CBO TESTIMONY

Statement of
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on
Medicare Subvention for the Department of Defense

submitted to the
Subcommittee on Military Personnel
Committee on National Security
U.S. House of Representatives

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Mr. Chairman and Members of the Subcommittee, I am pleased to submit this statement covering the budgetary issues related to a demonstration project in which Medicare would reimburse the Department of Defense (DoD) for care that DoD would provide to some beneficiaries who are eligible for care through both DoD and Medicare. The discussion applies to a legislative proposal prepared by DoD and more generally to other proposals presented to the Congressional Budget Office (CBO) by various Congressional staff.

BACKGROUND

For a long time, military retirees have been eligible to receive care under two DoD programs--a direct care program in which beneficiaries are treated in DoD's own facilities, and an insurance program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in which treatment is provided in the private sector and costs are shared by DoD and the beneficiary. Retirees who are eligible for health coverage under Medicare may seek care in a military treatment facility (MTF) but are ineligible to participate in CHAMPUS. Medicare, however, does not currently reimburse DoD for care provided at an MTF to retirees eligible for Medicare.

Many military retirees prefer to be treated at an MTF, primarily because they face lower out-of-pocket costs than they would under Medicare. In practice, however, constraints on resources have prevented many retirees eligible for Medicare

from being treated in an MTF. We expect that this situation will be exacerbated as DoD downsizes its system and restructures its health care programs to include a managed care program called Tricare Prime.

In 1994, the Senate Committee on Armed Services reported legislation to authorize Medicare to reimburse DoD for the care it provides to beneficiaries eligible for Medicare. Presumably, with funding from Medicare, DoD could provide care to more retirees eligible for Medicare. However, CBO estimated that five years after enactment of such legislation Medicare costs would rise by about $2 billion annually. More recently, CBO has seen proposals for more limited reimbursement that would first be tested through a demonstration project.

OUTLINE OF DEMONSTRATION PROJECT

The discussions of a demonstration project that would offer more limited reimbursement, termed Medicare subvention, have pointed to a program with the following characteristics:

- The program would occur over two or three years in no more than three of DoD's administrative regions;

- Beneficiaries would be required to enroll in DoD's managed care health plan (Tricare Prime);

- DoD and the Health Care Financing Administration (HCFA) would establish a base level of effort equal to what DoD would provide under current law to retirees eligible for Medicare;

- DoD would pay for all care up to the base level and would be reimbursed by Medicare for increments above the base level; and

- Medicare's payment to DoD would be based on the per capita amount that it currently pays to risk-type health maintenance organizations (HMOs).

The three regions under consideration are Region 6 (Texas), Region 11 (Washington/Oregon), and Region 12 (Hawaii/Pacific). Those regions contain approximately 220,000 retired military personnel and their dependents who are entitled to Medicare insurance coverage in addition to being eligible to receive care in DoD medical facilities.

The stipulation that Medicare pay no more than it would under current law is intended to ensure budget neutrality--that is, that the deficit will not increase. But the

stipulation also has significance because Medicare costs are subject to the pay-as-you-go procedures of the Balanced Budget Act, unlike DoD's costs, which are met through annual appropriations. Thus, even though the sum of Medicare and DoD costs could net to zero, different treatment under the Balanced Budget Act could subject the proposal to the pay-as-you-go procedures.

BUDGETARY IMPACT

The legislative goal is that the demonstration project would not increase either DoD's or HCFA's costs. DoD would continue to pay for the care that it would provide under current law to beneficiaries eligible for Medicare, and HCFA would continue to pay for people receiving care in the private sector. HCFA's costs would experience no net change because payments to DoD would be offset by lower payments to private-sector providers. DoD's net costs would remain the same because the receipts from HCFA would be matched by higher outlays for the care it would provide to extra patients.

The key question for estimating costs is whether the stipulation that the project be budget neutral for both DoD and Medicare would work. The answer depends on how accurately DoD and HCFA can determine the amount of DoD's health care workload for beneficiaries eligible for Medicare under current law--that

is, the base level of DoD effort that would not be eligible for Medicare reimbursement. That measure involves determining the current level of effort and projecting what level of effort would be made in future years without Medicare reimbursement.

As Table 1 shows, the likely outcome would be greater Medicare costs. Even though the legislative goal is budget neutrality, three factors would lead to greater costs. First, knowing how many Medicare beneficiaries will participate in Tricare Prime is difficult enough in the short term, and that uncertainty only grows over time as populations change and the availability of discretionary funding for DoD's health care programs varies. Second, DoD and HCFA face different incentives and access to information. As a result, DoD would have an advantage in the negotiations with HCFA over the base level of care that would work against budget neutrality. Third, Medicare's costs could rise if relatively healthy beneficiaries switched from receiving care in the private sector on a fee-for-service basis to receiving it in DoD's managed care program, since HCFA would pay more for such individuals on a managed care basis than it would on a fee-for-service basis. In terms of its relationship with DoD, HCFA would pay more to DoD than it now pays to the private sector, whereas DoD would be free to spend the extra reimbursement on things other than medical care for the beneficiaries eligible for Medicare.

TABLE 1. MONETARY FLOWS UNDER MEDICARE SUBVENTION

Medicare (Health Care Financing Administration)	Department of Defense
Legislative Goal	
Payments to DoD under subvention Less: forgone payments to private providers Equals: no net change in Medicare costs	Receipts from Medicare Less: outlays for incremental medical care Equals: no net change in DoD's spending
Likely Outcome	
Payments to DoD under subvention Plus: unintended payments to DoD because of: o Uncertainty of DoD's workload under current law o Asymmetric information and incentives o Adverse selection by beneficiaries Less: forgone payments to private providers Equals: net increase in Medicare spending	Receipts from Medicare Less: outlays for incremental medical care Less: outlays for other purposes Equals: no net change in DoD's spending

SOURCE: Congressional Budget Office.

There is not now an agreed-upon method for establishing the base level of effort for the demonstration project. In fact, DoD does not have complete information about the extent to which its beneficiaries currently receive additional care from other sources, such as Medicare. Thus, establishing a base level is subject to considerable uncertainty about the numbers of beneficiaries, the extent of their receipt of care, and their response to being included in the enrollment system. Because of

those uncertainties, it is difficult to know whom DoD would include in the demonstration project's base level of effort if it was taking effect right now. Despite the lack of an enrollment system, DoD claims that it provides all health care to the equivalent of 68,000--or about 30 percent--of the 220,000 Medicare-eligible retirees or dependents living in the three regions. Probably many more people receive at least some care from DoD, but the number averages out to being the equivalent of all care for 68,000 people. Healthy retirees could be underrepresented in the base level (that is, they would become the financial responsibility of HCFA), even though they now get most of their care from DoD.

If the base level was expressed in terms of expenditures instead of individuals, some measurement problems might be solved, but others would emerge. The most serious new problems could pertain to DoD's future expenses under current law. How would a base level of effort stated in terms of dollars instead of people account for considerations of demography and capacity? How would the base level account for changes in prices for medical care? Would the base level of effort call for DoD to maintain its current level of expenditures or would DoD be expected to maintain the share of its medical budget going to retirees eligible for Medicare? How would the process account for shortfalls or windfalls in DoD's appropriations?

Those are relevant questions because estimates of the base level of effort will have to contend with a growing population of retirees eligible for Medicare and a

decline in DoD's system of hospitals and clinics, as well as the transition to a delivery system that continues to assign retirees the lowest priority for care in MTFs.

Although one could argue that the measurement issue could go either way, CBO believes that it is likely to result in cost shifting to Medicare. In other words, Medicare would probably pay costs that DoD pays under current law. DoD has a greater incentive to shift its costs to Medicare than HCFA has to prevent shifting. Because annual discretionary appropriations currently limit DoD's health care funding, the department would have to eliminate personnel or otherwise reduce its program in the face of losses from an inaccurate base level (alternatively, it could expand its programs if it can shift costs to Medicare). However, HCFA pays Medicare costs from a permanent and indefinite appropriation that is very large and would not readily reveal a loss stemming from a demonstration program such as this one. Only administrative costs are discretionary, and they would be unaffected by gains or losses from a DoD base level of effort. It would not be easy for the General Accounting Office or any other auditing agency to state the financial outcome of the demonstration because it, too, would have to rely on estimates and assumptions about events and behavior that would have been different under current law.

CONCLUSION

Although the ultimate costs of a demonstration project are extremely difficult to gauge, CBO estimates that the illustrative demonstration project would result in hundreds of millions of dollars of pay-as-you-go costs--ranging from about $200 million in 1997 to about $300 million in 2002 despite the supposed budget neutrality. We believe that 50 percent of costs could be shifted to Medicare because of measurement problems and institutional features. First, a 20 percent to 30 percent error could easily occur in measuring current efforts, and uncertainty about the future could add another 20 percent to 30 percent at least. Second, the differing incentives and information would lead to errors that compound rather than offset. Even though the estimate is imprecise, it is safe to say that the demonstration project could add to Medicare (and governmentwide) costs in the hundreds of millions of dollars each year.

Although the additional outlays from the Medicare trust fund would be paid to another government agency, DoD would be able to spend the reimbursements. Therefore, the additional outlays would be subject to the pay-as-you-go procedures established under the Balanced Budget Act. The increase in mandatory spending would allow discretionary authorizations to decline by the same amount, but no one would know for certain whether or in what amounts this demonstration project was providing net additional resources to DoD. Whether discretionary savings would actually occur would depend on annual appropriation action.