STRATEGY RESEARCH PROJECT

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THE MILITARY HEALTH CARE SYSTEM: ON THE ROAD TO PRIVATIZATION

BY

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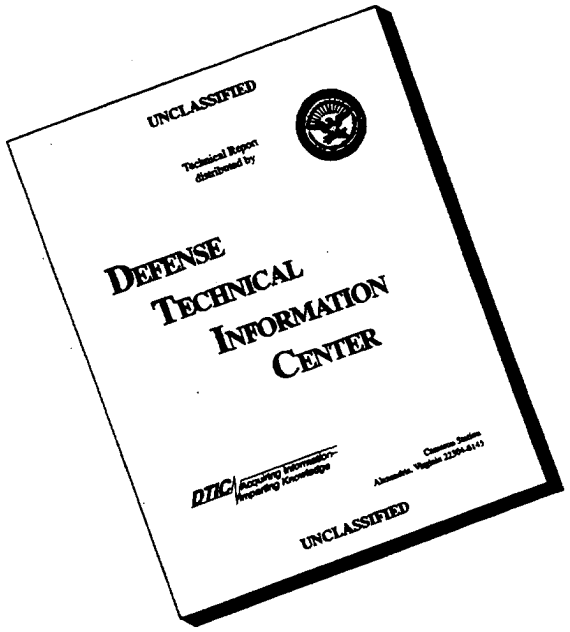

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USAWC STRATEGIC RESEARCH PAPER

THE MILITARY HEALTH CARE SYSTEM: ON THE ROAD TO PRIVATIZATION

by

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ABSTRACT

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There is a tremendous emphasis from congressional and senior military leadership to downsize the Defense Health Program (DHP) manpower. The new Deputy Secretary of Defense (DEPSECDEF) has come from the Commission on Roles and Missions (CORM) with the mission to privatize as many functions as possible. The direct care portion of the Military Health Services System (MHSS) is mostly at risk. It encompasses all healthcare provided beneficiaries in peacetime throughout all medical treatment facilities. This paper provides an update on the question whether to size the medical forces to wartime or peacetime requirements. The paper concludes that no matter how various models determine the "right size" of the medical force structure, downsizing pressures will lead to complete privatization of all direct healthcare for non-active duty beneficiaries within ten to fifteen years.

Military medicine is facing enormous challenges in a world of uncertainty and an age of scarce economic resources. Dr. Stephen C. Joseph, Assistant Secretary of Defense (Health Affairs)(OASD(HA), in his statement before the Defense Subcommittee, Senate Appropriations Committee, April 14, 1995, elaborated on two compelling and interwoven challenges facing military medicine. The first challenge was medical readiness: being prepared to provide the highest possible quality of care for our deployed servicemen and women. The second challenge was to provide everyday, accessible and excellent health care to our active duty force, retirees, family members and other beneficiaries. Each of these challenges is influenced by the financial and structural downsizing of the Department of Defense and by national and worldwide limits to spending and growth.[1]

This paper describes recent developments within the Department of Defense concerning the downsizing of the medical force structure, and the future of military health care. First, it examines the structure of the Military Health Services System (MHSS). It then analyzes the complex task faced by Congressional and military leadership between the dilemma of keeping the promise of "free" medical care, downsizing the force structure, and containing medical costs. Finally, it shows how the debate of sizing the medical force structure to wartime requirements versus peacetime requirements has shaped and set the direction of the MHSS toward eventual privatization.

The Military Health Services System

The Department of Defense (DOD) operates a large and complex health care system. About 8.3 million people are eligible to receive care through the MHSS. The MHSS has both a wartime and a peacetime mission. The wartime mission is to provide medical support to active duty military members in preparation for and during wartime or other contingencies. The peacetime mission is to maintain the health of the 1.7 million-member active duty force and, to the extent that space, staff, and other resources are available, to provide medical care to about 6.6 million non-active duty beneficiaries.[2]

The Army, Navy, and Air Force operate more than 600 medical treatment facilities (MTFs), including 127 military hospitals and 504 clinics located in the United States and at U.S. military installations throughout the world. Hospitals range in size from a one bed hospital in Kunsan, Korea, up to multi-specialty teaching medical centers operating more than 500 beds. The MTFs employ about 47,000 civilians, as well as 106,000 active-duty military personnel. In FY94 the MTFs admitted 704,232 patients, delivered 67,223 babies and had 46,189 outpatient visits.[3]

When care is not available in the MTFs or when MTFs are too far away, families of active duty personnel, retirees and their dependents under age 65, unmarried dependent children or unremarried spouses of deceased personnel are able to use civilian providers. For approved benefits, DOD reimburses those

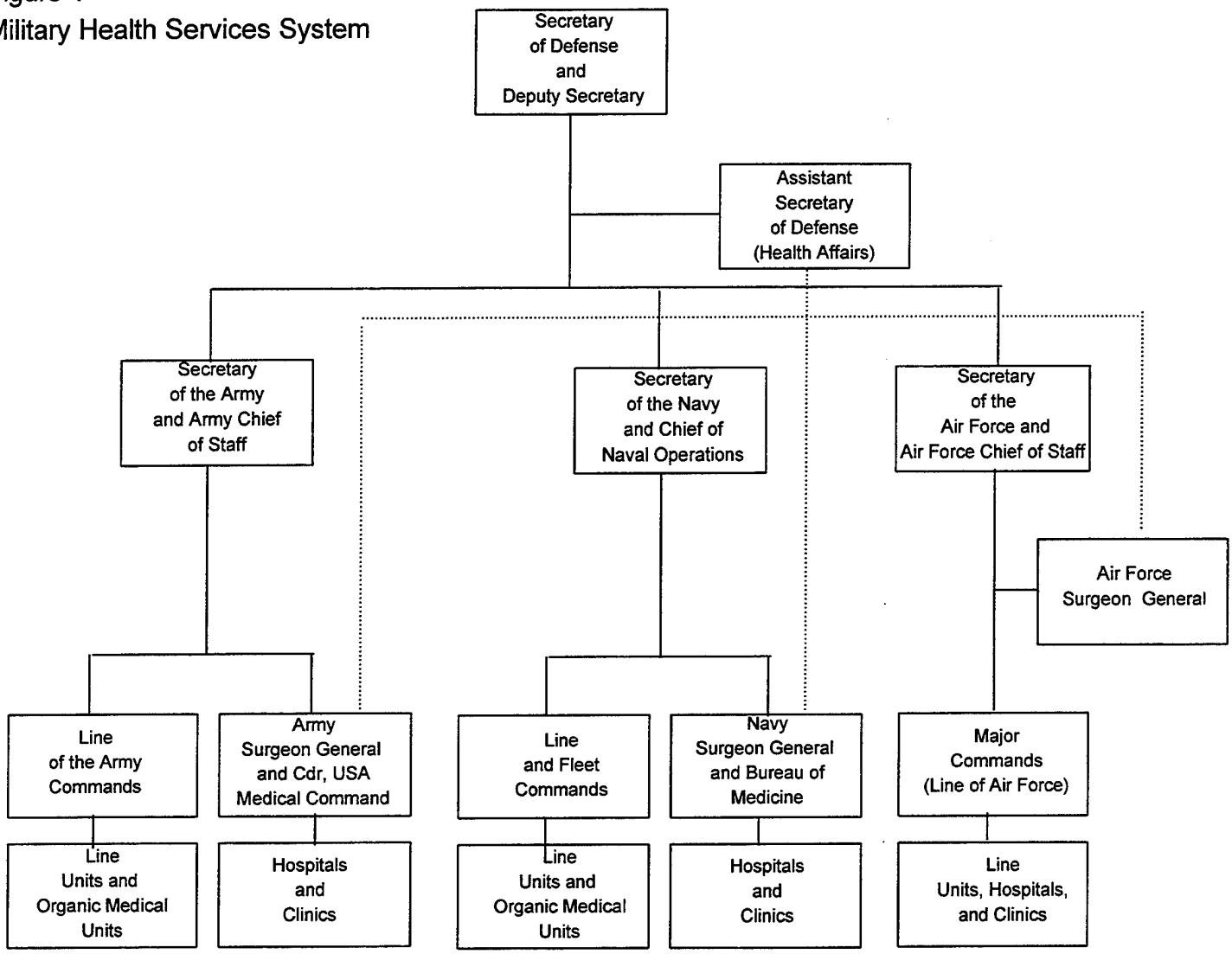
providers through an insurance program known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Generally, CHAMPUS covers most health care that is medically or psychologically necessary. Together, the care delivered through the MTFs and CHAMPUS make up the MHSS.

The MHSS has traditionally operated as three separate health care systems managed by the Army, Navy and Air Force (see Figure 1). Its supplemental system, CHAMPUS, is managed by the Assistant Secretary of Defense for Health Affairs (ASD(HA)).

The ASD(HA) is the principal staff assistant and advisor to the Secretary of Defense for all DOD health policies, programs, and activities. The ASD(HA) is responsible for overall supervision of the health affairs of the Department of Defense, exercises responsibility for DOD health resources, and serves as program manager for military medical activities.

An October 1991 reorganization of DOD medical functions consolidated CHAMPUS and the military departments' medical budget and programming responsibilities into a unified defense medical appropriations account, the Defense Health Program (DHP). The DHP does not provide funding for reserve personnel, combat support medical units/activities, and non-program 8 (Medical) management headquarters. The DHP budget was $9.6 billion in FY94, approximately $9.9 billion in FY95, and programmed for $10.2 in FY96.[4]

Figure 1
Military Health Services System



Keeping the Promise

A core issue of restructuring the MHSS must essentially address the perceived promise to provide no cost or low cost lifetime health care to other categories of beneficiaries -- dependents of active duty personnel, and military retirees and their dependents and survivors. The origin of this belief is explained by David Burrelli:

> Health care for retirees and dependents has always been considered a somewhat ancillary function of the military

health care system. Prior to 1956, the statutory authority to provide health care to retirees and dependents was not clear.

> The Dependents' Medical Care Act (Public Law 84-569; June 7, 1956; 70 Stat. 250) described and defined retiree/dependent eligibility for health care at military facilities as being on a space available basis. Authority was also provided to care for retirees and their dependents at these facilities (without entitlements) on a space available basis. This legislation also authorized the imposition of charges for outpatient care for such dependents as determined by the Secretary of Defense. Although no authority for entitlements was extended to retirees and their dependents, the availability of health care was almost assured given the small number of such persons. Therefore, while not legally authorized, for many the "promise" of "free" health care "for life" was functionally true. This "promise," it is widely believed, was and continues to be a useful tool for recruiting and retention purposes.[5]

This promise of military health care is a major issue confronting the leaders of Congress. Senator Inouye (D-HI) reminded the Congress:

> One of the benefits promised to the potential recruits was world-class quality health care, not only for themselves but also for their family members throughout their career and even after retirement. No one said, "unless we have to downsize". They may not understand the distinction between "entitled to" and "eligible" nor what space available care means. What the soldiers and sailors and marines and airmen heard, what they were promised, was lifetime health care for themselves and their dependent family members.[6]

In the Chairman's Program Assessment, the Chairman of the Joint Chiefs of Staff, speaks of the priority of the enabling capabilities of our national military strategy. He strongly supports the three vital components of support for military personnel: adequate and fair compensation, steady and dependable level of medical benefits, and a stable retirement system.

Specifically, he states:

> We must preserve an affordable, accessible health benefit for our military people - with no surcharge for active duty personnel and their families. Changes in how health care is delivered to our personnel are inevitable and necessary. Our concern is whatever the mix of care we decide on, the cost of the active duty member should not be increased. There should be no surcharge on active duty members or their dependents.[7]

Because the DOD medical establishment is sized against wartime requirements, it tends to provide more capacity in peacetime than is needed to meet the health care demands of the active force. The DOD uses this extra capacity to provide care to the other categories of beneficiaries. The less excess capacity the medical establishment has to care for these beneficiaries the more reliance it has on private sector health care. All of this may result in higher costs as well as curtailment of services that by statute requires prior Congressional approval.

The Military Medical Drawdown

The question that must be addressed is whether DOD should maintain a health care establishment larger than required in peacetime to carry out the wartime mission. Over the past several years, the military forces have undergone considerable downsizing. The active force will have come down from 2.1 million service members in 1990 to 1.45 million by 1997, a 32-percent reduction from cold war levels.[8]

The military medical force structure has been reduced through revised manpower estimates and base closures. As

currently programmed between FY95 and FY01, the Defense Health Program will reduce approximately 22 percent of its civilian employees, on top of the 31 percent military medical personnel drawdown. Thus, the combined military and civilian loses between FY89 and FY01 are projected to be 26 percent, while the beneficiary population will decrease by approximately 10 percent.[9] Beyond the personnel loses, DOD has eliminated considerable infrastructure. The first three rounds of Base Realignment and Closure (BRAC) legislation will result in the closure of 25 military hospitals and numerous clinics by September 1996.[10]

Although the health community was reduced substantially, the Pentagon protected it from the severe end strength reductions occurring in the total force structure. The goal was to maintain the current care for all beneficiaries: active duty, dependent and retiree. The result of this emphasis is that today, one of every four O-6s and over 20 percent of all field grade officers on active duty are in the health care community. Under the current projections, there will be 12,500 physicians on active duty in FY 2001. Various analyses have come up with different numbers, but all reach the same conclusion: the medical force is too large to be justified by operational and wartime needs alone.

Congress directed DOD, through Section 733 of the National Defense Authorization Act of Fiscal Year 1992 and Fiscal Year 1993, to analyze the fundamental issues bearing on the size of the military medical system. The study director was the

Director, OSD Program Analysis and Evaluation (OSD(PAE)). The "733" Wartime Medical Requirements Study (733 Study) put the maximum wartime requirement at roughly half the number of doctors now on active duty.[11]

The Services never concurred with the results of the study, citing specific shortcomings of the study. They insisted that the study failed to recognize the synergism that exists within the healthcare system, and the cost-effective quality and quantity of care provided to servicemembers, their dependents and retirees. Essentially, the 733 Study relies on a reduction in demand for services generated by cost shifts and copays by beneficiaries -- contrary to the service opinions -- contrary to quality of life process, etc.

The Chairman of the Joint Chiefs of Staff, also recognized the dilemma for military medicine. In his Draft Chairman's Program Assessment he wrote:

> There is a mixed message for military health care - it is top priority as a quality of life issue, but it is too expensive as currently configured and consumes too much active duty end strength, particularly field grade officers. We must investigate possible savings and end strength reductions in the military medical corps as part of our effort to control medical costs within DOD.[12]

DOD somewhat agreed with the need for further study of the problems. The Secretary of Defense directed an update of the 733 Study to determine the Commanders-in-Chief's (CINCs') operational military medical requirements. OSD projects the updated study completion by the summer of 1996.

Meanwhile, OSD(PAE) seeks savings through a combination of medical end strength reductions and a change in the military health care benefit. One alternative proposes reducing medical end strength to 733 Study proposed levels (approximately 50% of POM end strength); a second alternative is an adaptation of the recommendations from the recent independent Commission on Roles and Missions study.

As an alternative the OASD(HA) recommended developing a DOD Medical Manpower Sizing Model which uses the 733 Study as the baseline. The medical sizing model will not be completed until after the Program Review Cycle has ended. Meanwhile, OSD(PAE) will attempt to identify the 733 Study as the sole baseline for determining wartime medical force structure in the Program Decision Memorandum (PDM).

Although it recognizes the necessity to downsize, DOD still expects the medical departments to provide the same level of support to defense plans that call for conducting two nearly simultaneous major regional contingencies (MRCs), possibly in conjunction with one or more operations-other-than-war (OOTW) scenarios. The medical departments recognize the need to stay combat ready to support the military services, joint and combined operations as well as meet the healthcare needs of soldiers, soldiers' family members, and retirees and their family members. The Pentagon hopes the move toward making health maintenance organization services available to military families would free up military doctors to concentrate on active-duty personnel.

Attempts at Cost Containment

The Congress became concerned with large cost overrun in the military health care system during the late 1980s and early 1990s. Military health care expenditures were growing as fast as health care for the general population. CHAMPUS was the fastest growing item in the U.S. military budget. In the first year of the program, fiscal year 1967, costs were $166 million. By fiscal year 1992, CHAMPUS cost the federal government nearly $3.4 billion in benefits -- an increase of more than 250 percent in the eight years between 1984 and 1992.[13]

Congress authorized DOD to experiment with several alternative health care programs to determine how the military could provide the best health care for the fewest dollars. Out of these initiatives came the CHAMPUS Reform Initiative in California (CRI) and its successor, the TRICARE program.

DOD started the CRI in 1987. It operated in California and Hawaii. It offered eligible CHAMPUS beneficiaries a private insurance-like plan with a health maintenance organization (HMO) and a preferred doctor option. The Rand Corporation, commissioned by the DOD to study the budgetary success of the program, showed that CRI did not cut health-care costs. The Rand Corporation recommended in 1992 that the program be cancelled.[14]

TRICARE is the current initiative now in its implementation phases. The TRICARE system -- so called because it combines the medical programs of the Air Force, Army, and Navy -- is the

department's initiative to create the best combination of health care services through military treatment facilities, CHAMPUS, and other payment mechanisms. A major component of the TRICARE initiative is the managed care support contracts, which will provide supplemental care for patients whom the military medical facilities do not have the capacity or specialty to treat.

DOD recently formed twelve regional military health care delivery networks under the oversight of headquarters called Lead Agents. After coordination with the Lead Agents, the Department is procuring, on a competitive basis, regional fixed price, at-risk contracts to support these networks in delivering health care to eligible beneficiaries. There are to be seven, fixed-price, at-risk contracts, supporting the twelve regions, competitively awarded before the end of fiscal year 1996.[15]

Managed care support contracts are very lucrative to civilian health care contractors. They are the largest such government contracts in the country. So far, DOD has awarded three contracts. Foundation Health Federal Services (FHC) seems to be the big winner. FHC won the $2.5 billion military health care contract, valued at about $500 million a year, for about 720,000 military dependents and retirees in California and Hawaii.[16] The FHC also won the bidding for the five-year $1.8 billion military health-care contract for Texas, Louisiana, Oklahoma and Arkansas. The agreement, valued at about $360 million a year, covers the managed health care for at least 613,000 military dependents and retirees under CHAMPUS. The

third contract for Region 11, valued at $438.1 million, went to one of FHC's closest competitors.[17]

The Senate Subcommittee, Senate Appropriation Committee, has recommended slowing the growth of TRICARE. In its version of the DOD Authorization Act for Fiscal Year 1996, the committee would order the Pentagon to refrain from establishing TRICARE beyond Oregon, Washington, Texas, Arkansas, Louisiana and possibly, California and Hawaii in 1996.[18]

DOD costs under TRICARE are likely to go up. Neil M. Singer, the Congressional Budget Office's (CBO's) Deputy Assistant Director of the National Security Division, told Congress that the effects of TRICARE are likely to range between additional costs of about six percent to savings of less than one percent -- meaning that the Pentagon will save no more than $100 million and could pay an extra $500 million in 1996. The CBO concludes that, if TRICARE was fully operational in 1996, the total cost of DOD's peacetime health-care mission probably would increase by about three percent or about $300 million.[19]

CHAMPUS and TRICARE have not been the cost-effect alternatives expected by the Congress. Some members of Congress believe other federal health care plans would be less costly and more equitable for beneficiaries. Congress also asked the CBO to study a TRICARE alternative featuring the Federal Employees Health Benefit Program (FEHBP).

The CBO compared beneficiary cost sharing and benefits under the TRICARE Uniformed HMO Benefit with similar features of

Table 1. - TRICARE (Prime) - FEHBP COMPARISON					
		TRICARE Prime Benefit			
	Families of ADDS E-4 and Below	Families of ADDS E-5 and Above	Retirees and Family	FEHBP-Kaiser Mid-Atlantic	FEHBP-Group Health Puget Sound Std
Annual Enrollment Fee or Premium (Individual/Family)	$0/$0	$0/$0	$230/$460	$463/ $1,328	$488/ $1,129
Copayment for Services outside Military Treatment Facilities:					100 Deductible
Outside Visits (Including Separate Lab Svcs and Home Health Visits)	$6	$12	$12	$0	$5
Emergency Room Visits	$10	$30	$30	$0	$100
Mental Health Visits (Individual)	$10	$20	$25	$0	$15.70
Ambulatory Surgery	$25	$25	$25	$0*	$0
Prescriptions	$5	$5	$9	$7	$7
Inpatient Per Diem (General)	$11	$11	$11	$0	$0
Inpatient Per Diem (MH/Substance Use)	$20	$20	$40	$0	20%**
Est Avg Family Costs	$110	$160	$800	$1,700-$2,500***	
* No copayments, but coverage limited to 25 visits and 30 days per year.					
** Plan pays full after $1,500 individual and $3,000 family.					
*** Washington Consumer Checkbook,Checkbook's Guide to 1995 Health Insurance Plans for Federal Employees.					

selected programs available in the FEHBP (see Table 1). Since there was no nationwide HMO-type plan in FEHBP, the CBO chose arbitrarily some local plans.

The study showed that the family enrollment fee for TRICARE Prime was zero for active duty families, or $460 for retired families; comparable amounts for the FEBHP HMO-type plans across the country ranged from $800 to $4,400. Copayments under the three FEHBP HMO-type plans were similar, but typically somewhat lower.[20]

More useful than looking at copayments or premiums

separately is considering their combined effect. For the FEHBP HMO-type plans, the expected annual costs for a family, including the costs of premiums and out of pocket expenses, are estimated at $1,700 to $2,500 by Washington Consumer Checkbook in their Checkbooks Guide to 1995 Health Insurance Plans for Federal Employees. The estimates of an average family out-of-pocket costs under the Uniform HMO Benefit, including the effects of access to military facilities, are $110 for families of active duty members E-4 and below, $160 for families of active duty members E-5 and above, and $800 for families of retirees and survivors. Therefore, TRICARE Prime offers its enrollees significantly lower out-of-pocket costs than comparable FEHBP plans.[21]

Overall, it appears that FEHBP plans offer similar coverage to that available under TRICARE, at considerably higher cost to the beneficiary. The study concluded that DOD would need to provide a substantial subsidy to offset the higher FEHBP premium cost in order to make these plans a cost-effective alternative for its beneficiaries.[22] Thus, whereas TRICARE savings may be illusory when compared to retaining current medical infrastructure, pursuing an FEHBP-type plan apparently could only save DOD money if significant costs are passed on to current beneficiaries.

The Move Toward Privatization

The move toward privatization has become the focus of major

Washington debate. Specifically, Congress wants to know whether is it cheaper to provide direct medical care to beneficiaries or to reimburse military beneficiaries for care obtained in the private sector.

The Congress chartered an independent commission, the Commission on Roles and Missions of the Armed Forces (CORM), with recommending how to streamline the U.S. Military. In its May 1995 report, the commission provided its views of significant changes that need to be made in order to develop a DOD able to handle the challenges of an uncertain and constantly changing future security environment.

The commission's most controversial suggestion was that the military is overextended by providing wartime medical support, peacetime health care for family members and retirees, and graduate training for military doctors. No one on the commission disputed the government's obligation to the families of soldiers, but they questioned whether it is necessary to use military doctors to treat them.

The CORM recommended large-scale, carefully planned privatization of such defense support activities as depot maintenance, supply logistics, financial services and family health care. Specifically regarding the military medical establishment, the CORM made the following recommendations:

- reemphasize the primacy of medical support to military operations,
- develop uniform procedures for sizing the medical

departments,

- increase access to private sector health care,
- require mandatory enrollment within the military health services system,
- set a user fee structure, and
- institute a medical allowance for active duty families.

The CORM endorsed TRICARE "as an important step to a total quality medical program", but it stated that "TRICARE currently does not provide the degree of choice needed to establish a competitive environment that will foster more efficient health care."[23]

Dr. John P. White has been an aggressive supporter of what he calls "outsourcing" since he served as chairman of the CORM. As Defense Secretary William J. Perry's top deputy, he could use his sizable influence to put the panel's recommendations into effect. He wrote to two dozen members of his top-level privatization team, "Drawing on those capabilities will enable us to do our job better, to generate savings and improve quality, and in the process enhance our ability to meet our military mission."[24]

The CORM is not the only authorized study group to reach this consensus. The Pentagon's quality-of-life task force became the latest Pentagon panel to endorse privatization. Retired General John Wickham, a former Chief of Staff of the Army, who studied privatization as a member of the quality-of-life task force, is a cautious proponent of privatization because he

believes cutting costs in support areas is the only way to preserve fighting power in tight budgets. He endorsed the move toward privatization with one caveat. He cautioned the services against contracting out entire skills lest they lose the capability to respond to wartime emergencies.[25]

Resistance to privatization has come from the traditional places. Commanders are trying to slow the campaign because it is likely to result in more troop reductions. Other military officials have been reluctant, citing worries that private contractors may not be able to provide supply and services during emergencies and the many cases of fraud, waste and abuse in the 1980s resulting from Pentagon contracting. While some commissioners and others would like to see a faster, broader shift to private sector alternatives; the Service Chiefs have argued for giving alternative solutions like the TRICARE initiative more time.[26]

The Economics of Make vs. Buy

This brings us to the dilemma facing Congress and the DOD medical establishment. Downsizing will force the medical departments to rely on more costly civilian contracts over which the services have significantly less control than their in-house cost controls. In fact, the U.S. Army Medical Command's experience with commercial activities studies has shown that it is almost always considerably less expensive for the military system to provide health services than it is to contract for

them.

For instance, contracting for health care services shows that direct hire civilian employees are almost always the most cost-effective alternatives when hiring on the margin one-for-one. A Department of the Army civilian nurse costs $40K annually versus $60k for a contract nurse. At Fort Drum, NY, where contracting care is required because there is no inpatient medical facility on post, the per beneficiary costs are 56 percent higher than costs at similar military installations. In his testimony before the Congress, Senator Inouye cites further evidence that provision of in-house health care is less expensive than outsourcing. He points to a Rand Corporation study which showed that medical treatment facilities' in-house care is more cost effective than their civilian counterparts by 24 percent overall and even more in some areas such as primary care.[27]

The Future Years

In the near-term future, the Pentagon health chief and the services' Surgeons General will devise methods to tailor the size of their forces and consider new ways to provide peacetime care. The CORM recommended that DOD establish uniform procedures for sizing the Department's operational medical needs. The CORM also recommended that "care should be taken to ensure that the remaining system can recruit and retain the mix and skills of medical specialties needed for operational missions."[28] Reading the handwriting on the wall, the DOD Medical Sizing Model is the

military medical community's last hope of having a true analytical basis to decide medical end strength requirements. The model is still evolving, and will not produce any definitive results in time to influence the ongoing Program Review of Medical End Strength.

The military medical departments' analysts are projecting that the force structure needed is somewhere between the number of military medical personnel required in peacetime and that required to meet projected wartime needs. The near-term compromise between force structure reductions and privatization will enable the Services to:

- Have the flexibility that ensures both training capacity and proper rotation base for afloat and overseas personnel
- Retain a quality MHSS
- Refrain from eliminating duty position essential for the sustainment of enlisted skill proficiency; and
- Benefit from in-house Graduate Medical Education (GME): providing specialty and subspecialty care and increases in physician productivity due to the teaching environment.

Other benefits include lower patient care expenses, the attraction of more qualified physicians to the academic environment of teaching hospitals and a higher retention rate of physicians, especially for those trained in military facilities, which leads to lower acquisition and training costs.

Conclusions

It is evident, then, that right sizing the medical force structure presents senior civilian and military leadership with a substantial dilemma. There is data that supports a slightly reduced medical force based on wartime requirements. However, a move to a smaller medical force would increase beneficiaries' cost and even exclude some retirees from the beneficiary population.

The medical force structure is going to reduce. The DOD leadership will not continue the disproportionate number of medical personnel on active duty at the expense of the combat force end strength. The medical department chiefs have a well-articulated corporate position to defend the MHSS against attack. For a time, they will even win the sizing war and eventually justify most of the FY99 program by showing that they can do the peacetime health care mission with higher quality and at a lower price than either hiring civilians or contracting.

Beyond FY99, there will be a huge void in the medical system caused by downsizing. Congressional leadership will be influenced to fill that void by beneficiaries (retirees and dependents), contractors, and special interest groups such as the American Medical Association and the American Association of Retired Persons. Private corporations are huge stakeholders who are primed to fill that void with provision of their services.

The dilemma over the size of the medical force structure and ways to provide affordable, accessible and quality peacetime care

is likely to continue. Meanwhile, events over the last two years have shaped and set the direction of the MHSS. The new Deputy Secretary of Defense (DEPSECDEF) has come from the CORM with the mission to privatize as many functions as possible. No matter how various models determine the "right size" of the medical force structure, downsizing pressures will lead to complete privatization of all direct healthcare for non-active duty beneficiaries within ten to fifteen years.

ENDNOTES

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