The Department of Defense says that those who have tried the new managed health-care system like it.

The Transition to Tricare

By Suzann Chapman, Associate Editor

Contract Status in Tricare Regions

KEY

Region

States
Lead Agent
Contractor
Start Date

1

Connecticut
Delaware
Washington, D. C.
Maine
Maryland
Massachusetts
New Hampshire
New Jersey, New York
Pennsylvania
Rhode Island
Vermont
northern Virginia

Rotates annually among Walter Reed Army Medical Center, National Naval Medical Center, and Malcolm Grow Medical Center in the Washington, D. C., metropolitan area

Pending

*August 1, 1997**

2

North Carolina
southern Virginia

Navy Medical Center Portsmouth, Portsmouth, Va.

Pending

*September 1, 1997**

3

Florida
Georgia
South Carolina

Dwight David Eisenhower Army Medical Center, Fort Gordon, Ga.

Humana Military Healthcare Services

July 1, 1996

7

Arizona
New Mexico
Nevada
extreme western Texas

William Beaumont Army Medical Center, Fort Bliss, Tex.

TriWest Healthcare Alliance, Inc.

*February 1, 1997**

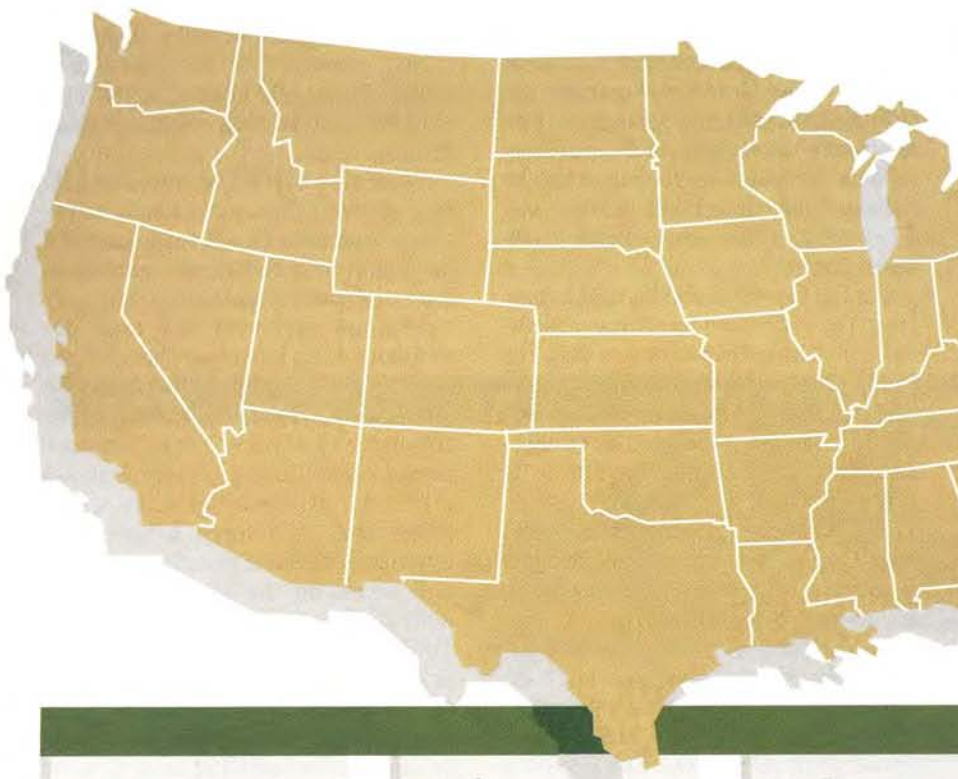
8

Colorado
southern Idaho
Iowa, Kansas
Minnesota
Missouri, Montana
Nebraska
North Dakota
South Dakota
Utah
Wyoming

Evans US Army Community Hospital, Fort Carson, Colo.

TriWest Healthcare Alliance, Inc.

*February 1, 1997**



By fall 1997, Tricare, the Pentagon's new managed healthcare system, will be functioning in all twelve geographic regions of the continental United States. This transition to Tricare has become less bumpy for contractors and beneficiaries alike; most people now seem to think well of the new program. The word from DoD is that those who have Tricare like Tricare.

Enrollment has been heavier than anticipated for Tricare Prime, the system's health maintenance organization (HMO) option. Tricare Prime was first introduced in Region 11 and then in Region 6. In Region 11, first-year enrollments were more than twice the projected number. In Region 6, the one-year goal for enrollment was met in just five months.

4

Alabama
Mississippi
Tennessee
Florida's western panhandle, eastern Louisiana

Keesler Air Force Medical Center, Keesler AFB, Miss.

Humana Military Healthcare Services

July 1, 1996

5

Indiana
Illinois
Kentucky
Michigan
Ohio
West Virginia
Wisconsin

Wright-Patterson Air Force Medical Center, Wright-Patterson AFB, Ohio

Pending

*September 1, 1997**

6

Arkansas
Oklahoma
Texas (except extreme western Texas)
most of Louisiana

Wilford Hall Air Force Medical Center, Lackland AFB, Tex.

Foundation Health Federal Services, Inc.

November 1, 1995

Under the DoD Tricare plan, seven contracts will cover the twelve regions: Regions 2 and 5 are grouped, as are Regions 3 and 4, Regions 7 and 8, and Regions 9, 10, and 12.

9

Southern California

San Diego Naval Medical Center, San Diego, Calif.

Foundation Health Federal Services, Inc.

April 1, 1996

10

Northern California

David Grant Air Force Medical Center, Travis AFB, Calif.

Foundation Health Federal Services, Inc.

April 1, 1996

11

Washington
Oregon
northern Idaho

Madigan Army Medical Center, Fort Lewis, Wash.

Foundation Health Federal Services, Inc.

March 1, 1995

12

Hawaii

Tripler Army Medical Center, Honolulu, Hawaii

Foundation Health Federal Services, Inc.

April 1, 1996

** Estimated start date*

This fast enrollment pace and problems in the contracting process have caused some setbacks. However, DoD health officials report that they have been able to alleviate the turmoil by sharing lessons learned between regions.

The Pentagon's top health official, Dr. Stephen C. Joseph, told Congress in June that the military health-service system (MHSS) had been "successful in tackling a variety of difficulties and obstacles, from enrollment glitches to contract award protests."

For example, the Tricare contractor for Region 11 did not employ sufficient trained personnel in the first days of program implementation and had problems handling the early sign-up rush. The Region 6 contractor, which started operations some months later, took note of Region 11's backlog problems and hired and trained additional temporary workers before starting enrollments.

As each new region comes on line, administrators in search of solutions review the pitfalls encountered elsewhere.

Containing Costs

At present, three corporations have won contracts. These contractors are administering the program in nine regions. *[See chart on pp. 46–47.]* The Pentagon plans to issue seven contracts to cover the twelve regions.

One goal is to contain costs. Even before establishment of Tricare, the MHSS had been driving down its costs. Ten years ago, the bill for DoD's Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was rising by some fifteen percent a year. Overall costs of the MHSS were increasing by almost twelve percent a year. However, between 1994 and 1996, CHAMPUS costs rose only 3.8 percent, and that, according to Dr. Joseph, includes some start-up, one-time additional costs of managed-care support contracts and buyouts of CHAMPUS claims. The cost of the overall defense health program increased by only 1.2 percent, he said.

"Considering that the national average for health-care cost inflation was over seven percent during that period, we think that's an important achievement," said Dr. Joseph. However, he added, "we do have to measure the views of our beneficiaries against those financial achievements."

Those beneficiaries report that their number one concern is lack of access to the Defense Department's military treatment facilities (MTFs). Dr. Joseph took note of the severity of this problem by listing what he called "our first three problems." They were, in his words, "access, access, access."

Part of the problem, he said, stems from the fact that the military medical force has shrunk faster than the total number of beneficiaries. He said that, since 1989, the number of operating beds has been reduced by twenty-one percent, military hospitals by thirty percent, and military and civilian medical staffs by thirteen percent. During this same period, the DoD beneficiary population decreased by only about 8.5 percent.

Those statistics have led to considerable concern on the part of beneficiaries who traditionally have received care within the MHSS on a space-available basis. Active-duty family members, as well as military retirees and their dependents, have voiced displeasure about increasingly tight restrictions on access.

There is a real problem, and Tricare is the cure, said top doctors at the Pentagon. In their Congressional testimony on the Fiscal 1997 defense budget, Dr. Joseph and the surgeons general emphasized that Tricare will not only help keep costs down but will also alleviate access problems.

In fact, Dr. Joseph said the Pentagon has "hard data" indicating "a reduced number of patient complaints and improvement in the overall access situation."

Lt. Gen. Edgar R. Anderson, Jr., while USAF surgeon general, cited positive surveys and said he was encouraged by feedback from lead-agent staffs and patients already participating in Tricare.

He said, "Results from beneficiary focus groups in the region [Region 11] conducted by a private contractor confirm that our customers feel Tricare offers improved access and continuity of care." The General added that, in a smaller telephone survey conducted by the clinic at McChord AFB, Wash., enrollees showed high rates of satisfaction with primary and specialty care.

"Great System"

An active-duty family member in Region 11 stated that, before Tricare, "You had to go to the emergency room just to get seen." She called Tricare "a great system" and said that making appointments was easy.

DoD's own 1995 health-care survey showed that access was a primary concern. Dr. Joseph said the survey reinforced "our determination to pursue Tricare."

Military members and their dependents long have been bewildered by the precise timing requirements for making routine appointments through the MHSS. When the telephone caller finally gets through to a clinic, he or she often hears something like, "I'm sorry, all pediatric appointments have been filled. Please call again on the first Tuesday of next month between 7:30 a.m. and 10:00 a.m." The beneficiary dutifully calls back, again getting a busy signal repeatedly. Once finally connected, the beneficiary realizes he or she has missed the appointment queue again and must start over the following month.

All that is changing under Tricare, officials maintain. For instance, Region 11, containing 400,000 beneficiaries, has set up a Tricare Regional Appointment Center. It employs fifty operators who field an average of 60,000 calls per month. It runs eleven hours a day and uses an automated call-distribution system.

The system's operators are connected to DoD's Composite Health-Care System, a database of information on patients worldwide. By consulting this database, they can check a caller's eligibility for health care. They can also update such personal data as home addresses and telephone numbers. Center officials say the average length of a call from initial connection to confirmed appointment is about three minutes.

Each region has access standards that apply whether treatment is given by a military or civilian provider. However, the standards apply only to beneficiaries enrolled in the HMO-type plan, Tricare Prime. As listed in a December 1995 policy letter, there are five baseline requirements:

- Same-day access to primary care manager.
- Thirty minutes of travel time from residence to health-care facility, except in remote areas.
- Thirty minutes of office wait-

ing time in nonemergency situations.

- Night and weekend coverage for urgent health-care needs.
- Emergency services within the community, available twenty-four hours a day.

The policy letter also lists maximum appointment waiting times: one day for urgent or acute (but nonemergency) care, one week for a routine visit, and four weeks for health maintenance and specialty care.

The regional service also features free phone-in health-care advice from registered nurses, the services of health-care "finders" who help locate appropriate care, and customer service centers that handle enrollment and general questions. Even military primary care managers operating under a Tricare Prime contract must set up a twenty-four-hour on-call system similar to an on-call provider in a civilian group practice.

These changes are just now beginning to permeate the MHSS. System officials say that most beneficiaries won't feel the full effect for another few years.

Defense officials also credit DoD's use of capitation financing for helping to control costs and to improve health-care delivery. Traditionally, the Defense Department used a work load–based approach to allocate medical dollars. That system, said critics, rewarded increased production regardless of outcome.

Under capitation financing, all MTFs receive a fixed annual budget based on their population of beneficiaries. The MHSS now focuses on using managed-care principles to ensure the right level of care, promote healthy lifestyles, emphasize preventive measures, and return patients to full health as quickly as possible.

The FEHBP Debate

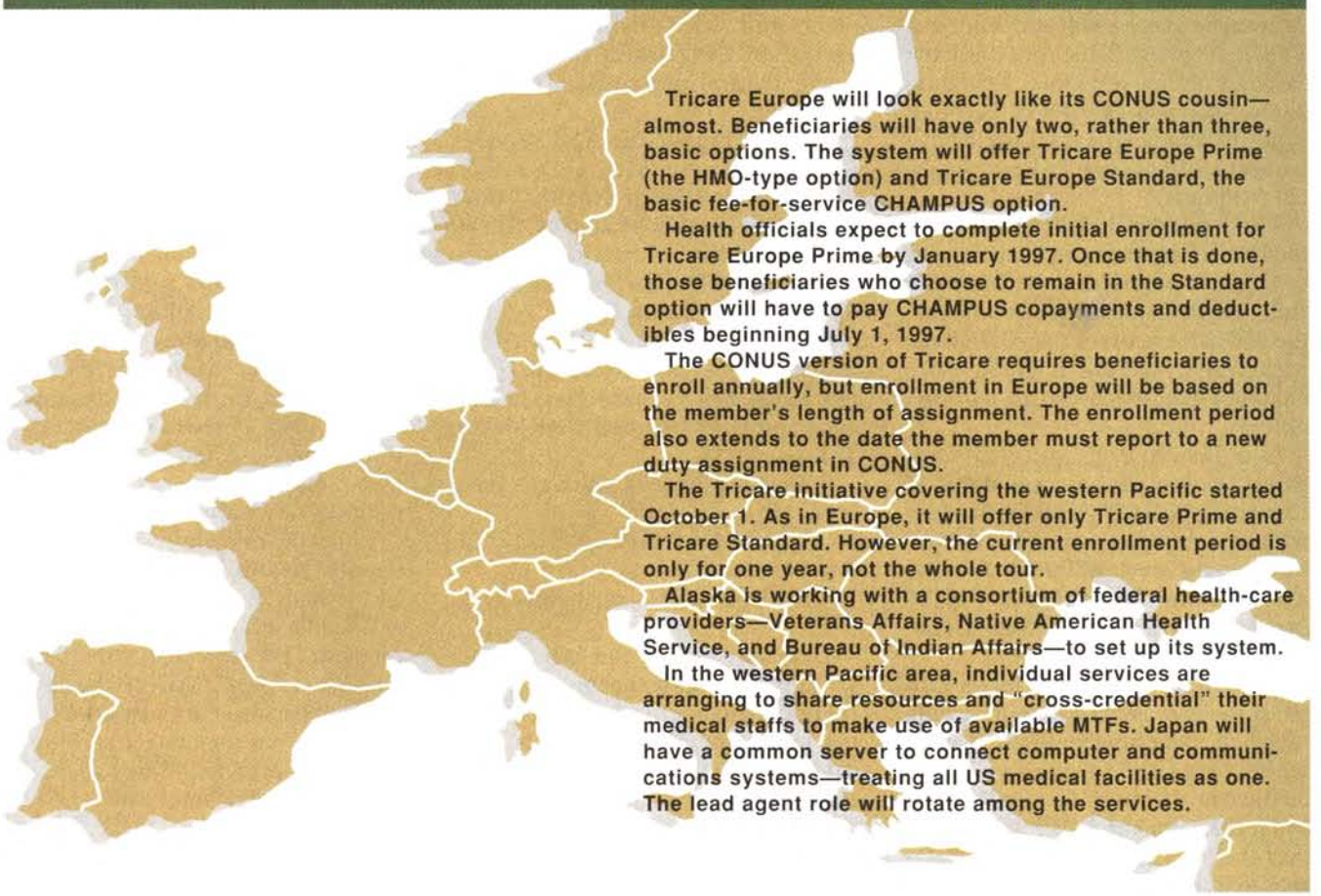
Despite the early successes of Tricare, many beneficiaries and veterans groups still express concern about the future of the MHSS. The question of access appears to be most prominent among military retirees, especially those sixty-five and older.

Current law prohibits Medicare-eligible individuals from enrolling in Tricare Prime. Such beneficiaries lose their CHAMPUS eligibility at age sixty-five and thus cannot enroll in the military HMO plan. *[See "Military Hospitals and Medicare," June 1996, p. 63.]*

The Pentagon, members of Congress, and numerous veterans associations have been trying for years to win approval for Medicare Subvention. Under this new concept, the federal Health-Care Financing Agency would be permitted to divert Medicare funds to reimburse the Defense Department for its costs in providing care to military retirees and their dependents over the age of sixty-five.

On September 10, officials of the Department of Defense and Department of Health and Human Services

Overseas With Tricare



Tricare Europe will look exactly like its CONUS cousin—almost. Beneficiaries will have only two, rather than three, basic options. The system will offer Tricare Europe Prime (the HMO-type option) and Tricare Europe Standard, the basic fee-for-service CHAMPUS option.

Health officials expect to complete initial enrollment for Tricare Europe Prime by January 1997. Once that is done, those beneficiaries who choose to remain in the Standard option will have to pay CHAMPUS copayments and deductibles beginning July 1, 1997.

The CONUS version of Tricare requires beneficiaries to enroll annually, but enrollment in Europe will be based on the member's length of assignment. The enrollment period also extends to the date the member must report to a new duty assignment in CONUS.

The Tricare initiative covering the western Pacific started October 1. As in Europe, it will offer only Tricare Prime and Tricare Standard. However, the current enrollment period is only for one year, not the whole tour.

Alaska is working with a consortium of federal health-care providers—Veterans Affairs, Native American Health Service, and Bureau of Indian Affairs—to set up its system.

In the western Pacific area, individual services are arranging to share resources and "cross-credential" their medical staffs to make use of available MTFs. Japan will have a common server to connect computer and communications systems—treating all US medical facilities as one. The lead agent role will rotate among the services.

announced agreement on a Medicare Subvention demonstration program. The test was designed to run for three years in Regions 6 and 11, starting on January 1, 1997. However, at the eleventh hour Congress failed to pass legislation approving the test.

In addition to pushing for Medicare Subvention, veterans groups (including many in the Military Coalition, such as AFA) have moved to have the Federal Employees Health Benefits Program opened to military retirees and active-duty dependents. The Pentagon still does not think the FEHBP option is viable. Pentagon health officials say it will be more costly to beneficiaries and might have a negative impact on military medical readiness.

The Pentagon has been studying the FEHBP option over the past year but has not yet released its complete findings. Pentagon officials note that the FEHBP has more than 350 plans nationwide, making it much more complex than Tricare with its three options.

In a March 1995 letter to Congress, Dr. Joseph maintained that in comparing FEHBP's HMO-type plans with Tricare Prime, the FEHBP option would cost $800 to $4,400. Tricare Prime beneficiaries pay $0 (active-duty families) to $460 (retirees and families).

Top defense health officials also stress the necessity of keeping a wide range of beneficiaries—all ages—within the MHSS to sustain military medical proficiency. General Anderson told lawmakers, "We do not support the FEHBP as a viable alternative to Tricare, not only because of complexity and the increased costs. We also feel strongly that it would threaten medical readiness, the very reason for our existence: to provide support to the Air Force warfighting capability."

Dr. Joseph noted another risk in offering an FEHBP option: CHAMPUS-eligible beneficiaries who don't currently rely on the government for their health-care coverage—who have other primary health-care coverage—might be tempted to drop nongovernment coverage and use government care, thus generating new costs for DoD. He estimated the tab at $500 million a year.

He added that a parallel circumstance exists for Medicare-eligible DoD beneficiaries. "Offering FEHBP coverage to DoD Medicare eligibles," he said, "would require additional, new funding for DoD, estimated at up to $1.5 billion."

Enter USTFs

The Pentagon provides another, little-known option for some active-duty dependents and military retirees: Uniformed Services Treatment Facilities. In 1982, Congress designated ten former Public Health Service hospitals, now under civilian ownership, as USTFs and made them part of the DoD health-care system. Today there are seven USTF organizations:

- Johns Hopkins Medical Services Corp., Baltimore, Md.
- Brighton Marine Health Center (Saint Elizabeth's Medical Center), Boston, Mass.
- Lutheran Hospital (Fairview Health System), Cleveland, Ohio.
- Sisters of Charity Health-Care System (Saint Joseph Hospital, Houston, Saint John Hospital, Nassau Bay, and Saint Mary Hospital, Port Arthur, Tex.)
- Martin's Point Health Care, Portland, Me.
- Pacific Medical Center & Clinics, Seattle, Wash.
- Bayley Seton Hospital, New York, N. Y.

DoD has footed the bill for the USTFs. They have become increasingly expensive to operate, according to studies. Recent reports indicate they may now be more costly than CHAMPUS and other health-care providers. A 1994 DoD study found that, if USTF members changed to CHAMPUS or military hospitals for care, the Defense Department would save an estimated $93 million to $146 million per year. It also stated that to be budget neutral, the USTF program should increase cost sharing, impose enrollment fees for members under age sixty-five, and ensure that all members received all their care through the USTF.

The Congressional Budget Office presented similar findings in a 1994 study comparing USTF cost-effectiveness with that of the MHSS and civilian HMOs.

A Congressionally directed 1996 study by the Institute for Defense Analyses estimated that the USTF program cost DoD more than $193 million more per year than it would have spent had the members relied on the MHSS for their care. The institute also pointed out that many USTF members have private insurance coverage and may receive care outside the USTF, even though DoD made per capita payments to the USTFs to cover all their care.

Dr. Joseph stressed to Congress, "We think the best way to go is to try to bring the USTFs onto a level playing field within the Tricare system with retention of their independent status, but it has to be on a level playing field. GAO has attested to their higher cost per unit of service. . . . With resources as tight as they are these days, every dollar that we spend unnecessarily on one privileged group of providers is a dollar directly out of health care that's available in the MTFs for our other beneficiaries."

To help cut DoD's costs, the Fiscal 1996 Defense Authorization Act required USTFs, after October 1, to adopt Tricare enrollment fees and copayments. In the recently passed Fiscal 1997 defense authorization bill, Congress established the seven USTF organizations as "designated providers" within the MHSS.

Under the new Uniformed Services Family Health Plan (USFHP), the USTFs will provide the same coverage and benefits as the Tricare Prime program. The new plan will start by October 1, 1997. All of the nearly 125,000 persons currently enrolled in the USFHP are guaranteed enrollment in the new program if they wish. Unlike DoD's Tricare Prime, USFHP enrollees can continue in the program after reaching sixty-five. Congress also stipulated that the USTFs will not enroll more than 110 percent of the previous year's enrollment. That leaves the door open for DoD beneficiaries who live near a USTF to enroll once they become Medicare-eligible.

DoD also is trying to extend its new health program to cover beneficiaries located in areas not near an MTF. It started a test on May 1, 1996, in Region 11 offering the Tricare Prime option to active-duty dependents in remote locations.

The transformation of the vast military health-care system won't be completed for several years. However, according to Dr. Joseph, the bottom line on the Tricare program is that "we are well on track—not without problems, but well on track." ■