The Pentagon seeks a transfer of funds from Medicare to avoid forcing older retirees out of the military medical system.

Military Hospitals and Medicare

By Suzann Chapman, Associate Editor

For years, military recruiters spoke of a solemn agreement that the services had with their members—the promise of lifetime medical care. They said the government would provide free (or nearly free) care to every military retiree and his dependents, even after he took off the uniform.

Recruiters pointed to this benefit as a key reason for serving a full twenty-year career.

Unfortunately for retirees and their dependents, fulfillment of the promise is in doubt. With the cost of health care soaring and base closures shutting the doors of military medical centers, some officials and analysts have begun claiming that the promise never was an absolute pledge in perpetuity. Recruiters, they maintain, exceeded their authority, making promises that are not binding.

Even so, no one has seriously challenged the retiree claim that military recruiters did in fact make such promises, that they continued to do so until at least 1993, and that many people based career and retirement decisions on these pledges. Nor has the government explained why it for decades made so little effort to correct such a significant and high-visibility "mistake" on the part of the recruiters.

For the Pentagon, these factors add up to big trouble. If the pledge is shown to be just another empty Washington promise, the government will face charges that it has broken faith with its own troops. Pentagon officials worry that the dispute could undermine today's force. They say current members will draw the appropriate conclusion about government promises and be less likely to pursue a full military career.

The Defense Department's present position is that it has a moral obligation to provide health care to military retirees. That is why DoD, when it presented a health-care reform plan

Military Health-Service System Beneficiaries

	FY '90	FY '91	FY '92	FY '93	FY '94	FY '95	FY '96	FY '97
Active-duty members	2,284,795	2,243,030	2,108,908	1,977,440	1,834,176	1,707,444	1,645,964	1,612,865
Active-duty dependents	2,922,790	2,938,121	2,860,956	2,778,638	2,593,968	2,427,207	2,337,301	2,297,275
Retirees	1,142,263	1,147,606	1,157,010	1,159,920	1,147,655	1,151,949	1,131,243	1,119,029
Retiree dependents	1,837,384	1,822,469	1,841,477	1,866,099	1,869,583	1,928,296	1,917,181	1,885,354
Medicare-eligible beneficiaries	894,297	947,200	993,830	1,035,768	1,086,360	1,144,145	1,213,194	1,273,440
Total	**9,081,529**	**9,098,426**	**8,962,181**	**8,817,865**	**8,531,742**	**8,359,041**	**8,244,883**	**8,187,963**

"Active-duty" figures include members of the four armed services, the Coast Guard, commissioned corps of the National Oceanic and Atmospheric Administration, and eligible Public Health Service employees. "Retirees" and "Retiree dependents" refer to CHAMPUS-eligible retirees and dependents. "Medicare-eligible beneficiaries" refers to both retirees and their dependents. Fiscal 1996 and 1997 are projections.

Source: DoD

to Congress in 1994, included a financing proposal called "Medicare Subvention." Under this plan—in which Medicare would reimburse DoD for care provided to older retirees—the Pentagon could keep open the option to make good on the promise to retirees without worrying that the services will go broke.

The post–Cold War drawdown of the 1990s, with its severe reductions in uniformed personnel and bases, has sharply undercut the once almost unlimited ability of the military health-service system (MHSS) to accommodate its beneficiaries, whether active-duty dependents or retired persons. By 1997, the MHSS will have closed fifty-eight hospitals—thirty-five percent of the entire system that existed in Fiscal 1988.

The Space-Available Crunch

The problem is especially difficult for retirees. Military treatment facilities have always handled retirees on a space-available basis, but the shrinking military system has made it increasingly difficult to find available space. The older retirees have to seek coverage either under Medicare or through civilian health insurance, which many do not want to do.

With the introduction of the All-Volunteer Force in 1973, the number of military careerists—and future retirees—began to increase, meaning that, even though the active-duty pool has shrunk following the end of the Cold War, the retiree population only began to drop slightly last fiscal year. (See chart, p. 63.)

Inevitably, the number of military retirees and dependents eligible for Medicare—those who have reached age sixty-five—is growing. These military retirees are no longer considered eligible for coverage under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Adding to the dilemma facing this older group of retirees has been DoD's introduction of Tricare—a managed-care health program. Current rules state that Medicare-eligible beneficiaries may not enroll in the program's health-management option, known as Tricare Prime, because it combines the MHSS with a network of civilian providers. *[See "Sizing Up Tricare," August 1995, p. 64.]*

Even before the inauguration of Tricare, military retirees and their family members age sixty-five or older were no longer eligible for CHAMPUS. However, in the past, the MHSS normally has been able to provide free or very low-cost space-available health care to its Medicare-eligible beneficiaries, but that option is disappearing.

"With continuing reductions in military medical facilities and end strength, our 'space available' will decline," Dr. Stephen C. Joseph, assistant secretary of defense for Health Affairs, told Congress last year. "As this occurs, there is little doubt that our Medicare-eligible patients will be forced to seek care from civilian providers under the Medicare system."

Today, nearly 600,000 retired military personnel and dependents who are at least sixty-five years old receive some of their medical care at military treatment facilities. The Pentagon estimates that about 380,000 used MTFs exclusively in 1995.

DoD puts the annual cost of treating Medicare-eligible beneficiaries at $1.4 billion. As DoD's budgets tighten, it will be increasingly difficult to absorb this expense. In fact, defense officials state that the cost to care for all Medicare-eligible military beneficiaries who might want to participate in Tricare Prime is more than the department can afford.

Saving the Government Money

Dr. Joseph emphasized that if those Medicare-eligible beneficiaries are forced out of the military system, the cost to the government might well increase. The Pentagon reported in a 1994 study that MTFs can provide health care far less expensively—by some ten to twenty-four percent—than can CHAMPUS through civilian providers.

A 1990 General Accounting Office study also concluded that the military could save money by treating patients in MTFs rather than with CHAMPUS providers.

The Pentagon's top health official offered two additional reasons why MTFs should continue treating the Medicare-eligible beneficiaries. Not only is DoD morally obligated to do so, said Dr. Joseph, but military health professionals also need older patients as subjects. Their wide range of health conditions provides training for medical readiness skills and helps maintain clinical proficiency.

Air Force leaders are taking this moral obligation seriously. However, they stated that care for Medicare-eligible beneficiaries will become more and more constrained until changes are made in the law. USAF's top doctor, Lt. Gen. (Dr.) Edgar R. Anderson, Jr., wrote a special article in the Air Force retiree newsletter to reassure retirees and family members sixty-five and older that the Air Force remains "committed to providing your care."

Along with the services, veterans' groups have vigorously petitioned Congress to implement Medicare Subvention.

The Air Force Association stated its support for Medicare Subvention formally in a 1995 issue paper. AFA members believe the proposal will provide "seamless health-care coverage for military retirees regardless of age" and maintain the guarantee of "military health care for life."

Two bills now before the House of Representatives outline plans for the federal Health Care Financing Agency (HCFA) to reimburse the Defense Department for the treatment that MTFs provide to Medicare-eligible beneficiaries.

Rep. Joel Hefley (R-Colo.) introduced one bill on January 19, 1995, maintaining that this is a "reform that is long overdue." As of May 1, 1996, the Hefley bill had 253 cosponsors (109 Democrats, 142 Republicans, and two Independents).

The second bill, introduced by Rep. Randy "Duke" Cunningham (R-Calif.) on February 8, 1995, seeks to expand the new financing provision to treatment in veterans' medical facilities as well as MTFs. It has six cosponsors (three Democrats and three Republicans).

Currently, no comparable bills have been introduced in the Senate. However, Sen. Phil Gramm (R-Tex.) introduced a bill on December 20, 1995, that would establish a demonstration project for Medicare Subvention. Three more demonstration project bills were proposed on March 21. Sen. Bob Dole (R-Kan.) introduced another bill in the Senate. Representatives Hefley and J. C. Watts (R-Okla.) presented bills in the House.

The Pentagon has already been working with the HCFA to outline a

demonstration project, which DoD hopes to implement in the fall.

Increased Costs?

There is some concern that Medicare Subvention would increase costs to the HCFA. However, the Military Coalition, an alliance of veterans' and military groups (including AFA), points out that DoD has been effectively subsidizing the Medicare trust fund over the years by treating military Medicare-eligible beneficiaries. Those same beneficiaries paid payroll taxes to the fund during their years of government employment.

The coalition contended in Congressional testimony last year that Medicare costs will increase as the drawdown and Tricare implementation push more Medicare-eligible military beneficiaries into the private sector. "Subvention would not cause Medicare cost growth; it would help ease it by giving Medicare an option to secure DoD care at lower cost," the coalition argued.

Representative Hefley says he believes his Medicare Subvention legislation is "cost neutral."

"Medicare is simply paying DoD just as [it] would pay any approved provider," he wrote in a "Dear Colleague" letter to other members of Congress. He also emphasized studies that have shown military care to cost less and added, "This means that Medicare would be paying less money to DoD than it would in the private sector."

The Retired Officers Association (TROA) estimates that, by 2000, the number of Medicare-eligible military beneficiaries will grow to 1.6 million. If these new beneficiaries rely on Medicare as their sole source of care, said TROA, it would increase Medicare's cost by $7.7 billion. TROA further states that Medicare Subvention could help reduce this cost increase by $361 million.

However, the Congressional Budget Office said that Medicare Subvention as outlined in some 1995 proposals could increase the overall deficit. The CBO stated that, as long as there are fixed caps on discretionary spending, any savings in DoD's budget from Medicare Subvention can be spent on other defense or nondefense discretionary programs. Thus, enacting Medicare Subvention alone would increase the deficit by the amount of the Medicare payment. In 1995, Congress asked the CBO to study other options, such as using the Federal Employees Health Benefits Program (FEHBP), for military health care.

The FEHBP Option

In its July 1995 report, "Restructuring Military Medical Care," the CBO suggested that the military should downsize its medical establishment to its wartime requirement—thereby generating "substantial" savings.

Using the Pentagon's own study of wartime medical requirements, the CBO said, DoD could cut the number of direct-care facilities from 120 to eleven. Those eleven facilities and a similarly downsized medical force could cover wartime requirements and about thirty-three percent of the peacetime care for active-duty beneficiaries, said the CBO.

For the remaining sixty-seven percent of active-duty personnel, the services would need to seek peacetime health care from the civilian sector. The report proposed that, to handle the non-active-duty beneficiaries, the government should shut down CHAMPUS and shift coverage of this group to the FEHBP.

The CBO's analysis concluded that the health care provided in military medical facilities in peacetime bears little relation to battlefield medicine and that the services do not need peacetime health care to train effectively for wartime.

In Congressional testimony, Neil M. Singer, the CBO's deputy assistant director, National Security Division, stated, "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 FEHBP." He added, "At the same time, our analysis indicates that for an FEHBP approach to achieve savings, many military beneficiaries would have to pay a larger share of the cost of health care than they do today."

However, the CBO also noted that it did not include the cost of downsizing the military health-care system in its report but said it would take from five to ten years to realize any savings.

A Defense Department review of the FEHBP option was due out soon. However, in September 1995 Congressional testimony, Dr. Joseph flatly denied the viability of the CBO approach. He said, "Wholesale conversion of military health care to FEHBP . . . would be disastrous to readiness and unacceptably expensive for our beneficiaries."

He criticized not only the cost to beneficiaries but also the report's failure to consider the need to maintain professional medical skills.

The FEHBP option, unlike CHAMPUS and Tricare, would provide coverage for Medicare-eligible military beneficiaries. However, Dr. Joseph noted that the cost would be greater. "The FEHBP is significantly more expensive than Tricare, and the strongest statements from our military retirees regarding their health care are about costs," he said.

He emphasized that, in using data from the Pentagon wartime medical requirements report (known as the "733 Study"), the CBO failed to mention a major point of that study—the MHSS provides the most cost-effective health care. In fact, the study found that reducing the medical force to a wartime-only size would be more expensive.

The Military Coalition also disagreed with the CBO analysis. Its representatives told Congress last year that the coalition would not support FEHBP as an alternative if it were offered as a replacement for CHAMPUS. The threat of increased cost was the central issue.

Nonetheless two bills are now in Congress that would permit military retirees and their dependents to enroll in FEHBP. Rep. James P. Moran, Jr. (D-Va.), introduced his bill on March 5, and Sen. John W. Warner (R-Va.) presented his FEHBP option bill March 28. Rep. Ed Pastor (D-Ariz.) also had introduced a bill September 29 to permit a demonstration project for the FEHBP option.

DoD expects to have its new Tricare program up and running in all twelve regions during Fiscal 1997. If no Medicare Subvention provision or other option exists, Medicare-eligible military retirees who choose to use MTFs, some twenty-three percent, may lose their spaces in the military health-care line.

In its Medicare Subvention position paper, the Air Force Association noted that military retirees are the only group of retired government employees who lose their health-care coverage at age sixty-five. ■