus, in those cases the government might incur net costs.

Effect of FEHB on Beneficiaries

Under the basic option, dependents of active-duty personnel would pay more for health care on average than they do now or than they will under Tricare. Retirees and their families could pay less, depending on their choice of plan and the availability

TABLE 4. ENROLLMENT RATES OF ELIGIBLE MILITARY BENEFICIARIES IN THE FEHB PROGRAM COMPARED WITH CURRENT RATES OF RELIANCE ON THE MILITARY HEALTH CARE SYSTEM (In percent)

	Dependents of Active-Duty Personnel (All Ages)	Retirees and Dependents	
		Under 65	65 or Older
Current Rate of Reliance[a]	90	57	30
Basic FEHB Option			
Self only	70	52	95
Family	70	37	95

SOURCE: Congressional Budget Office estimates based on data provided by the Department of Defense.

NOTE: FEHB = Federal Employees Health Benefits.

a. Estimates of the percentages of eligible beneficiaries who rely on the military health care system for their care.

of care from nonmilitary sources. All beneficiaries would have more choices under FEHB than they currently do, and they might choose to reduce their net costs by enrolling in lower-cost plans. CBO's estimates of the net costs of the three options make no adjustment for the possibility of that type of behavior. As a result, our estimates of savings may be conservative.

CONCLUSION

Offering the Federal Employees Health Benefits program to military beneficiaries is under discussion largely because of the opportunity to downsize the military's direct care system to be commensurate with wartime requirements. Only deep reductions in the direct care system, accompanied by elimination of CHAMPUS, can generate enough savings to offset the cost of providing health care to military beneficiaries under FEHB. To achieve those savings would require coordinated actions by Congressional committees responsible for federal health benefits programs and those responsible for national security programs.

Shifting to an FEHB approach, however, does not guarantee that savings will be achieved. The net cost to the government of providing health care for military beneficiaries through the FEHB program could offset some--or perhaps even all--of the savings that would be realized from downsizing the military health care system.

At the same time, CBO's analysis indicates that for an FEHB approach to achieve savings, many military beneficiaries would have to pay a larger share of the cost of health care than they do today. If FEHB was as heavily subsidized for military beneficiaries as CHAMPUS and the military's direct care system are now, the government's overall cost would probably increase.

Even if their out-of-pocket costs rose, many military beneficiaries might prefer the FEHB program. Access to medical care would be improved for those who are not able to use military facilities today, and for others who may not be able to use them under Tricare. Beneficiaries who are 65 or older and eligible for Medicare would stand to benefit the most, assuming that the FEHB plans they choose would provide wraparound benefits to supplement their coverage under Medicare.