FEHBP/CHAMPUS: IMPROVING ACCESS TO HEALTH CARE FOR MILITARY FAMILIES

HEARING

BEFORE THE

SUBCOMMITTEE ON
CIVIL SERVICE

OF THE

COMMITTEE ON GOVERNMENT
REFORM AND OVERSIGHT
HOUSE OF REPRESENTATIVES

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FEHBP/CHAMPUS: IMPROVING ACCESS TO HEALTH CARE FOR MILITARY FAMILIES

TUESDAY, SEPTEMBER 12, 1995

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON CIVIL SERVICE,
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:05 a.m., in room 2154, Rayburn House Office Building, Hon. John L. Mica (chairman of the subcommittee) presiding.

Present: Representatives Morella, Bass, Moran, and Holden.

Also present: Representative Davis.

Staff present: George Nesterczuk, staff director; Daniel R. Moll, senior policy director; Caroline Fiel, clerk; Cedric Hendricks, minority professional staff; and Jean Gosa, minority staff.

Mr. MICA. If I may have your attention please, I would like to call this meeting of the House Subcommittee on Civil Service to order and say a great, good morning to you, Washington, on this almost-fall morning.

I see we have the new member of our subcommittee, Mr. Tim Holden, joining us. Welcome. I am delighted to have you assigned to our panel. I think you will find that we have a most cordial relationship and working partnership on this subcommittee on both sides of the aisle, led by your ranking member, Mr. Moran, who looks relaxed and rested after his recess. We welcome you to the panel and look forward to your full participation. Thank you for joining us this morning.

This morning, our subcommittee is going to examine the current status of health care for military families. We will also review some of the problems with CHAMPUS as we know it. One thing I have discovered since coming to Congress is that just about any change, even the most positive recommended change, is difficult to promote and effectuate here. However, when programs are not working properly, we must seize every opportunity to institute change. Such is the case for the health care system of our military retirees and the families of our servicemen and women.

I believe we have a responsibility to ensure that those who serve us, or have served us in the past, and their families, have access to proper care when they need it. One of the purposes of today's hearing is to carefully consider what problems may be encountered if we attempt to make changes in the system developed to accommodate the needs of our military families and retirees.

We have asked representatives from the Department of Defense to testify before us today to assist us in better understanding the

problems they have with the current system and also, to hear their recommendations for future changes.

The Dependents Medical Care Act of 1956 provided medical care for families of active duty personnel and for military retirees and dependents at a military medical facility, primarily on a space-available basis.

Ten years later, the demand for health care exceeded the capacity, and legislation was passed that created the Defense Department-sponsored health insurance program, which is called the Civilian Health Care Medical Program of Uniformed Services—most of us know it as CHAMPUS—which allows military families access to private health care when military medical facilities do not have space available.

Now, 30 years later, I believe we are long overdue in correcting growing deficiencies in the military health care system. With numerous base closures, budget reductions, and general downsizing, the military health care system appears to be relegating military families to second-class status when it comes to health care.

I find this situation deplorable and unacceptable and crying out for our review of the process, and also for reform. As chairman of the House Civil Service Subcommittee, I believe a simple alternative may be to make available the use of the Federal Employee Health Benefit Program, FEHB, to our civil counterparts to CHAMPUS. I think it's worth looking at, and that's part of the purpose of this hearing today.

It is notable that despite all the problems and difficulties I have seen in various Federal programs under our civil service system, the FEHB is one of the free enterprise-based programs that I believe is working extremely well. Overhead and administrative costs are low, while choices for employees include a broad array of options to meet their specific health care needs. CHAMPUS, which was originally intended for those few living far from the military installation, is fast becoming the primary benefit for many military families; a growing number of beneficiaries feel CHAMPUS is not a satisfactory alternative to military medical facilities because of often exorbitant and unpredictable out-of-pocket costs.

The General Accounting Office has found also that the CHAMPUS program is vulnerable to fraud and abuse.

Additional problems confront military beneficiaries, age 65 or older, as they lose CHAMPUS eligibility. They must rely on availability of space at military medical facilities or turn to Medicare. This group is at particular disadvantage since they are the last in line for care at our military medical facilities.

I find it unacceptable that military retirees who have fought in two or three wars should be treated less favorably in their access to health care than the civilian employees of our Federal Government.

A possible solution, as I said, to some of these problems may be found in the FEHB program. FEHB is the largest employer-sponsored health care program in the country and it provides enrollees with reliable, comprehensive medical benefits at what I believe is reasonable cost.

The program is administered by the Office of Personnel Management, which approves qualified plans for participation, manages

premium payments, and negotiates with plans to determine benefits and premiums. The FEHB insurance carriers have been highly successful in containing costs without cutting benefits, and holding the line on premiums.

This week the U.S. Congress and the House begin formal consideration of the new majority plans for revamping the largest Government health care programs: that of Medicare and Medicaid. It is equally important that our subcommittee today begin consideration of reforms to the military health care system.

I want to welcome our witnesses today. We are going to hear from the National Military Family Association about some of the problems in the military health care system. We will also hear from the Congressional Budget Office and the Office of Personnel Management. They will address the possibility of opening up the FEHB to beneficiaries of the military health system.

The Office of Program Analysis and Evaluation of the Department of Defense will testify regarding their well-recognized "733 study," which addressed the mission of the military medical system. Finally, we will hear from the Office of Health Affairs at the Department of Defense about some of the difficulties they anticipate in dealing with this issue and also their comments relating to some proposed changes.

I look forward to the testimony of our witnesses and hope that we can thoroughly examine the military medical system and the possibility of opening up that system to FEHB and to a population particularly that deserves better access to more reliable health care.

Those are my opening comments. I would like now to yield to our ranking member, the distinguished gentleman from Virginia, Mr. Moran.

[The prepared statement of Hon. John L. Mica follows:]

PREPARED STATEMENT OF HON. JOHN L. MICA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Good Morning. At today's hearing we will examine the current status of health care for military families. We will also review some of the problems with CHAMPUS as we know it. One thing I have discovered since coming to Congress is that change, even the most positive change, is difficult to promote. However when programs are not working properly, we must seize the opportunity to institute change. Such is the case for the health care system of our military retirees and the families of our servicemen and women.

We have a responsibility to ensure that those who serve us, or have served us in the past, and their families have access to proper care when they need it. One of the purposes of today's hearing is to carefully consider what problems may be encountered if we attempt to make changes in the system we have developed to accommodate the needs of military families and retirees. We have asked representatives from the Department of Defense to testify before us today, to assist us in better understanding the problems they have with the current system and their suggestions for future changes.

The Dependents Medical Care Act of 1956 provided medical care for families of active duty personnel, and for military retirees and their dependents, at military medical facilities on a space-available basis. Ten years later the demand for health care exceeded the capacity, and legislation was passed to create a Defense Department-sponsored health insurance plan. This program, called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) allows military families access to private health care when military medical facilities do not have space available.

Now, 30 years later, I believe we are long overdue in correcting growing deficiencies in the military health care system. With numerous base closures, budget

reductions, and general downsizing, the military health care system appears to be relegating military families to second-class status when it comes to health care. I find this situation deplorable and unacceptable, and badly in need of reform. As Chairman of the House Civil Service Subcommittee, I believe a simple alternative may be available using the FEHB program—our civilian counterpart to CHAMPUS.

It is worth noting that despite all the problems and difficulties I've seen in various federal programs under our Civil Service System, the FEHB is one free enterprise-based program that is working extremely well. Overhead and administrative costs are low, while choices for employees include a broad array of options to meet their specific health care needs.

CHAMPUS, which was originally intended for those few living far from a military installation, is fast becoming the primary benefit for many military families. A growing number of beneficiaries feel CHAMPUS is not a satisfactory alternative to military medical facilities because of often exorbitant and unpredictable out-of-pocket costs. The General Accounting Office also found that the CHAMPUS program is vulnerable to fraud and abuse.

Additional problems confront military beneficiaries age 65 or older as they lose CHAMPUS eligibility. They must rely on availability of space at military medical facilities or turn to Medicare. This group is at a particular disadvantage since they are last in line for care at military medical facilities. I find it unacceptable that military retirees who have fought in two or three wars should be treated less favorably in their access to health care than civilian employees of the federal government.

A possible solution to some of these problems may be found in the FEHB program. FEHB is the largest employer-sponsored health care program in the country and it provides enrollees with reliable, comprehensive medical benefits at a reasonable cost.

The program is administered by the Office of Personnel Management, which approves qualified plans for participation, manages premium payments, and negotiates with plans to determine benefits and premiums. FEHB insurance carriers have been highly successful in containing costs, without cutting benefits and holding the line on premiums.

This week as Congress begins formal consideration of the new majority plans for revamping the largest government health care programs—Medicare and Medicaid—it is equally important in our Subcommittee today that we begin consideration of reforms to the military health care system.

I want to welcome our witnesses today. We will hear from the National Military Family Association about some of the problems in the military health care system. We will also hear from the Congressional Budget Office and the Office of Personnel Management. They will address the possibility of opening up the FEHB program to beneficiaries of the military health system. The Office of Program Analysis and Evaluation of the Department of Defense will testify regarding their well-recognized "733 study" addressing the mission of the military medical system. Finally we will hear from the Office of Health Affairs at the Department of Defense about some of the difficulties they anticipate in dealing with this issue.

I look forward to your testimony and I hope we can thoroughly examine the military medical system and the possibility of opening up the FEHB program to a population that needs and deserves better access to more reliable health care.

Mr. MORAN. I thank my distinguished chairman. Many of my comments are similar to yours, Mr. Chairman, although it might be useful to reiterate them to show that this is a bipartisan effort and, in fact, to get some of this onto the record more than once.

The Department of Defense has one of the largest and most complex medical systems in the world. The quality of care that is provided at many of its medical treatment facilities—and we are going to hear the term "MTF" throughout this hearing; it stands, of course, for the military treatment facilities around the country—much of that is among the best and most advanced. I know at Bethesda and Walter Reed we have terrific medical facilities, and they clearly exist in many parts of the country.

The active duty military receive all this top-quality medical care free of charge. The reason that they do, the mission is to ensure that its active duty forces, which amount to an estimated 1.7 million men and women, are medically fit for a wartime situation.

The situation is not the same, however, for retired military and their families. And although there is no statute that guarantees free medical care for life, all the retired military were promised this during recruitment so there is no legislation that was passed, but when you hand out brochures and the recruiting officer tells you that one of the benefits for enlisting is that you're going to get lifetime free medical care, there is a type of contract there and we ought not take lightly.

That promise while they were on active duty, of course, was fulfilled. The problem is that the costs of military medical care have risen by 65 percent, when you take inflation into account, since 1979. It now claims 6 percent of the entire defense budget, which is up from 4 percent. That's an enormous increase that obviously has to be addressed. This year, the Department of Defense will spend $15.2 billion to operate that military health care system and of that $11.7 billion goes to military treatment facilities.

The retired military come at the end of a long list of priorities in terms of who is eligible to receive that care, and they are finding it increasingly difficult to get timely and good-quality medical care through the military system. Among retired military and their families who participate in CHAMPUS, finding a civilian provider who will accept the very low reimbursement rates has proven to be increasingly difficult.

I know it's almost impossible in the Washington area because the rates simply aren't sufficient and so nobody outside the military treatment system wants to accept CHAMPUS payments. If they have been treating a member of the family, they let other members of the family in, but beyond that, they don't accept new patients because the reimbursement is insufficient.

So we heard all kinds of anecdotal stories, and I suspect all the members on the panel—I hear a lot of them because I represent so many military families, and many of them are very much involved and are leaders on a national level in terms of providing the—securing the kinds of benefits that retired military are entitled to and always assumed that they would get from the military.

We have lots of administrative problems, as well, from CHAMPUS. In response to the continued escalation of military costs and all of those administrative problems, not to mention the overall beneficiary dissatisfaction with the program, Defense has come up with the TRICARE program that has a great deal of potential for addressing many of the problems for active duty military personnel. The problem is that it does not address the problems of retired military and their families.

There are an estimated 6.6 million nonactive duty military personnel and dependents who fall into this category. And also by almost the end of this millennium, by 1999, 40 percent of them are not going to live within 40 miles of a military treatment facility, so that makes it prohibitive to take advantage of military treatment facilities. So you've got a major problem and that's what these hearings are all about.

CBO projects that under TRICARE retirees will face much higher premiums for the private sector care and longer waiting lines in military treatment facilities. And those retired military and their spouses who are Medicare eligible are the biggest problem. In other

words, those who are over 65 are excluded from the program. They have no new options.

The Department of Defense, in recognition of this problem, has promised to allow them into the program, but only if the Health Care Financing Administration, the people who run Medicare over at the Department of Health and Human Services, will pay for their costs through the Medicare program. That's $1 billion a year and that's going to be a problem, given the budget restraints which we read about on the front page every day. That's clearly swimming against the tide. That's why I would like to explore the option of using the Federal Employees Health Benefits Plan.

It's an employer-based health insurance plan where the employer pays an average currently of 72 percent. That may go down with some of the proposals that have been made in the reconciliation bill, but right now it is a very good plan with a very high level of satisfaction, and that is what we would like to see, if that might be made available to military retirees particularly.

But what we want to do in the hearing today is to learn more about the system and all the potential for reform that we might have available to us beyond FEHB, as well. We want to work closely with DOD and OPM to ensure that we can provide the highest quality health care both to active military and their dependents, and to military retirees.

I am aware of the impact an imprudent decision would have on young military families and I share the Department's concern and interest in ensuring that all of its members from the highest officer to the oldest veteran to the youngest recruit are adequately covered.

I don't think we ought to close the current medical treatment facilities. I don't want to force young military dependents to give up their current health care benefits and force them to join a new system. I don't think we should deny access, though, to any military dependent or military retiree.

And so hopefully this hearing will take the first step in focusing on the costs of the options, the benefits, and the risks of allowing Medicare-eligible military retirees to participate in the Federal Employees Health Benefit system. It is an intriguing possibility. I think it has some potential, but we can't reach that conclusion, really, until we hear from all sides concerned; and that is why I appreciate so much, Mr. Chairman, us having this hearing today and getting the quality of panelists that you have. We are going to hear from all the perspectives, and I know this is going to be a constructive hearing. Thank you, Mr. Chairman.

Mr. MICA. I thank the gentleman and I would like to yield now to the vice chairman of the subcommittee, who traveled from the crisp New Hampshire countryside to be with us this morning.

Mr. BASS. My distinguished colleague from Florida is most right. New Hampshire is indeed the grandest State in the Nation. I will yield a minute initially to my distinguished colleague from Virginia, Mr. Davis.

Mr. DAVIS. Thank you. I thank my colleague for yielding.

Mr. MICA. I didn't see Mr. Davis, who probably had to survive coming across the 14th Street Bridge or something. Welcome to you, too. I welcomed everyone but you this morning.

Mr. DAVIS. That is fine. Although I am on the full committee, but not on the subcommittee, I wanted to be here today. I ask unanimous consent to insert a longer statement in the record.

I just want to commend our chairman, Mr. Mica; our ranking minority member; and the vice chairman of the committee for holding these hearings. I think that providing a defined benefit plan for all members of the uniformed services will fill a significant health care void that now exists, when beneficiaries turn 65 and are essentially locked out of the military health care system.

I just want to remind my colleagues, even if we go forward with this proposal, it is short of the promise to a number of our retired military personnel who, I think, felt originally that having to pay health care premiums is really a contradiction to what they believe is a commitment to free health care for life. But this proposal can be a major improvement.

I applaud you for moving forward and I would like to insert a longer statement. Thank you very much.

Mr. MICA. Without objection.

[The prepared statement of Hon. Thomas M. Davis follows:]

PREPARED STATEMENT OF HON. THOMAS M. DAVIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF VIRGINIA

Thank you Mr. Chairman. In April 1994, senior Department of Defense (DoD) health care officials announced the establishment of a DoD-wide, joint-service managed care system called TRICARE. TRICARE is intended to streamline health care delivery and reduce duplication of effort in the military health system. However, experts have already identified a number of problems with the TRICARE system. Unfortunately, retirees and dependents over the age of 65 are not eligible for TRICARE; however, they do retain eligibility for space-available treatment in military medical facilities. To remedy this situation, Rep. Joel Hefley of Colorado introduced H.R. 580 to allow military retirees over age 65 to use Medicare benefits at military treatment facilities (MTF's). Although the "Medicare subvention" proposals contained in H.R. 580 should help improve the health system for military retirees, I think that providing a defined benefit plan for all members of the uniformed services will fill a significant health care void.

In addition to the difficulties military retirees are experiencing with the TRICARE system, active duty dependents are finding that there is often not enough space available in MTF's to provide care for them as well. Active duty servicemen and women have the highest priority when using MTF's, and their dependents follow. Unfortunately, the downsizing of the American military has led to a reduction in the total number of beds available in MTF's. This is an unintended consequence of the reduction in force that DoD has experienced since the end of the Cold War; and, is not acceptable considering the information that most military received during the recruiting process regarding the health care that both they and their families would receive.

Earlier this year, American Legion Post 176 in Springfield, Virginia recognized the fact that military personnel were not well informed about the system that would be providing their health care in the future. Members of Post 176 organized the first of several grassroots medical forums at which experts in the military medical field and representatives from government attempted to find a way to make the health system work. It was at one of these hearings that the idea being explored today, the inclusion of military personnel in FEHB Plans, was first brought to my attention. I applaud the Chairman and Mr. Moran for holding these hearings and also thank them for their hard work on this important issue. I hope that we can develop a plan to give military dependents and retirees a much improved health system.

Mr. MICA. Mr. Bass, you are recognized.

Mr. BASS. Thank you very much, Mr. Chairman. I thank you as well, along with my colleagues on this subcommittee, for calling this important hearing today on improving access to health care for military families. I am sure that everyone on this subcommittee as

well as probably every Member of Congress has received complaints from constituents about the level and quality of care available at military medical facilities and the deficiencies of the CHAMPUS program. I have also heard from a number of residents from my State who are anxious about the implementation of TRICARE which, as I understand it, is supposed to be fully implemented in 1997. However, at the same time, I feel that we need to be concerned about the costs associated with this proposal, the proposal being to allow the military to take—to participate in the FEHBP health care program.

As we all know, as I said, CHAMPUS costs have tripled between 1984 and 1990 and will cost roughly $3.8 billion in 1996. It is therefore appropriate that we would be examining the Federal Employee Health Benefits Program, FEHBP, closely. This plan has consistently delivered high beneficiary satisfaction and has traditionally enjoyed slow premium growth. Furthermore, the FEHB offers a variety of plans allowing beneficiaries to tailor their health coverage to their needs.

As one who believes that FEHB holds many lessons for Congress on how we might deliver better health care to more people, I am particularly looking forward to the testimony of our witnesses this morning; and with that, I would like to thank the witnesses for their time and attention.

And I will have the chairman know that I rose this morning at 4:30 in my hometown of Peterborough, NH, in order to be here to attend this important hearing. Thank you very much, Mr. Chairman.

Mr. MICA. I thank you again for your comments and for your commitment.

[The prepared statement of Hon. Charles F. Bass follows:]

PREPARED STATEMENT OF HON. CHARLES F. BASS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW HAMPSHIRE

Mr. Chairman, I thank you for calling this important hearing today on improving access to health care for military families. I am sure that almost every member of this committee has received complaints from constituents about the level and quality of care available at military medical facilities, and the deficiencies of the Civilian Health and Medical Program of the Uniformed Services, or CHAMPUS. I have also heard from a number of residents from my State who are anxious about the implementation of TRICARE.

At the same time, we need to be concerned about costs. CHAMPUS' costs tripled between 1984 and 1990, and will cost $3.8 billion in FY96. It is therefore appropriate that we will be examining the Federal Employees Health Benefits Program, or FEHBP. FEHBP has consistently delivered high beneficiary satisfaction and has traditionally enjoyed slow premium growth. Further, FEHBP offers a variety of plans, allowing beneficiaries to tailor their health coverage to their needs.

As one who believes that the FEHBP holds many lessons for Congress in how we might deliver better health care to more people, I am particularly looking forward to the testimony of our witnesses this morning. With that, I would like to thank the witnesses for their time.

Thank you, Mr. Chairman

Mr. MICA. I will now turn to the gentleman, our newest member, Mr. Holden.

Mr. HOLDEN. Thank you, Mr. Chairman. I do not have an opening statement, but I commend you for holding this hearing and look forward to hearing the testimony.

Mr. MICA. Thank you. With brief statements like that, you will be a very appreciated member of the panel, at least to start out with, Tim. Thank you.

To move things along, I would like to call our first panel this morning which consists of Sylvia Kidd, president of the National Military Family Association, accompanied by Dorsey Chescavage, the government relations department of the National Military Family Association; Susan Jones of Hanover, MD; and Pamela M. Gildersleeve of Palm Harbor, FL.

If I might first of all welcome you and thank you for coming. Mrs. Guildersleeve I think you came up at your own expense from Florida. We appreciate that so much and we have another panelist here who's an expectant mother. Somebody told me that today is your due date, is that true?

Ms. JONES. Friday.

Mr. MICA. Friday, OK. I just want to let the media know that we will put this event off until Friday. Timing is everything.

It is also the custom of this panel, which is an investigative panel, to swear in our witnesses. So if you would stand, I will swear you in.

[Witnesses sworn.]

Mr. MICA. The record will reflect that the witnesses answered in the affirmative.

Again, welcome. Thank you for all for your participation. You all have provided some rather lengthy testimony. I read most of it last night. It's also the custom of the panel, to have you try to summarize, so that you don't read the whole statement. Your entire statement will be made part of the record; so if you would please summarize and maybe hit the high points. And we are going to use our timer, so when the lights go on and off—they give you a little warning that we try to keep each testimony to 5 minutes—that will allow the panelists time to question you about the statement you submitted and also your testimony.

We will start with Sylvia Kidd, president of the National Military Family Association.

STATEMENTS OF SYLVIA E.J. KIDD, PRESIDENT, ACCOMPANIED BY DORSEY CHESCAVAGE, GOVERNMENT RELATIONS DEPARTMENT, NATIONAL MILITARY FAMILY ASSOCIATION; SUSAN JONES, HANOVER, MD; AND PAMELA M. GILDERSLEEVE, PALM HARBOR, FL

Ms. KIDD. Thank you, Mr. Chairman, for your interest in military families. The issue today is the military health benefit, what is it, how does it work and should it be restructured.

The end of the cold war has caused major erosion in the health care benefits of military families, survivors, and military retirees and their families. Base closures, the downsizing of active duty forces have all resulted in less health care delivered by military hospitals and clinics. The Department of Defense has an obligation to provide a health care benefit to all those men and women and their families who have made a career in the uniformed services.

Many of these men and women fought in World War II, Korea, and Vietnam. Many served in the Persian Gulf and Somalia and

are now serving in the Balkans; and many of those are survivors of those who gave their lives in service to our country.

Career military men and women are not wards of the Government they are not looking for a handout. They are part of the Federal work force. Military retirees are retired from Federal service.

The military health benefit consists of space-available medical care in military treatment facilities and the CHAMPUS program for those who are not eligible for Medicare. Until the mid-1980's, this system worked because there was enough space in military health hospitals and clinics for most of us who lived near military facilities. CHAMPUS was a program we used when we were assigned away from or decided to retire away from the military installation.

This situation has changed over the past few years. Retirees and their families started living longer. At the same time, the country switched from a draft military to an all-volunteer force.

Currently, over 60 percent of the active duty force is married. In other words, the beneficiary population grew while the medical system did not and more and more military beneficiaries were forced to rely on CHAMPUS or Medicare for their health care.

By law, a priority appointment system exists in military health care facilities. All active duty service members must be given appointments first. Second are active duty family members and survivors of those who died on active duty, and last priority is given to retirees and their families and survivors of retirees. Unfortunately, this priority system has become a means by which to ration health care, and the beneficiary group hurt the most by this rationing is the older group of retirees, the ones who need health care the most.

As the country celebrates the end of World War II, military retirees are rightly being thanked by every American for their valiant service, but they are fighting another battle. They are losing their military health benefit.

CHAMPUS is a wonderful program for a healthy person, but it can become a nightmare when illness strikes. The annual out-of-pocket limit for active duty families is supposed to be $1,000; for retirees and their families, it's $7,500. However, these limits apply only to CHAMPUS allowable charges. Military beneficiaries are responsible for the balance billing, so their bills can run into thousands and thousands of dollars. NMFA is receiving more and more reports that doctors are refusing to see CHAMPUS patients. In some States, Medicaid pays better than CHAMPUS; therefore, doctors will see Medicaid patients but not CHAMPUS patients. The effect this has on the morale of service members cannot be underestimated. Some welfare recipients have better health benefits than the families of military men and women.

One of the biggest misconceptions regarding the use of CHAMPUS is that it gives beneficiaries the freedom to choose their own doctors and hospitals. In fact, beneficiaries who reside near a military facility must obtain permission from the military hospital commander for all nonemergency inpatient care and certain outpatient procedures. Each local commander sets the requirements and DOD has the authority to expand the list.

The military medical system cannot provide health care to all who are eligible and yet it will not let us go. Beneficiaries are

yanked back and forth between the two systems like yo-yos. Continuity of care is completely disregarded. The question must be asked, does the system exist to serve the beneficiaries or do the beneficiaries exist to serve the system?

Base closure and realignment has a devastating effect on retired military beneficiaries. Those retirees who are no longer eligible for CHAMPUS because of age have completely lost their military health benefit. The health benefits of Federal civilian retirees, on the other hand, are not at all affected and this is grossly unfair.

DOD has proposed restructuring the military health benefit, and this is called TRICARE and it is intended to replace the military hospital—military health services system, which includes hospitals and clinics, as well as CHAMPUS. TRICARE will exclude all military beneficiaries who are not eligible for CHAMPUS except those who are currently on active duty. The men and women who made a career of serving in uniform from World War II through Vietnam are excluded from the new military health care benefit.

Several military beneficiaries have offered to relate their experiences with the military medical system. I'd like to read you the ending statement from one. As she says, "My husband will not reenlist. He will have to choose between the Army and me. I have always been willing to sacrifice for the Army, putting up with long separations, low pay, and worries while he was in the Gulf War, but I will not sacrifice my family's health."

These are real stories by real people. Obviously, not all military beneficiaries have trouble with the health care system, but unfortunately, these people and these stories are not unique.

We envision that retirees and their families will be offered the opportunity to participate in FEHBP on the same terms as Federal civilian retirees. This includes those who are eligible for CHAMPUS, as well as those who are eligible for Medicare.

Mr. MICA. We thank you for your testimony, and I see you have accompanying you from the National Military Family Association, Dorsey Chescavage.

We will yield to you now. Did you have a statement?

Ms. CHESCAVAGE. No, Mr. Chairman. I am just here to answer questions.

Mr. MICA. All right. Thank you.

[The prepared statement of Ms. Kidd follows:]

PREPARED STATEMENT OF SYLVIA E.J. KIDD, PRESIDENT, NATIONAL MILITARY FAMILY ASSOCIATION

The National Military Family Association (NMFA) is a non-profit, predominantly volunteer organization composed of members from the seven uniformed services, active duty, retired, reserve component, and their family members and survivors. NMFA is the only national organization whose sole focus is the military family and whose goal is to influence the development and implementation of policies which will improve the lives of those family members. NMFA appreciates this opportunity to express its views.

Thank you Mr. Chairman for your interest in military families. The issue today is the military health benefit. What is it? How does it work? Should it be restructured?

The end of the Cold War has caused major erosion in the health care benefits of military families, survivors and military retirees and their families. Base closures and the downsizing of active duty forces have resulted in less health care delivered by military hospitals and clinics. The Department of Defense has an obligation to provide a health care benefit to all those men and women who have made a career in the Uniformed Services. Many of these men and women fought in World War II, Korea, and Vietnam. Many served in the Persian Gulf and Somalia and are now serving in the Balkans. Their spouses stayed home and raised families. Many are survivors of those who gave their lives in service to our country. Career military men and women are not wards of the government, they are not looking for a handout. They are part of the federal work force. Military retirees are retired from federal service.

The military health benefit consists of space-available medical care in military hospitals and clinics, known as military treatment facilities and the Champus program for those who are not eligible for Medicare (generally, people under the age of 65). Until the mid 1980s, most military beneficiaries received their health care in military facilities. The space-available system worked because there was enough space in military hospitals and clinics for most of us who lived near a military facility. Champus was a program we used when we were assigned away from a military installation or if we decided to retire away from a Post or Base.

Military beneficiaries firmly believe they were promised free medical care for life in return for their service. Until recently, most military beneficiaries who wanted that free medical care could obtain it in a military facility. This situation has changed gradually over the past few years. Retirees and their families started living longer. At the same time, the country switched from a draft military to an all volunteer military. Unlike draftees, volunteer service members tend to marry and start families early in their service careers. Currently, about 60% of the active duty force is married. In other words, the beneficiary population grew, while the medical system did not. More and more military beneficiaries were forced to rely on Champus or Medicare for their health care. Free medical care for life gradually became just another promise, not the reality.

By law, a priority appointment system exists in military health care facilities. All active duty service members must be given appointments first. Second priority is to active duty family members and to survivors of those who died while on active duty. Last priority is given to retirees, their families, and survivors of retirees. Unfortunately, this priority system has become a means by which to ration health care. The beneficiary group hurt the most by this rationing is the older group of retirees, the ones who need health care the most.

As the country celebrates the end of World War II, military retirees who are rightly being thanked by every American for their valiant service, are fighting another battle. They are losing their military health benefit. When a Champus eligible beneficiary is denied treatment in a military facility and forced to use the Champus program, the costs to Champus are borne by the Department of Defense (DoD) and the Services. When a Medicare eligible beneficiary is denied treatment in a military facility, it costs DoD and the services nothing. Consequently, even though it is illegal to discriminate among military retirees, the practice of denying health care to older retirees is widespread.

Champus is a wonderful program for a healthy person. It can become a nightmare when illness strikes. The annual out of pocket limit for active duty families is supposed to be $1,000; for retirees and their families, $7,500. However, these limits apply only to Champus allowable charges. Military beneficiaries are responsible for the balance billing, so their bills can run into

thousands and thousands of dollars. Doctors are not supposed to bill Champus patients more than 15% over the Champus allowable charges. However, the only penalty is the loss of Champus authorization. Since Champus pays at an extremely low rate, NMFA is receiving more and more reports that doctors are refusing to see Champus patients. In some states, Medicaid pays better than Champus, therefore some doctors will see Medicaid patients, but not Champus patients. The effect this exclusion has on the morale of service members cannot be underestimated. In some cases, welfare recipients have better health benefits than the families of military men and women. Beneficiaries and doctors both report serious reimbursement problems with Champus. Claims are returned over and over for non-existent mistakes. Many doctors simply refuse to have anything to do with Champus, viewing it as another inefficient government program.

One of the biggest misconceptions regarding the use of the Champus program is that Champus gives beneficiaries the freedom to choose their own doctors and hospitals. In fact, beneficiaries who reside near a military facility must obtain permission from the military hospital commander in the form of a Non-Availability Statement for all non-emergency inpatient care. In addition, this permission is required for certain outpatient procedures. (See attachment 1) Each local commander sets the requirements, and DoD has the authority to expand the list. This system causes constant disruption in the continuity of care. For example, beneficiaries who are denied treatment in a military facility, will try to develop a relationship with a civilian doctor and yet when the doctor determines certain procedures are necessary, the patient will be forced back into the military system. The military medical system cannot provide health care to all who are eligible, and yet it will not let us go. Beneficiaries are yanked back and forth between the two systems just like yo-yos. Continuity of care is completely disregarded. The question must be asked, does the system exist to serve the beneficiaries, or do the beneficiaries exist to serve the system? (See attachment 2)

Base closure and realignment has a devastating affect on retired military beneficiaries Those retirees who are no longer eligible for Champus because of age have completely lost their military health benefit. The health benefits of federal civilian retirees, on the other hand, are not affected at all. This is grossly unfair.

DoD has proposed restructuring the military health benefit. It has named the new benefit Tricare to reflect the three medical systems of the Army, Navy and Air Force. It is intended to replace the Military Health Services System which includes military hospitals and clinics as well as Champus. Tricare was designed in the context of President Clinton's Health Care Reform. In that context, it offered consumer choice and ensured a revenue stream through Medicare reimbursement and employer mandates. Without the President's Plan, Tricare does not offer the military consumer any choice outside the system and limited choice within the system It has no non-appropriated revenue source beyond third party payer collections, a program which, ironically, Tricare places in jeopardy.

Tricare will exclude all military beneficiaries who are not eligible for Champus except those who are currently on active duty. **The men and women who made a career of serving in uniform from World War II through Vietnam are excluded from the new military health care benefit.** DoD has tried to foist its responsibility for providing a health care benefit to this group on Medicare. These men and women who served the country so well are federal retirees, they have earned a military health benefit.

Tricare Prime, which is supposed to resemble an HMO will be available only at selected sites. It is comprised of two parts, the military part and the civilian network part. Health care received in the military part of Prime will generally cost beneficiaries nothing, while health care received in the civilian network will cost beneficiaries either $6.00 (families of E-4 and below) or $12.00 per visit. Assignment of enrollees to the military part of Prime will be capped because resources are limited.

Each local military hospital commander will decide which Prime enrollees will receive free health care and which enrollees will pay $12.00 a visit. Decisions will be based on status and rank. Officer families in areas where a large enrollment in Prime is possible could be receiving free health care. At the same time enlisted families stationed in areas where enrollment in Prime and assignment to the military hospital is capped will be paying $12.00 per visit.

Assignment to the military part of Prime will be at a greater rate at one of the 12 military medical centers. Assignment will be smaller in areas where the military only has community hospitals. For example, assignment to Madigan Army Medical Center at Fort Lewis, Washington, will be much larger than assignment to the community hospital at Fort Hood, Texas, even though Fort Hood is the largest Army post in the world. The inequities of Tricare as a health benefit are obvious. Resentment within the active duty community will be widespread.

The retired community will fare even worse under Tricare. They will be divided by location and age. Retired military men and women who are also eligible for Medicare will have no military health care benefit. A few will be given health care in a military hospital on a case-by-case basis. If their illness or disease is important to graduate medical education or if they are of sufficiently high rank, they might be granted access to a military hospital or clinic. Younger retirees and their families will be offered enrollment in Tricare Prime depending on where they live and the decisions of the local hospital commander. Some will have free care, others will be paying $12.00 a visit, all will pay annual enrollment fees. Still others will be reliant on Tricare Standard, which is the replacement for Champus. There is no consistency in Tricare. It does not define the military health benefit.

Several military beneficiaries have offered to relate their experiences with the military medical system. The statements of Mary Ellen (Nell) Mulhern, Laura Colbert, DeAnn Shaw, Pamela Gildersleeve, and Tami Littleton are presented to the Subcommittee separately. Nell Mulhern lost her husband Richard in the horrible Blackhawk disaster over Iraq a little over a year ago. Since that time, she has tried to use the military system, but was forced to resort to Champus when treatment for her son was not available. Survivors of service members killed on active duty have only one year of active duty benefits from the date of death Nell's family is now in the retired category. Since her husband's death, she has bought two Champus supplemental insurance policies, and must purchase a dental policy for her children. Nell is an incredibly brave woman and her story is truly poignant. Laura Colbert's husband Specialist Jeffrey C. Colbert was also killed in the Blackhawk disaster. Her five year old daughter, Beth has leukemia and is undergoing treatment at Johns Hopkins through Champus. Beth's medical bills to date are over $200,000. Laura must pay up to the Champus out-of-pocket

limit of $7500, and cannot afford to do so. No FEHBP plan has such a high out-of-pocket limit.

DeAnn's story relates her battle with Hodgkin's disease while trying to work her way through the direct care system and Champus. Every time her Marine Corps pilot husband is transferred, she has to start over again. Pam's story is a nightmare. While trying to care for her dying husband, she was forced to deal with an insensitive and unyielding bureaucracy. Tami's story is one of pain and humiliation. Donna Bisson's letter (attachment # 3) to Representative Bateman also reflects the sheer frustration, anger, and fear of these active duty military families. Something is desperately wrong with their health benefit when active duty families must ask for help from their Representatives

Lisa is the wife of an E-5 stationed at a large Army installation. Lisa's statement is attachment # 4. I would like to read it to the subcommittee.

Susan Jones was kicked out of a military hospital five weeks before she was due to deliver her first child. Susan will read her statement herself.

These are real stories by real people. The problems are real. We are talking about health care, not commissaries, PXs, bowling alleys or golf courses. Obviously, not all military beneficiaries, have trouble with the health care system, but these people and these stories are not unique.

What do military families see in the future? What are we afraid of? We read reports that the military medical system was not ready for Desert Storm. We hear reports that they are not ready now, they need more training and equipment. We even hear they may not be ready for war because their time, money and efforts are directed toward providing us with health care. I can assure you, Mr. Chairman, unequivocally the 1st priority that ALL military families have for military medicine is that it must be ready to go with our service members the minute they are sent in harm's way. If the reduction in the peacetime mission is the way to accomplish 100% readiness, then it must be done.

NMFA sees further closings of military hospitals; we see further reductions of doctors and nurses because of budget cuts. Tricare is causing great fear and confusion. We must be reassured of a secure health benefit. All military beneficiaries, regardless of age must have a military health benefit.

NMFA envisions the following scenario: Tricare Prime, if modified, can function as a military health plan supporting military hospitals at locations selected by DoD. All military beneficiaries who live in those locations should be able to enroll in these plans if they wish to do so.

All non-active duty beneficiaries, including active duty families should have the opportunity to participate in any non-restricted FEHBP plan. Active duty families must be given a health care allowance, similar to their housing allowances, in addition to the regular government contribution. The combination of health care allowance and regular government contribution for active duty families should be at least 96%, but we would suggest closer to 100%. Active duty service members put their lives on the line every day they are in uniform. They must have secure health care coverage for their families. An allowance for surviving families like the Mulherns and the Colberts must be considered as well.

NMFA envisions that retirees and their families will be offered the opportunity to participate in FEHBP on the same terms as federal civilian retirees. This includes those who are eligible for Champus as well as those who are eligible for Medicare. NMFA envisions a future military health benefit which gives military beneficiaries the choice of a military health plan where it is available or a plan from the FEHBP. Either choice could be made during Open Season.

Opponents of the NMFA Proposal claim the FEHBP would cost us more than we are paying now. No one knows how much we are paying now. Some of us are still receiving most of our health care free through a military hospital or clinic, but most of us are paying for Champus supplements, other health insurance through employers, Medicare premiums and Medicare supplements. All of us are paying for dental plans, if we can find one. The average premium for a Champus supplemental policy for a retiree, age 55, with a spouse and two children is $107 a month. The premiums go up with age. With an annual out-of-pocket limit of $7,500, and the beneficiaries' responsibility for balance billing, the costs of the

Champus benefit for military retirees is incalculable. At any rate, Mr. Chairman, it's our money, and it should be our choice as to how we spend it for health care. Many military beneficiaries will save money with an FEHBP Plan. At least we would have the security of a proven, competitive health benefits program, the choice of a health plan would be ours and not the government's and we would not lose our health benefits when we reach age 65.

Therefore, Mr. Chairman we respectfully request this subcommittee seriously consider giving military beneficiaries the opportunity to participate in the Federal Employees Health Benefits Program. We further request that you consider an adjusted premium for active duty families. Since the active duty member would not be eligible for FEHBP, perhaps active duty families could be offered a single enrollment instead of a family enrollment. This would apply also to dual military couples who have children. Perhaps the children could be given a single enrollment.

In conclusion, Mr. Chairman, the military health benefit must be restructured. Military bases and hospitals have closed. More will close in the next few years. The medical system can no longer provide health care to all of us. It will not completely disappear, but it will be streamlined. Mr. Chairman, no more promises, no more demonstration projects, no more space-available health care, no more health plans which exclude retirees over the age of 64. Career military men and women are the military part of the federal government. When they retire, they are retired from federal service. FEHBP is the logical program for military beneficiaries.

NMFA
National Military Family Association
6000 Stevenson Avenue, Suite 304
Alexandria, Virginia 22304
(703) 823-NMFA
FAX (703) 751-4857

NON-AVAILABILITY STATEMENTS (NAS) REQUIRED FOR CHAMPUS PAYMENT

CHAMPUS eligible beneficiaries who live in the catchment area of a Military Treatment Facility must obtain Non-Availability Statements (NAS) for all non-emergency inpatient care. A catchment area is generally defined by zip codes within a 40 mile radius of a Military Treatment Facility. All beneficiaries should check with local Health Benefits Advisors to determine if they reside within a catchment area.

Non-Availability Statements are **not** required for outpatient care with the **exception** of the following procedures. **These procedures require Non-Availability Statements.** ***If NAS are not obtained when required, CHAMPUS will not pay for the hospitalization or the outpatient procedures.***

Certain hernia repairs

Breast mass or tumor removal

Nose repair (rhinoplasty - changing the shape of the nose)

Removal of tonsils or adenoids

Cataract removal

Strabismus repair (surgery to lengthen or shorten muscles that help the eyes function together)

Dilation and curettage (widening of the cervical canal and scraping of the uterine cavity)

Upper or lower GI endoscopy (visual examination of the interior of the upper or lower gastrointestinal tract)

Myringotomy or tympanostomy (incision of the tympanic membrane in the ear to relieve pressure and drain the middle ear - includes placement of tubes in the ear to aid drainage)

Ligation or transection of the fallopian tubes (cutting the fallopian tubes to prevent fertilization)

Arthroscopy (use of an instrument to visually examine the interior of a joint)

Gynecological laparoscopy (use of an instrument called a laparoscope to examine female reproductive organs in the abdomen)

Cystoscopy (use of an instrument to examine the interior of the bladder)

Neuroplasty (decompression or freeing of nerves from scar tissue)

Maternity Care (pregnancy, delivery, six weeks postpartum care)

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Attachment 1

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
NATIONAL NAVAL MEDICAL CENTER
8901 Wisconsin Avenue
Bethesda, Maryland 20889-5000

30 May 95

In reply refer to:
0304

Dear Patient

The current staffing in the Gynecology Clinic does not allow us to provide care to you at the present time. Our goal at this time is to provide assistance in meeting your health care needs outside of the National Naval Medical Center (NNMC). I appreciate that this option may be an undesirable one for you, but I assure you that it is only reluctantly used when no other alternatives are available.

In order to lessen the hardship that his decision may impose upon you, I would like to offer as much help as possible in obtaining needed care. Enclosed are: (1) a listing of Military Treatment Facilities in the local commuting area if you wish to seek treatment in another military establishment, (2) a listing of phone numbers for the Health Benefits Advisors in this area, (3) a copy of your consult, (4) a CHAMPUS handbook, and (5) a CHAMPUS claim form. Our Health Benefits Advisors and Health Care Coordinators are able to assist you with any questions you may have concerning CHAMPUS/Medicare. They can explain your rights and responsibilities when you seek care in the civilian sector and can provide assistance in locating appropriate care. They can be reached by telephone at (303) 295-6612/6613.

This letter is not a Nonavailability Statement nor approval for one. If one is needed, bring a letter on your civilian doctor's letterhead addressing the procedure/care you require to the CHAMPUS office at NNMC or one of the Branch Medical Clinics for processing. Please refer to the bottom of page 62 in the CHAMPUS handbook for more information.

Although we cannot presently offer the requested care in this clinic, we may be able to help in the future. It also does not apply to other clinics and services at NNMC or affect your eligibility for care here. I would ask that you continue to utilize our services to the greatest extent possible. I sincerely regret that we are unable to meet your needs at this time but please be assured that we will continue to look for every possible way to improve access to care for all of our eligible beneficiaries.

2954394

J. D. NASH
Captain, Medical Corps, U.S. Navy
Head, Obstetrics & Gynecology
By direction of the Commander

Attachment 2

Donna D. Bisson
5505 Warren Street
Chincoteague, VA 23336
May 19, 1995

The Honorable Herbert Bateman
U.S. House of Representatives
Washington, D.C. 20515

Dear Congressman,

I am writing concerning the unusual delay in processing my son's, Joseph Keith Bisson, Champus Claim. (Champus Control Number:432221614) We live here on the Eastern Shore and since there in not a military treatment facility available we must use Champus.

In November I submitted a claim for my son's speech therapy for the month of October. I contacted Champus to see what materials were to be included to process this claim. I sent Champus a letter from the family physician, evaluation from the speech therapist, Dr. Robert Scherr, the itemized bill, and the completed claim form.

The end of November I received a denial from Champus stating the provider was not Champus approved. On December 5th I call Champus and was informed that they would send Dr. Scherr and application in order to become an approved provider again. On January 8th, I spoke with Dr. Scherr and he had not received the packet. I called Champus again and requested another application be sent to him directly. Also on January 18th, I sent a letter of appeal to Champus. (The letter is enclosed.) On January 31, 1995, Champus received Dr. Scherr's completed application.

I was told in February by a Champus representative that if would take 2 1/2 months from the time the packet was received to be approved due to the overload in the processing department.

I called again several times in April to check the status of the approval and still Dr. Scherr had not been updated. The first week of May, I requested to speak to a supervisor at Champus. I was told I would receive a call back which I never have. I was also informed that I could not speak to the processing department because they only speak with the providers.

On May 11th I made yet another call and Champus still stated it has not been updated and perhaps there was a problem and they had contacted the provider. On May 15th, I spoke with Dr. Scherr and he had not been contacted by Champus. On May 17th, I contacted the National Military Family Association for assistance on this matter and they referred me to your office.

Attachment 3

I have over $500.00 worth of claims to submit that I have already paid out of my pocket and will not be reimbursed until Champus approves this provider. This is also causing a problem with the local physician receiving their benefits.

Congressman, I truly believe that 3 months is long enough to process this provider. My patience has finally been exhausted. I would appreciate any help in expediting this matter.

Enclosed is copies of the claim and letters I have sent. Thank you for help in this matter.

Donna D. Bisson

I am writing to share with you my experiences trying to get the health care I thought we were entitled to when my husband reenlisted for his tenth year in the Army. My husband is an E5 and stationed at a major Army installation.

Three years ago when I became pregnant I was found to have a Stage 3 CIN abnormal pap smear. After my child was born I had laser treatment to remove the malignancy. I received my treatment at the Army hospital where I was told of the seriousness of my situation and the importance of getting regular check-ups including a colposcopy test every four months.

When it came time for me to get my check up and test I was told that I could no longer use the hospital because I was now assigned to a certain clinic because of my husband's unit. But the two doctors who could perform the test were now only seeing active duty women and I was told there were no appointments available. I contacted the hospital again asking for an appointment since they were the ones who treated me originally and prescribed the follow-ups. I was denied an appointment and told to use Champus. I looked into using Champus but I knew I could not meet these unexpected costs.

I believed I was entitled to get my test done through one of the military facilities and I continued to try to get an appointment. At one point I got someone to read my colposcopy record and was urged to go get a test at any cost because I was such a high risk case. This really frightened me so I tried to get a Champus supplement. I was told that because of my precondition I would have to wait one year for coverage. However, the nice people I called helped me out and I think I will be covered.

I had my test done and now I face premiums for Champus supplemental insurance and I must meet the Champus deductible for this fiscal year and then in just one month, start over and meet the deductible for next fiscal year. This is an extreme expense for my family on an E5 salary. When my husband re-upped four years ago we were not told that we would suddenly face medical bills. When I was first treated for the malignancy my case was treated with concern and urgency and then just months later I am kicked out the door or told to wait regardless of the health implications they warned me about. During my ordeal I watched a contractor on the post plant a magnificent and probably costly display of flowers. Everytime I saw them I thought that while the post was being beautified my health care benefit was being treated like dirt.

My husband will not reenlist. He will have to choose between the Army and me. I have always been willing to sacrifice for the Army, putting up with long separations, low pay, and worries while he was in the Gulf War, but I will not sacrifice my family's health.

Attachment 4

Mr. MICA. Our next witness, Susan Jones, is from Hanover, MD. I read your testimony last night. Welcome. Your testimony will be heard at this time.

Ms. JONES. Thank you. Good morning. My name is Susan Jones, and I am the wife of an active duty Air Force member who has served for 18 years in the military. We have been married almost 17 years and are expecting our first child any day now.

Mr. MICA. Can you pull the mike closer?

Ms. JONES. Sure.

We are stationed at Ft. Meade, MD. Unfortunately, they don't have an obstetrics clinic in the hospital, and pregnant women are given the choice of being treated and delivered at either Andrews Air Force Base, MD, Bethesda Naval Medical Center, Bethesda, MD, or Walter Reed Army Community Hospital, Washington, DC.

Since all three are approximately the same distance from our home, which is 45 minutes, and we are an Air Force family, we chose to be treated and delivered at Andrews.

For 8 months, I was seen at Andrews. Five weeks before I was due to deliver, the officer in charge of the OB clinic told me they would no longer treat me or deliver my baby at their hospital. I was told the reason for this was because Walter Reed was closing their OB clinic, or had closed it, and had to refer their OB patients to either Andrews or Bethesda. Therefore, the number of deliveries at Andrews for the month of September is beyond what they feel they could handle. Their limit is 100 deliveries and the extra patients they have taken en masse brought them up to 114 deliveries. They don't feel they can give quality medical care to each patient due to the overcrowding. To bring their quota down, dependent OB patients are being bumped out since active duty OB patients have priority.

I was told to stop and see the CHAMPUS advisor, but I had to go out to the civilian community and find my own doctor and hospital for the remainder of my maternity care.

My challenge was to find an obstetrician who was not only an approved CHAMPUS provider but who also accepted the CHAMPUS allowable charge. While I was able to find an obstetrician, I found it difficult to find an anesthesiologist and pediatrician who met both requirements.

The problem is, I don't know who will be on call when I go to deliver, and by then it will be too late. If they don't meet the CHAMPUS requirements, then I am responsible for paying their fees.

What if something goes wrong with either me or my baby and specialists have to be called in? I will be responsible for paying their fees also.

After 3 days of phone calls trying to find someone to treat me, I finally called Bethesda Naval Medical Center to see if they would accept me as a patient, and I was told, no, they weren't accepting any new patients through November. I then called Bolling Air Force Base, Washington, DC; they told me they would accept me for OB visits, but they didn't deliver there, that deliveries were done at Andrews Air Force Base, which left me back at square one.

Another Air Force spouse suggested I try DeWitt Army Community Hospital in Fort Belvoir, VA. Thankfully, they took me on as

a patient and will deliver me. Unfortunately, the hospital is more than an hour away from my home. I have since learned they are no longer accepting any new patients at the present time.

As the budget is cut, so are the services that the military clinics and hospitals provide to military members. This means, increasingly, that military families must travel to another military facility or go into the civilian community and find a CHAMPUS provider who meets the CHAMPUS requirements. As military families, we are constantly uprooted, moving from one place to another every few years. We must deal with constant separations due to deployments, TDY's, remote tours, and double shifts for which we are not compensated; and in exchange for these sacrifices, we were promised, among other things, care at military health facilities for little or no cost to us. Now it is being slowly taken away from us and we are increasingly asked to pay out of our own pockets for civilian health care or we must buy private health insurance.

My husband and I are reluctantly looking at private health insurance. I say "reluctantly" because private health insurance is expensive. Also, it seems ridiculous to pay for health insurance when we can be treated at a military health facility for little or no cost to us. However, we are willing to pay these high costs for insurance even though it will be a financial burden to us, because we don't want to go through this ordeal again. And it will happen again and again, not only to us, but to other military families.

As you can see, it is becoming frustrating and stressful to get care at a military health facility. There are many more examples of military families dealing with these kinds of problems, active duty and retirees both. All you have to do is ask and you will hear all kinds of stories, from referrals to other facilities far away to waiting lists of 2 or more months and then only on a space-available basis. There is a chance that once you get your appointment, you will be bumped or pushed back.

We need to take action and you need to take action. Military health care is declining. The solution to this problem is to provide Federal health care insurance to military families, active duty and retirees both, and to provide us with a health care allowance.

The sort of thing that happened to me must be addressed so you can understand the impact of downsizing on the quality of medical care. We have given our lives to our country and for our country and promises have been broken. Our medical care is deteriorating and something must be done. Please hear my plea and the pleas of others. We need your help.

Thank you.

Mr. MICA. Thank you for your testimony.

[The prepared statement of Ms. Jones follows:]

PREPARED STATEMENT OF SUSAN JONES, HANOVER, MD

Good Morning,

My name is Susan Jones. I am the wife of an active duty Air Force member who has served 18 years in the military. We have been married almost 17 years and are expecting our first child any day now.

We are stationed at Ft. Meade, Maryland. Unfortunately, they don't have an Obstetrics clinic in the hospital and pregnant women are given the choice of being treated and delivered at either Andrews AFB, Maryland, Bethesda Naval Medical Center, Bethesda, Maryland, or Walter Reed Army Community Hospital, Washington, DC. Since all three are approximately the same distance from our house, 45 minutes, and we are an Air Force family, we chose to be treated and delivered at Andrews.

For eight months I was seen at Andrews. Five weeks before I was due to deliver, the Officer in Charge of the OB clinic told me they would no longer treat me or deliver my baby at their hospital. I was told the reason for this was because Walter Reed closed their OB clinic and had to refer their OB patients to Andrews and Bethesda. Therefore, the number of deliveries at Andrews for the month of September is beyond what they feel they could handle. Their limit is 100 deliveries and the extra patients they have taken on has brought them up to 114 deliveries. They don't feel they can give quality medical care to each patient due to the overcrowding. To bring their quota down, dependent OB patients are being bumped out since active duty OB patients have priority.

I was told to stop and see the CHAMPUS advisor, that I had to go out in the civilian community and find my own doctor and hospital for the remainder of my maternity care. My challenge was to find an obstetrician who was not only an approved CHAMPUS provider but who also accepted the CHAMPUS allowable charge. While I was able to find an obstetrician, I found it difficult to find an anesthesiologist and pediatrician who met both requirements. The problem is that I don't know who will be on call when I go to deliver and by then it will be too late. If they don't meet the CHAMPUS requirements, then I am responsible for paying their fees. What if something goes wrong with either me or my baby and specialists have to be called in? I will be responsible for paying their fees also.

After three days of phone calls trying to find someone to treat me I finally called Bethesda Naval Medical Center to see if they would accept me as a patient and was told no, they weren't accepting any new patients through November. I then called Bolling AFB, Washington, DC. They told me they would accept me for OB visits but they didn't deliver there, that deliveries were done at Andrews which left me back at square one. Another Air Force spouse suggested I try Dewitt Army Community Hospital in Fort Belvoir, Virginia. Thankfully, they took me on as a patient and will deliver me. Unfortunately, the hospital is more than an hour away from my home. I have since learned they are no longer accepting any new patients at the present time.

As the budget is cut, so are the services that the military clinics and hospitals provide to military members. This means that increasingly, military families must either travel to another military facility or go into the civilian community and find a CHAMPUS provider who meets the CHAMPUS requirements.

As military families, we are constantly uprooted, moving from one place to another every few years. We must deal with constant separations due to deployments, TDYs, remote tours, and double shifts for which we are not compensated. In exchange for these sacrifices we were promised, among other things, care at military health facilities for little or no cost to us. Now it is being slowly taken away from us and we are increasingly asked to pay out of our own pockets for civilian health care or we must buy private health insurance.

My husband and I are reluctantly looking at private health insurance. I say reluctantly because private health insurance is expensive. Also, it seems ridiculous to pay for health insurance when we can be treated at a military health facility for little or no cost to us. However, we are willing to pay these high costs for insurance, even though it will be a financial burden to us, because we don't want to go through this ordeal again. And it will happen again and again not only to us but to other military families.

As you can see, it is becoming frustrating and stressful to get care at a military health facility. There are many more examples of military families dealing with these same kinds of problems - active duty and retirees both. All you have to do is ask and you will hear all kinds of stories - from referrals to other facilities far away to waiting lists of two or more months and then only on a space available basis. There is a chance that once you get your appointment, you will be bumped or pushed back.

We need to take action. You need to take action. Military health care is declining. The solution to this problem is to provide federal health care insurance to military families, active duty and retirees both, and to provide us with a health care allowance.

The sort of thing that happened to me must be addressed so you can understand the impact of downsizing on the quality of medical care. We've given our lives to our country and for our country. Promises have been broken. Our medical care is deteriorating and something must be done. Please hear my plea and the pleas of others. We need your help.

Thank you.

BY SUSAN JONES

Andrews to expectant mom: Get out

I am the wife of an active-duty Air Force member who has served for 18 years.

We are assigned to Fort Meade near Baltimore.

After 17 years of marriage, we are expecting our first child in mid-September. For us, this is an exciting time, especially after all these years of marriage, but it has been made especially tense and difficult by our hospital situation.

Here is my story.

Because we are assigned to Fort Meade, I obviously wanted to see a doctor there and have my baby delivered at Meade.

But Fort Meade, because of the force reduction, refers all obstetrics patients to either Andrews Air Force Base or Bethesda National Naval Medical Center, both near Washington, D.C. I did not have a problem when I was asked to go to Bethesda or to the Malcolm Grow Medical Center at Andrews. My first choice was Andrews because we are Air Force members.

> ***"To tell me five weeks before delivery that I no longer can be accommodated is reprehensible and irresponsibile."***

During my entire pregnancy, I was seen by the doctors at Malcolm Grow, and everything seemed to be going well. I was satisfied with the care I was receiving and was looking forward to having my baby at Andrews.

But at my appointment Aug. 7, I was told by health-care officials that the doctors at Andrews no longer could see me and that I couldn't have my baby delivered there. I was told I had to go out into the community and make my own arrangements for medical care through CHAMPUS. I was shocked and a little scared.

Why was I bumped from Malcolm Grow?

The officer in charge of the obstetrics clinic there said that September was a busy month and that the staff could deliver only 100 babies.

She added that the influx of patients because of the May 26 closure of the obstetrics unit at Walter Reed Medical Center in Washington, brought them to 114 deliveries. She also said the doctors at Malcolm Grow were concerned that they would be unable to provide good care if they took care of too many people.

I understood this rationale but felt I didn't count, and my baby didn't count.

The obstetrics official said active-duty patients have priority, and civilian spouses such as myself could be bumped. It did not matter to her that I have made every change-of-station move with my husband and in many ways I have served the Air Force, too.

Having a baby: Susan Jones and her husband, Master Sgt. Bruce Jones, are excited about having their baby. But they also are angry that officials at Malcolm Grow Medical Center at Andrews Air Force Base near Washington, D.C., told them to get medical care elsewhere.

At that point, I was given a list of health-care providers in the Washington and Baltimore areas and the telephone number for the CHAMPUS representative in the region and sent on my way. I received no other help or advice from either officials or the doctors I had been seeing. In fact, I called and I left two messages with the hospital commander's office at Malcolm Grow to try and resolve the situation, but my calls were not returned.

For the next three days, I was tied to the telephone, attempting to find a health-care provider to deliver my child, a provider that could meet CHAMPUS requirements.

After several sleepless nights and enormous frustration, I was put into contact with officers at the Army's DeWitt Hospital at Fort Belvoir in Alexandria, Va. They told me they would deliver my baby. I contacted Belvoir after another pregnant Air Force spouse recommend that I do so.

Before Belvoir accepted me, however, I made numerous phone calls trying to explain why I was switching doctors and hospitals so late in my pregnancy. I repeatedly was told that it is not wise to make a switch at the last minute.

If you have not been through this, it may not seem like such a big deal, but it is. Over the months, you develop a working relationship with a physician and hospital, and it is a blow when that relationship is suddenly shattered.

I am aware that Air Force Instruction 41-115 gives the hospital at Andrews the right to bump me and that care is offered only on a space-available basis.

But I think it is pretty lousy that after all the sacrifices that we have made, including constantly uprooting our lives, enduring repeated separations, deployments and double shifts, this sort of thing happened to us.

To tell me five weeks before delivery that I no longer can be accommodated is reprehensible and irresponsible.

Despite all the talk by military leaders, including Defense Secretary William Perry, about quality-of-life issues, it seems that little people like ourselves occasionally get lost in the cracks.

For my part, all I wanted was to receive good care from the same hospital that I had gone to for months and have my baby delivered in familiar surroundings. I am not angry about being turned away because of the overcrowding (I understand this can happen), but rather because I was turned away without being given sufficient information. In fact, I was told virtually nothing other than to go find help.

Why didn't the people at Andrews help me? Obviously, Fort Belvoir was able to treat me and deliver my baby. Why didn't the personnel people at Andrews know there was space for me at Belvoir? Why weren't my phone calls returned?

Had I been informed of this situation three months earlier, my husband and I could have planned for alternative measures with a great deal less stress.

After I was turned away by Andrews, I contacted the Air Force inspector general's office at Fort Meade to voice my complaint. He was considerate and promptly contacted the hospital administration at Andrews to verify my situation.

At Meade, representatives of the inspector general asked what it would take to resolve my complaint. I asked whether I could give birth at the Bethesda center because it is closer to Fort Meade than is Belvoir.

I later was informed that there simply was no space at Bethesda, but I still appreciate the concern I was shown by the Fort Meade inspector general.

I should add that the inspector general's office at Andrews decided to investigate my case after being contacted by Meade.

At this point, my husband and I have begun to review our health-insurance plans so that this sort of thing won't recur in the future.

The sort of thing that happened to me must be addressed by Congress and by our Air Force leadership so they can clearly understand the impact of downsizing on the quality of medical care and what it does to our morale.

Susan Jones of Hanover, Md., is a reality specialist for the Army Corps of Engineers in Baltimore. She is the wife of Master Sgt. Bruce Jones, a commissary management specialist with the Defense Commissary Agency at Fort Meade near Baltimore. On Aug. 24, a spokesman at Andrews Air Force Base said the base inspector general is investigating the Jones case but declined comment until the completion of the investigation. The spokesman said there were "inconsistencies" in Jones' account but declined to elaborate.

AIR FORCE TIMES 9/4/95

Mr. MICA. Now we will turn to Pamela Gildersleeve from Palm Harbor, FL. Welcome.

Mrs. GILDERSLEEVE. Thank you. Mr. Chairman and members of the subcommittee. I am the widow of a retired Marine.

Ten days ago when I heard about this subcommittee meeting, I sent a letter to be included with a statement and asked if I could come forward and testify. I had been unable to condense my original letter to you into a 5-minute statement until I came across the letter from my husband that he wrote in 1993 to General Mundy, then Commandant of the Marine Corps. I don't intend to single out the Marine Corps, but Ross's letter to them was concise and General Mundy's response was typical of the response we received wherever we went for help.

Ross wrote:

Dear General Mundy, I would like to take the time to tell you a little bit about myself and ask for your help in extending more support to Marines such as myself.

I retired from the Marine Corps in September 1989, as a major having served 20 years. My last duty station was as CO of the Marine Detachment at Lakehurst, NJ. Like all my fellow Marines, I felt my health care had been good and that my benefits were everlasting. How wrong I was. I took a job flying for Pan Am, but in January 1991 it became apparent that they would not survive. In order to job hunt, I took a physical only to find I had advanced stage prostate cancer which spread to my bones. With no treatments available, I enrolled in a test program at NIH in Bethesda. How shocked I was to have my medical record audited there and find that the Navy had found the lump in my prostate in 1983. I was never told. The lab tests were never done. And my flight physical every year since had not addressed that problem. My retirement physical is blank. The last two-and-a-half years have been hell.

I immediately became eligible for Social Security Disability though that does not provide any income for five months, and Medicare coverage does not start for two years. This was all the easy part. I soon learned that there was no central department to dispense health and information. My wife has worked full time, gone to school full time and fought for every benefit we have received over the last two years, while I have fought for my life. No family should have to go through what we have to survive. CHAMPUS has been a problem—excuse me—CHAMPUS has been a problem, trying to change my status to disabled through the VA was a horror, requiring the help of the DAV. Now my health record is lost. I have a copy. Trying to have my retirement status changed to disabled took almost two years and an act of Congress. We had to buy a fax to compete with the paperwork. You can't imagine how many times headquarters can lose the same set of papers.

My disease has progressed and my ability to cope has diminished. I now only have months to live and my problems have multiplied. I became eligible for Medicare in August; that means I lost my CHAMPUS as primary insurance, my CHAMPUS supplement became a Medicare supplement. My drug bills are $3,000 a month for chemo alone. If I am lucky, TROA will let me switch my supplement back to a CHAMPUS supplement so that I won't have to pay 25 percent of that bill each month.

I go to two VA centers and McDill Air Force base each month to get the rest of my meds. Even though Andrews Air Force Base has my chemo, McDill won't get it for me. I have spent two months trying to become an outpatient at Haley VA Center in Tampa. Now that I have a foot in the door, I have found out that if I use Haley as an outpatient center to get my drugs, I will lose Medicare for inpatient coverage.

My VA oncologist works 7 a.m. to 12 noon Mondays only. The last time I had a question, I spent 3 days trying to get an answer on the phone. I never got that answer so went to my local doctor and was admitted to the local hospital. That bill will not be paid by Medicare if I continue to go to the VA. So I have given that up. When I tried to get my drugs from the VA Center at Bay Pines, I was told they would rather spend $3,000 on 3,000 aspirin for 3,000 men instead of $3,000 for chemo for one man.

I gave my life to the Marine Corps and service to my country. Because of Navy medicine, I will lose my life.

I implore you to hear my story and listen to the many other Marines who have the same type of story. We need help and can't be forgotten. Better care that is easi-

er to obtain is a must. CHAMPUS for those under 65 that are on Medicare needs to be more than a supplement. Information on entitlements for those who are disabled needs to be readily available for someone who knows the rules.

We aren't second-class citizens due to our disabilities. I shouldn't be made to feel that I have to crawl to get benefits. I shouldn't have to ask my Congressman for help each time there is a problem.

And the Commandant wrote back 4 months later:

Thank you for your recent letter. I am very distressed to hear about your illness and regret that you have not received the quality of support that your service warrants.

You have my assurance that I will continue to support initiatives which ensure access to quality medical care and expand benefits when possible for our entire Marine Corps family. I will continue to work with the Surgeon General of the Navy to be sure that the special needs of our retired Marines and their families are carefully considered in all decisions concerning future health care programs or modifications to the current entitlement package.

Let me close by saying that your service to Country and Corps has not been forgotten and your legacy will live on in all whom you touched.

My husband died 6 weeks later.

Mr. MICA. Thank you, Mrs. Gildersleeve. I read your testimony last night about the difficult time your family and your late husband encountered in receiving care, and the trials and tribulations that you have been through. Hopefully, your participation today will enlighten this panel and the Congress so that others don't suffer the same fate. We admire your courage and your determination and thank you for sharing your experience with us today.

[The prepared statement of Mrs. Gildersleeve follows:]

PREPARED STATEMENT OF PAMELA M. GILDERSLEEVE, PALM HARBOR, FL

Pamela M. Gildersleeve
2709 Scobee Dr.
Palm Harbor, Fl. 34683
Tuesday September 12, 1995.

TESTIMONY RESPECTFULLY SUBMITTED AT A HEARING ON OPENING THE FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM TO BENEFICIARIES ELIGIBLE FOR MILITARY HEALTH CARE

House Committee on Government Reform and Oversight

Sub-Committee on Civil Service

Mr. Chairman, and distinguished committee members, I would first like to say thank you to all of you for taking the time to look at the important issues of military health care. In light of todays budget deficits and resulting cutback of benefits, pay and services, many of us are only too aware of how difficult a change would be. For the military member, and his family, there is a clear need for a change in health benefits. Though no one will argue the need to have trained military doctors available for the active duty service member, it is becoming apparent that they can no longer fill the needs of service families and active duty personnel. As military treatment facilities close, and the cut backs are felt, retirees will also be affected by both quality and quantity of care. It has been my experience that Champus was not set up to meet the needs of the large numbers of people it serves, nor is the VA health system equipped to handle the overflow. There seems to be nowhere to turn when we get caught in the trap. Many of us would welcome the chance to pay a premium, and thus participate in a group health insurance plan, so that we have available to us the health care we have been guaranteed.

I was asked to share with you today my families experience with Champus. I would like to be able to say that ours was an isolated incident--but on the contrary it is becoming an ever increasing problem for both the active duty and retiree families alike.

My husband Ross retired from the Marine Corps on September 1, 1989 after a total combined Navy/Marine Corps service of 21 years.

Just 18 months later, in January 1991, he was diagnosed with advanced stage/terminal prostate cancer. He was 43 years old.

He died June 10, 1994 from that cancer. He fought a long hard battle.

What my family and I went through is enough to boggle your mind, but in conjunction with my working, raising a family, taking care of Ross and his many medical bills it was an almost impossible task. I frequently felt that it was grossly unfair to have to fight for

ones benefits while attempting to care for a dying family member. Had it not been for my experience with Champus, because of a sick child, and my experience with Navy Relief as a volunteer when Ross was active duty, I would not have had the knowledge and perseverance to continue this battle through Ross' illness.

When Ross was diagnosed, he was told he had had the cancer 8-9 years. The doctor recommended that he apply for VA benefits. We did and were turned down immediately, based on my income as a nurse. I tossed the letter away, giving little thought to it's strange denial and continued on. Ross had been accepted in an experimental program at the National Institutes of Health, so for the next two years most of his medicines and care was taken care of by them.

During the first of his many visits to NIH our copy of his active duty health record was reviewed. Imagine our shock when they found that in 1983, during a flight physical, a lump was found in the left side of his prostate. This was where Ross' cancer was found. Ross was never told, the lab work that was ordered was never done and no one addressed the issue again during Ross' remaining 6 years in the Marine Corps. With this information we were able to get his VA denial for benefits changed to 100% disabled due to prostate cancer and 100% disabled due to bone cancer.

As Ross continued his 2 years at NIH, I waged a one man letter writing campaign. It included The Commandant of the Marine Corps, Congressman, and the Surgeon General of the Navy. Some of their responses are included.

As we started 1993 it became very apparent that Ross was not winning this battle. He was discharged from NIH's care and returned to our family doctor for terminal care. As our cost share responsibility for his medicines and medical care increased so did our problems with champus.

Each time Ross required admission to the hospital, the doctors office had to call McDill AFB and get permission for that admission, though the base readily admitted they had no one to care for him. Our doctor finally wrote McDill a letter stating that with his poor prognosis more admissions were likely, and what could they do to help. McDill finally gave us a one year non-availability statement in advance.

During this same time a lump was found in my breast. I was immediately referred to a surgeon who arranged to biopsy it the next day. He called McDill. We were denied civilian care though they couldn't tell us when a biopsy could be done, or even when I might be able to see a doctor. We explained our situation to them to no avail. They did suggest that I have the surgery and then apply for an appeal after my claim was denied. I did all this and then wrote to the hospital CO about my denial. I reminded him that Ross was on continuous narcotic pain medication and he was unsafe to drive the one hour 10 minutes needed to get to the base. If I had had surgery there he would have had to drive me home. To no avail again, I paid the bill.

During the Spring of 1993 Ross' medical bills began to have a significant impact on us.

He was wearing duragesic patches-a narcotic coated patch for pain control. He wore 4 patches at all times and changed them every three days. At $150 a box, and 10 boxes a month our bill was climbing. Charging this every few days now required that I use three credit cards and rotate my purchases between cards. I was referred to Bay Pines VA-they had the medicine. They denied us these patches because Ross wasn't vomiting.

Ross had had many X-rays done, and received many radiation treatments since this started. The hospital took champus. I never thought to ask, but found out at work one day, the radiologists didn't take champus. They called me to ask for the $1800 that was my share because they didn't take champus.

I was now up to 6 credit cards with which to rotate Ross' drug purchases on. His monthly drug bills were reaching $3000-$5000 a month. Champus averaged 6-8 weeks for repayment of a claim, provided there were no errors. I had to charge these drugs.

August 1993 marked the end of the second year that Ross had collected SSDI. This meant he would now be eligible for medicare, and lose champus--my anxiety heightened. If we lost champus we would have no drug coverage. I was again able to network with a knowledgeable person and find that within the past 18 months the law had changed, champus now was a second payer to medicare. But I had a champus supplement and no one could tell what would happen to it. If it was switched to a medicare supplement I would be responsible for 25% of Ross drug bills per month, a hefty amount.

We decided to see if we could get some of his more expensive drugs from military pharmacies, we were already getting a few from the VA clinic. Ross was taking an oral chemo--$125 a pill. He took two a day. Bay Pines said they would rather spend $3000 on aspirin for 3000 servicemen than spend $3000 for my dying husband. Andrews AFB and Kessler AFB had this drug. They refused to ship it to us, or to McDill. I could go to Andrews or Kessler monthly and get it. Now Ross required care constantly, how was I going to do that.

In December of 1993 our supplemental company was able to confirm that we would be given a choice in what we wanted the policy to cover. We opted to move it back to a champus supplement giving us 100% coverage for our drugs. Now that Ross was on medicare, admissions to the hospital were harder to get. Ross looked into getting care at the oncology clinic at Halley VA. He waited for an appointment to the medical clinic. Then he waited for an appointment to the oncology clinic. The oncologist worked Mondays only from 7am to 1130am. He saw her once, she ordered tests. Before they were completed Ross was sick again. After two days of trying to reach her Ross was admitted to our local hospital again. It was four more days until he was able to reach the VA oncologist. A staff member then told us that if Ross pursued his attempts to become

a VA patient he would lose his medicare status. It was evident that they would not be able to offer him much care, and we couldn't afford civilian medical care again without medicare or champus. Ross gave up his pursuit.

By January 1994 Ross had had a stroke due to the cancer. He required almost constant care. He was confused and fell frequently. I could no longer work and be there to care for him. We tried Hospice but I was unable to get the amount of care he needed. Back to medicare we went. I tried every way I could think of to have champus help me. There was no way they were going to provide Ross with home care. Back to the VA we went. Well there was a program called nursing home intervention. We could get 36 hours of home care every two weeks. That was better than nothing. I worked 40 hours every two weeks. If we arranged the medicare nursing visits to coincide with the VA home care he was just about covered. I paid nurses aides myself for care for him every other night so I could get some sleep. Ross wasn't known for staying in bed more than 20 minutes at a time, day or night.

Ross became very sick again in early June. We tried to admit him to the hospital, we had already been told that it didn't take skill to die and he could therefore do it at home. I could not care for him though. We were able to admit him to a VA hospital on Wednesday. Friday he died there, they called to tell me my father had died.

This all was only a small part of the difficulties we had while Ross was sick. The Marine Corps had more pay problems, and the VA had multiple road blocks for us. It made for a very long four years. My children don't remember their father dying, they remember how much time I spent on the phone trying to straighten out problems.

Thank you,

Pamela M. Gildersleeve

DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
WASHINGTON, D.C. 20372-5120

IN REPLY REFER TO
6320
Ser 35/1U233992
8 May 92

Major Ross C. Gildersleeve, USMC, Retired
2709 Scobee Drive
Palm Harbor, FL 34683

Dear Major Gildersleeve:

I was deeply concerned when I read your letter describing the failure of our Navy Medical Department to follow-up on a prostate abnormality discovered in 1983 during a routine annual flight physical. Your service health record has been reviewed by our specialty advisor for urology, who, in essence, agrees that you should have been referred to a urologist or other specialist at that time. *

Until very recently, a serious lack of awareness prevailed among most practitioners, in and out of the military, regarding the techniques and procedures to expedite early diagnosis of prostate cancer. This lack of knowledge was aided and abetted by the rather slow course cancer of the prostate frequently takes, as well as the low visibility the problem has received generally. Further, the natural history of prostate cancer is not well understood. For example, about 30 percent of men with prostate cancer already have metastatic spread at the time of its discovery. Nevertheless, prostate cancer is the most common cancer in males, present in approximately 30 percent of men over age 50, with a 10 percent increase each subsequent decade, a fact not known by many practitioners.

It is thus clear that our efforts must be directed towards early discovery through increased physician awareness of the problem. In the past three years, the use of prostate specific antigen blood tests and transrectal ultrasound, as extensions of the digital rectal examination, have increased the sensitivity of diagnostic measures which may render prostate cancer diagnosable while it is still organ confined. These techniques are gaining increased use through our Navy health care system. An additional step would include the development of screening clinics. The screening clinic at the National Cancer Institute is an example of efforts we are seeking to emulate.

Although our specialty advisor states that your evaluation by the Navy Medical Department was consistent with community standards of care at the time you were seen, you have indeed identified an area where we can be and are trying to become more proactive. We are taking steps to educate our physicians about prostate cancer and train them early in their careers in early detection and treatment of the disease, using the new techniques mentioned above.

I sincerely thank you for sharing your concerns and suggestions for improving our health care system with regard to this extremely important issue. Although I cannot change the course of your disease, I hope that you know that your case is accelerating our efforts to emphasize this problem to our providers and that this is serving to offer at least some small comfort to you.

I want to thank you for taking the time to visit with Captains J. N. Rizzi, MC, USN and J. A. Miller, MC, USN in February 1992 to fully discuss your concerns and also for providing the copy of your health record; we have been unable to locate your original record, so it is indeed fortunate that you had a copy. If there is any further assistance I can provide, please do not hesitate to let me know.

Sincerely,

D. F. HAGEN
Vice Admiral Medical Corps
United States Navy
Surgeon General of the Navy

December 16, 1993.
2709 Scobee Dr.
Palm Harbor, Fl.
34683

Commandant USMC
Marine Corps Headquarters
Washington, DC

Dear General Mundy,

I would like to take this time to tell you a little about myself and ask for your help in extending more support to our Disabled Marines, such as myself;

I retired from the USMC in September 1989, as a major having served 20 years. My last duty station was as CO of the Marine Detachment at Lakehurst, NJ. Like all my fellow Marines I felt my health care had been good, and that my benefits were ever lasting. How wrong I was. I took a job flying for Pan Am, but in January 1991 it became apparent that they would not survive. In order to job hunt I took a flight physical, only to find I had advanced stage prostate cancer with spread to my bones. With no treatments available I enrolled in a test program at the NIH in Bethesda. How shocked I was to have my health record audited there and find that the Navy found a lump on my prostate in 1983. I was never told, the lab tests were never done, and my flight physical every year since has not addressed that problem. My retirement physical is blank! The last 2 1/2 years have been hell.

I immediately became eligible for Social Security Disability, though that does not provide any income for 5 months, and medicare coverage does not start for 2 years. This was all the easy part. I soon learned that there is no central department to dispense help and information. My wife has worked full time, gone to school full time and fought for every benefit we have recieved over the last two years, while I have fought for my life. No family should have to go through what we have to survive. Champus has been a problem, trying to change my status to disabled through the VA was a horror, requiring the help of the DAV. Now my health record is lost! I have a copy. Trying to have my retirement status changed to disabled almost took an act of congress. We had to buy a fax to compete with the paper work. You can't imagine how many times headquarters can lose the same set of papers.

My disease has progressed and my ability to cope has diminished. I now only have months to live, and my problems have multiplied. I became eligible for medicare in August, that means I lost champus as my primary insurance, my champus supplement became a medicare supplement. My drug bills are $3000 a month for chemo. If I am lucky TROA will let me switch my supplement back to a champus supplement so that I won't have to pay 25% of that bill each month. I go to 2 VA Centers and McDill AFB each month to get the rest of my meds. Even though Andrews AFB has my chemo Mcdill won't get it for me. I have spent 2 months trying to

become an outpatient at Haley VA Center in Tampa. Now that I have a foot in the door. I have found out that if I use Haley as an outpatient to get my drugs I will lose medicare for in patient coverage. My VA oncologist works 7am-12 noon Mondays only. The last time I had a question I spent 3 days trying to get an answer on the phone. I never got that answer so went to my local doctor and was admitted to a local hospital. That bill will not be paid by medicare if I continue to go to the VA, so I have given that up. When I tried to get my drugs from the VA Center at Bay Pines I was told that they would rather spend $3000 on 3000 aspirin for 3000 men instead of $3000 for chemo for one man. I gave my life to the Marine Corps in service to my country. Because of Navy medicine I will lose my life. I can't get any one to help with my bills. I lost my retired pay to get disability pay. I can't get more insurance, I can't work. My wife needed surgery for a possible breast cancer last month. Because we live near McDill we needed their permission for civilian surgery. McDill said no, but provided no military alternative. My wife had the surgery locally so I could help her, and so it could be done expediently. The base hospital CO refused on appeal to issue a non-availability and we are now paying off that bill. I can't even sue to get help.

I implore you to hear my story and then listen to the many other Marines who have the same type of story. We need help and can't be forgotten. Better care that is easier to obtain is a must. Champus for those under 65 that are on medicare needs to be more than a supplement. Information on entitlements for those who are disabled needs to be readily available from someone who knows the rules. We aren't second class citizens due to our disabilities. I shouldn't be made to feel like I have to crawl to get benefits. I shouldn't have to ask my Congressman to help me each time there is a problem.

Sincerely,

Ross C. Gildersleeve
Major USMC(ret)

24 March 1994

Dear Major Gildersleeve,

Thank you for your recent letter. I am very distressed to hear about your illness and regret that you have not received the quality of support that your service warrants.

You have my assurance that I will continue to support initiatives which ensure access to quality medical care and expand benefits when possible for our entire Marine Corps family. I will continue to work with the Surgeon General of the Navy to be sure that the special needs of our retired Marines and their families are carefully considered in all decisions concerning future health care programs or modifications to the current entitlement package.

Let me close by saying that your service to Country and Corps has not been forgotten and your legacy will live on in all whom you touched. Semper Fidelis.

Sincerely,

C. E. MUNDY, JR.
General, U.S. Marine Corps
Commandant of the Marine Corps

Major Ross C. Gildersleeve, USMC (Ret.)
2709 Scobee Drive
Palm Harbor, FL 34683

Mr. MICA. And another victim of the process is Susan Jones, whose testimony I read last night. I appreciate what you have been through. A lot of folks assume that because you are elected to Congress you know about all of these situations, but that is not a certain fact. We are just temporary elected representatives of the people who try to sort through the bureaucracy and the legislative process and make it functional and responsive. I thank both of you for helping us learn, by your participation, more about the problems and shortcomings. Hopefully, we can improve them.

Mrs. Kidd, Sylvia Kidd, as president of your association, you testified that you felt that welfare recipients in many instances were getting better care and access than some of our military dependents and retirees. Did I hear that correctly?

Ms. KIDD. Yes.

Mr. MICA. Specifically, I have asked that we look at making our military families, dependents, and retirees eligible for the Federal Employee Health Benefit Program. Do you think that that could be a workable solution, if offered?

I understand your association is somewhat supportive of that proposal. Could you elaborate?

Ms. KIDD. We are presently—many of us are presently paying for our health care now because we're having to buy the CHAMPUS supplements and the other insurances through employers or whatever to insure our health care. I think this would be very viable. Even in the military treatment facilities, or under TRICARE, there is a possibility that the enrollee is going to have to pay per visit; if he cannot be seen in the treatment facility, the commander has that option. If we're going to be paying, we deserve the opportunity to pick the system that we're going to be paying for.

Mr. MICA. So you are saying you are paying already in order to get that coverage?

Ms. KIDD. Many of us are.

Mr. MICA. You should not be denied access to the same program or benefits or choices that, say, Federal civilian employees and their families have; is that correct?

Ms. KIDD. Yes, it is.

Mr. MICA. One of the problems is that currently the Federal Government pays a portion of the cost of health care for civilian employees and the employees pays a share. Are you familiar with some of those payments? Do you think that would be in line and acceptable, and also do you think we should just offer that as an option and then let the average family make that choice?

Ms. KIDD. We believe that for active duty families that there should be an additional health care allowance, much like what we have for quarters allowance. If the families are seen in a military treatment facility, they don't receive that money. However, if they are required to go outside and use another system, then they should have access to that money so that they can spend their money as they see fit.

I'm sorry, I've forgotten the last half of your question.

Mr. MICA. Whether or not there should be a choice allowed?

Ms. KIDD. Definitely.

Mr. MICA. At this stage, there is no legislation before us; no specific proposal. What we are trying to do is test the waters and see what may be acceptable for some possible changes.

Ms. KIDD. TRICARE can work in situations where the families are living around the military treatment facility, and should be an option. However, we know that some hospitals are going to close, more than already have, and that's going to create more of a problem than we have now. So TRICARE obviously isn't the answer that it was touted to be when the changes first came about.

Mr. MICA. Well, you answered my next question, which was about effectiveness of TRICARE. My final question deals specifically with base closure which you have also mentioned. As we see this downsizing and base closing, there is less access to the military installations, and you are in fact seeing that as a serious and growing problem across the country?

Ms. KIDD. Yes.

Mr. MICA. I guess the Nation's Capital is a little bit isolated. We have certain military installations, but I think Ms. Jones testified that even with the broad array of military installations here—you have incurred tremendous difficulty. In fact, I think your testimony said you spent several days on the phone just trying to find someone who might accept you as a patient.

Ms. JONES. Yes.

Mr. MICA. Was that because you were far advanced in your pregnancy or was that because of lack of availability of services, or both?

Ms. JONES. I spent 3 days on the phone trying to find a civilian doctor, which is why I spent 3 days on the phone, because that was the only choice I was given. I received quite a bit of resistance at that late stage of my pregnancy, 5 weeks before I was due, that anybody wanted to see me. That was part of the problem.

The other part was again finding a provider who met the CHAMPUS requirements. That's when I started calling other bases in the Capital Region area, trying to find somebody who would take me.

Mr. MICA. Mrs. Kidd, I think you mentioned in your testimony that reimbursement for Medicaid or Medicare is sometimes greater than the CHAMPUS, so there is actually a door slammed in your face when you attempt to access CHAMPUS reimbursement; is that correct?

Ms. KIDD. Yes.

Mr. MICA. Well, those are my opening comments.

I see we have been joined by Connie Morella. I don't know if you had an opening statement or a quick comment that you wanted to make, but welcome to the panel, Mrs. Morella.

Mrs. MORELLA. I have an opening statement which I would like to ask permission to have inserted in the record.

Mr. MICA. Without objection.

[The prepared statement of Hon. Constance A. Morella follows:]

PREPARED STATEMENT OF HON. CONSTANCE A. MORELLA, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MARYLAND

I would like to commend Chairman Mica for calling this hearing to examine the ramifications of opening up the Federal Employees Health Benefits Program (FEHBP) to dependents of active-duty personnel, military retirees, and their fami-

lies. This is an interesting concept, and it warrants the attention of this Subcommittee.

I, however, would like to say from the outset that I have not formulated an opinion on this subject; however, I have formulated a number of concerns, many of which should be addressed today.

Another issue that will definitely be raised today is the future role of the military medical system. Its future role and structure are critical to any consideration of a FEHBP option for dependents of active-duty personnel and other eligibles. I know the Department of Defense (DoD) and the Congressional Budget Office (CBO) have divergent views on this, and I look forward to their insights.

If I used myself as an example, when I select a health insurance plan, I want doctors with competence and character, I want flexibility in services, I want services to be readily available, and I do not want the premiums or out-of-pocket expenses to be the reason I'm seeing the doctor in the first place. And it seems to me that no matter when, where or why you discuss health care that all roads lead to those issues—the quality of care, the affordability of care, and the convenience of receiving care. Providing access to the FEHBP to the dependents of active-duty personnel is not outside the realm of these factors. It is at the very heart of them.

The FEHBP is currently a model program. The program, which has been in existence since 1960, offers participants a choice of many diverse health care plans (fee-for-service plans and prepaid plans) with varying services and premiums. Approximately 9 million federal government employees, annuitants, and their dependents are currently covered under the plan.

CHAMPUS, of course, is the military equivalent of a health insurance plan for active duty dependents, military retirees, and the dependents of retirees, and survivors of deceased members. The plan, which is administered by DoD, has been in place since 1966. During that time, it has amassed die-hard supporters and staunch critics.

There have been criticisms of the CHAMPUS program, including the limited access to services and the costs, i.e., the out-of-pocket expenses of beneficiaries and the taxpayer's liability. There are also those who question the quality of care received under the program. I am very sensitive to the care women receive at military medical facilities. I believe I would get little arguement from DoD that improvements need to be made in this area.

The DoD and the Office of Personnel Management (OPM) have begun exploring strategies to address the integration of FEHBP into the military health care system. My understanding is that DOD is exploring the possibility of adding FEHBP as a fourth option under its TRICARE program. This would definitely provide greater access and services to individuals who are 65 and over and are ineligible for CHAMPUS. It also could create an adverse risk situation that would result in increased FEHBP premiums.

OPM has discussed the possibility of creating a military version of the FEHBP which would be seamless and identical to FEHBP. Under this system, OPM insists that a specific population be carved out and that this population only have FEHBP as an option. Depending on the population, this could also create an adverse risk situation, leading to higher FEHBP premiums and definitely higher premiums for the active-duty dependents of the military system.

In its report, Restructuring Military Medical Care, the Congressional Budget Office (CBO) analyzed the use of FEHBP as an alternative to the current military system for non-active duty beneficiaries. The report outlines three options with the biggest differences in them being the contribution levels for the Department of Defense and the premiums for impacted beneficiaries.

Although there are various solutions being examined and endorsed, it is clear that the organizations represented here want to assure that individuals receive quality care. If reform is found necessary, we should not lose sight of that.

Again, I would like to thank Chairman Mica for calling this hearing. I look forward to hearing from the witnesses.

Mrs. MORELLA. Just a few comments and a couple of brief questions. I am very moved by the panel. I first of all want to thank Chairman Mica for calling this hearing to examine the ramifications of opening up the Federal Employees Health Benefits Program to dependents of active duty personnel, military retirees, and their families. It's a very interesting concept.

I'm very open-minded to this as a possible resolution, and I think about the health care that I am interested in. When I select a

health insurance plan, I want doctors with competence and character, flexibility in services. I want the services to be readily available, and I don't want the premiums or out-of-pocket expenses to be the reason that I am seeing the doctor in the first place. And it seems to me that no matter when, where, or why you discuss health care that all roads lead to those issues: the quality of care, the affordability of care, the convenience of receiving care.

Providing access to the FEHBP to the dependents of active duty personnel is not outside the realm of these factors. In fact, I think, as I am hearing, it's at the very heart of it.

There have been criticisms of the CHAMPUS program, including the limited access to services and the costs. For example, the out-of-pocket expenses of beneficiaries and the taxpayers' liability. There are also those who question the quality of care received under the program, and that's what I have heard.

I am very sensitive to the care that women receive at military medical facilities. I believe I would get very little argument from the Department of Defense that improvements need to be made in this area. In its report, Restructuring Military Medical Care, the Congressional Budget Office analyzed the use of FEHBP as an alternative to the current military system for nonactive duty beneficiaries. The report outlines three options with the biggest differences in them being the contribution levels for the Department of Defense and the premiums for impacted beneficiaries.

So although there are various solutions being examined and endorsed, it's clear that the organizations represented here want to assure that individuals receive quality care. If reform is found necessary, we shouldn't lose sight of that, and that is a commitment we make on this subcommittee. And in response to the very moving statements that you have made in this situation, I'm going to ask: First of all, if the FEHB proposal doesn't go forward, what changes would you recommend to the current system; and then second, would you be willing to pay higher premiums under the FEHB program in order to gain access to the system?

Ms. CHESCAVAGE. If we were not given the opportunity for FEHBP, we would have to have two things. One, the military system would have to be open to all of us who are eligible. We should all have the opportunity to enroll, including those who are over the age of 64.

Second, the cost-sharing requirements have to be made equitable. It has to be, whatever system it is has to be offered to all of us, no matter where we live.

On the question of higher premiums, first of all, we don't, most of us—nobody knows how much most of us are paying for medical care. Some of us are paying for CHAMPUS supplements, Medicare supplements, other health insurance, and no one really knows how much all of us are paying. So it is quite possible that FEHBP will offer a great number of us lower premiums. But we do want to make sure that the active-duty families are protected, and they cannot afford to pay the same premiums as Federal civilians, and that is why we have proposed the additional allowance.

Mrs. MORELLA. Would you agree, too, Ms. Kidd with the statements that have been made?

Ms. KIDD. Yes.

Mrs. MORELLA. How would you personally rate, and I think I probably know the answer to this, the care or the service that is received at the military treatment facilities? I know that there is the problem with the convenience and where you are located, but the care and service?

Ms. JONES. As military dependents, there is an Air Force instruction that states that due to time and space restrictions, we can be bumped or pushed back out of appointments that we have made or care that we have sought to give active-duty patients. The quality of care that I have received has been good when I have received it, but the problem is getting that care.

Mrs. MORELLA. So it is not dependable, you just cannot rely——

Ms. JONES. No, it is not. As a member of an Air Force family for 18 years, it never occurred to me that this could ever happen to me, especially 5 weeks before I was due, and it came as quite a shock when I found out that I could be bumped and thrown out literally on the street by a military treatment facility because they did not have room for me. And it has been a very stressful time, these last 5 weeks, when it should not have been.

Mrs. MORELLA. So urgency didn't much matter?

Ms. JONES. I am sorry?

Mrs. MORELLA. Urgency of the case wasn't part of the criteria?

Ms. JONES. No, I believe I am second on the priority list. Active-duty have priority and dependents are second on the list, and then it goes down. I find the solution to my particular problem unacceptable.

Mrs. MORELLA. I guess you would agree?

Ms. CHESCAVAGE. Yes. You see, our health benefit is space available health care on a priority basis, and it is rationed health care. There is no other way to describe it.

Ms. KIDD. I would say that the vast majority of family members that are seen in military treatment facilities are happy with the treatment. The access is a problem and it is becoming much more serious every day. I think it shows when a Priority 2 can't be seen that Priority 3 is literally off-the-book altogether.

Mrs. MORELLA. I guess Ms. Gildersleeve is not happy with the service.

I just commend you for sharing your experience with us. Thank you.

Thank you, Mr. Chairman.

Mr. MICA. Thank you.

I thank the ranking member for his patience and invite his questions.

Mrs. MORELLA. I thank the ranking member also for his patience.

Mr. MORAN. As the chairman knows, I am always happy to defer to my good friend from Maryland.

Let me ask Ms. Kidd about a part of your testimony where you said that all nonactive-duty beneficiaries, on page 7, including active-duty families should have the opportunity to participate in nonrestricted FEHBP. So you would open it up to everyone in the military, including active-duty, but that active-duty families must be given a health care allowance similar to their housing allowance in addition to the regular Government contribution, and that would

equal 100 percent, so you would have the Department of Defense pay 100 percent of the premium, in other words, the normal 72 percent that the civilian Federal agencies pay plus the other 28 percent?

Ms. KIDD. Dorsey will answer that.

Ms. CHESCAVAGE. If it were feasible within the budget to have 100 percent, that would be wonderful, but we would recommend nothing less than 96 percent, but the higher we can go, that would be great.

Mr. MORAN. I understand that. We are having trouble getting 72 percent.

Ms. CHESCAVAGE. This would only be for active-duty families, and only 60 percent are married, and several are dual—the percentage of dual-career couples must be looked at because obviously they don't need the FEHBP, the man and the woman in uniform. We also have single parents, et cetera, so I think if we were modeling things, looking for a formula, we would have to consider those kinds of situations.

Mr. MORAN. No, I understand why it is being done, and of course active-duty families now have full free medical care, and so you would want it to be a comparable option and particularly one that would be available to someone like Ms. Jones in her situation?

Ms. CHESCAVAGE. Yes.

Mr. MORAN. OK.

Well, I don't want to delay the panel. I know we have other people both to ask questions on this panel but also to share with us other information, but I appreciate you taking, all four of you taking the time today.

Mr. MICA. I thank you, and yield to Mr. Bass.

Mr. BASS. Mr. Chairman, I don't have any questions at this time. I think the other members of the subcommittee have adequately covered the subject.

Thank you.

Mr. MICA. I will yield to Mr. Holden.

Mr. HOLDEN. Thank you, Mr. Chairman. I also do not have any questions.

This is my first hearing on the subcommittee, and I would just like to thank the panel for your very enlightening testimony. It is a problem that has only been brought to my attention in the last several days, and look forward to working with the members of the committee to see what we can do to resolve it.

Mr. MORAN. Well, so far you are going to be a very popular member of this panel. He is earning a lot of points.

Mr. HOLDEN. They said in the first 8 months I should take it easy for a while.

Mr. MICA. I think Mr. Mascara took your time for the rest of the year. No, we enjoyed his service and thank you.

I just want to have one final follow-up question to what Mr. Moran said. You had said 96 percent of payment by the Federal Government for active. What about others?

Ms. KIDD. The others would fall under FEHBP just as the——

Mr. MICA. And pay the same as others?

Ms. KIDD. Yes.

Mr. MICA. All right.

I want to thank each of you for your testimony and your participation, particularly you, Mrs. Gildersleeve, you came a long way at your own expense. You have had some tremendous problems which you described and you personally overcame them. I hope that the changes we make will be a little legacy to your husband's memory and your family. But we thank you.

Ms. Jones, we wish you well, and we are sorry your timing is off. It would have been a great media event to have the labor pains start about now. It sounds like you have already endured some pains with our Federal health care provisions that you are laboring under, but we thank you.

We look forward to working with your association, too, and hope we can do something to make some positive changes in the system.

So I thank you, and will excuse the panel at this time.

If I may, I would like to call our second panel which will discuss costs and other considerations relating to the military health care system and the FEHBP.

They are, first, Mr. Neil Singer, Deputy Assistant Director of the National Security Division of the Congressional Budget Office. We will also hear from William "Ed" Flynn, Associate Director for Retirement and Insurance, the Office of Personnel Management, a regular participant in many of our panels.

Gentlemen, your complete statements will be entered into the record, if you could, please summarize your remarks.

Even though I have sworn you in before, Mr. Flynn, we need to do that once again.

[Witnesses sworn.]

Mr. MICA. We will start with Mr. Neil Singer, Deputy Assistant Director of the National Security Division of CBO.

Welcome.

STATEMENTS OF NEIL M. SINGER, DEPUTY ASSISTANT DIRECTOR, NATIONAL SECURITY DIVISION, CONGRESSIONAL BUDGET OFFICE; AND WILLIAM E. FLYNN, ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE, OFFICE OF PERSONNEL MANAGEMENT

Mr. SINGER. Thank you, 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 Program or FEHB. As part of my testimony I would like to submit a paper entitled "Restructuring Military Medical Care" that CBO published in July at the request of the National Security Committee. My testimony summarizes some of the main points of that paper. Then I will be happy to respond to your questions.

[The information referred to has been retained in the subcommittee's files.]

Mr. SINGER. In the interest of time, I will skip some material—which I believe you have—that I prepared on the background of the military medical care system and its overall budgetary levels. Mr. Moran discussed that with great precision in his opening remarks, and I certainly would not attempt to expand on that.

Let me just note that 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, but according to one study conducted for the Department, the wartime mission doesn't 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 that we have used in our study, downsizing could eventually reduce military medical costs by about $9 billion each year. That estimate does not include the costs of closing facilities, and more important, those gross savings don't reflect the cost of providing another source of care 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 were downsized, DOD would have to find other ways to provide wartime training to medical personnel to keep them employed during peacetime and to furnish some of the care for active-duty personnel.

Strengthening affiliations with the civilian sector could achieve many of those goals. Beneficiary groups, DOD, and the Congress have all expressed concern about the performance of the military health care system in peacetime. Beneficiaries complain, and you heard some of it today, about limited access to the direct care system, the quality of care, and administrative burdens imposed by CHAMPUS.

DOD is concerned about the system's rising costs during an era of constant or falling overall defense budgets, and the Congress has mandated a number of experiments, demonstrations, and studies to improve the delivery of health care and to hold down costs. Out of those criticisms and analyses, DOD has developed its reform plan called TRICARE, which it is introducing in each of 12 service regions.

I won't summarize TRICARE; I will note only that it is now offered in just a few of the 12 service regions, and a judgment on the program, therefore, is premature. But we are skeptical about DOD's ability to achieve its stated objectives.

CBO's analysis suggests that the most likely outcome of TRICARE is an increase of about 3 percent over today's costs. Perhaps of more concern, the administrative changes that DOD has introduced appear to fall short of what is needed to improve the delivery of peacetime health care. With the 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 health care. 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 FEHB. We looked at offering military beneficiaries coverage under the basic FEHB program and two variations in our July report, which I believe you have before you.

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. All three alternatives would let military beneficiaries, excluding active-duty personnel, enroll voluntarily in FEHB. Let me summarize our results briefly.

First, we found that the number of military beneficiaries who would enroll would vary extensively among the three 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.

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 cost of the more generous alternative plans would exceed savings from downsizing the military system.

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 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. Our estimates make no adjustment for the possibility of that kind of behavior, so our savings estimates may be conservative.

In conclusion, offering FEHB 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, would not guarantee that savings would 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, our analysis indicates that for the 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 were 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. But even if their out-of-pocket costs rose, many military beneficiaries might prefer FEHB.

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 wrap-around benefits to supplement their coverage under Medicare.

Mr. Chairman, thank you. That concludes my prepared statement. I will be happy to answer your questions.

Mr. MICA. Thank you, Mr. Singer.

[The prepared statement of Mr. Singer follows:]

PREPARED STATEMENT OF NEIL M. SINGER, DEPUTY ASSISTANT DIRECTOR, NATIONAL SECURITY DIVISION, CONGRESSIONAL BUDGET OFFICE

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.

BACKGROUND ON THE MILITARY HEALTH CARE SYSTEM

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.

WARTIME MISSION

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.

FEHB AS AN ALTERNATIVE TO MILITARY 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.

Mr. MICA. We have referred to you as William, I guess it is William Edward Flynn, Associate Director of Retirement Insurance for the Office of Personnel Management.

Welcome back.

Mr. FLYNN. Good morning, Mr. Chairman.

Thank you, and the members of the subcommittee for inviting me to testify here today. You have my prepared remarks. I am going to shorten that a little bit. It covers some of the questions you had asked in your invitation, and then we will have some time for questions and answers.

It is my pleasure to be here today to offer the Office of Personnel Management's views on the possible ramifications of opening the Federal Employees Health Benefits Program to nonactive-duty beneficiaries of the military health care system.

Increasingly over the past several years, the President, the Congress and others have promoted the Federal Employee Health Benefits Program as a useful model for efforts to advance the quality of health care nationally. After 35 years of experience in administering the program, we believe we have developed a good understanding of the key features that have contributed to the success—market competition, informed consumer choice, and more recently, strong commitment to cost-containment initiatives such as managed care for the delivery of health services. We are always willing to respond to requests, such as this one from the subcommittee to discuss potential solutions to health care issues in the context of our experience.

But I think it is important to understand that as a first principle in any cooperative undertaking for purposes of helping others move in the direction we have, OPM's policy must be to avoid any change which would harm the Federal Employee Health Benefits Program population that we currently have now. The Federal Employees Health Benefits Program is an essential part of the Government's overall employee compensation package designed to recruit and retain a well-qualified work force to conduct the Government's functions. The Government, as an employer, must be able, therefore, to identify its health insurance costs as a component of total compensation in order to effectively manage its human resources.

By way of example, the President's recent economic plan for a balanced budget did not fold others into the Federal Employee Health Benefits Program. The President proposed that small employers could get coverage from plans that also provide coverage to Federal employees through this program, but that the coverage would be separately rated in each State, leaving premiums for Federal employees unaffected.

There are many reasons the program has been looked to as a model for expanding health care coverage. It offers eligible individuals many health care options, yet it is relatively simple in structure. Although the program is managed by the Office of Personnel Management, services are performed almost exclusively in the private sector. The program could offer great potential for capitalizing on economies of scale, particularly if the current contracting process, benefit structure, and informational materials can be used or tailored for new groups of entrants. Moreover, all Federal employee

health benefit plans are required to include cost-control incentives and the program provides uniform access to all beneficiaries.

If we were invited to consult on bringing new populations into the program, such as nonactive-duty military health care beneficiaries, it would be necessary to consider certain accommodations on behalf of the new entrants to maintain the most attractive features of the current program. First, for rate-setting purposes, we believe an eligible population must be clearly committed to the Federal Employee Health Benefits Program, that is, the program must be the exclusive or nearly exclusive vehicle for health care coverage for a sufficiently broad class of individuals, and individuals must be required to positively enroll in the program during prescribed periods. Group insurance principles rely on achieving a broad mix of individuals to maintain attractive rates.

As well, for program planning and administrative purposes, we believe it is essential to know the potential beneficiaries in advance. A new population must be considered as a separate risk pool for purposes of establishing premium charges, at least until such time as there is sufficient experience to determine whether or not there are any differences from the current population. The sponsoring organization for the new population must have the capability to counsel eligible beneficiaries and process enrollments, collect subscription charges, and otherwise administer program financing matters. And before adding any new group, consideration would have to be given to the potential effects on service delivery for those plans that might be adversely affected by a sudden influx of new enrollees.

Many plans now use managed care approaches to encourage enrollees to obtain care from approved providers. This may require prescribing a delayed or phased-in effective date to permit adequate planning for new populations.

Finally, opening the FEHB Program to CHAMPUS beneficiaries also opens the program to beneficiaries of the Civilian Health and Medical Program of the Department of Veterans Affairs.

Now, as I said, Mr. Chairman, I have tried in the statement to answer most of the questions you asked in your invitation, and I think I will conclude at this point and be available to answer any additional questions that you and the subcommittee may have.

[The prepared statement of Mr. Flynn follows:]

STATEMENT OF
WILLIAM E. FLYNN, III
ASSOCIATE DIRECTOR FOR RETIREMENT AND INSURANCE
U.S. OFFICE OF PERSONNEL MANAGEMENT

at a hearing of the

SUBCOMMITTEE ON CIVIL SERVICE
COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
U.S. HOUSE OF REPRESENTATIVES

on

EXTENDING FEHBP COVERAGE TO NON-ACTIVE-DUTY
BENEFICIARIES OF THE MILITARY HEALTH CARE SYSTEM

SEPTEMBER 12, 1995

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

THANK YOU FOR YOUR INVITATION TO COME TODAY AND OFFER THE OFFICE OF PERSONNEL MANAGEMENT'S VIEWS ON THE POSSIBLE RAMIFICATIONS OF OPENING THE FEDERAL EMPLOYEES HEALTH BENEFITS (FEHB) PROGRAM TO NON-ACTIVE-DUTY BENEFICIARIES OF THE MILITARY HEALTH CARE SYSTEM.

INCREASINGLY OVER THE PAST SEVERAL YEARS, THE PRESIDENT, THE CONGRESS, AND OTHERS HAVE PROMOTED THE FEHB PROGRAM AS A USEFUL MODEL FOR EFFORTS TO ADVANCE THE QUALITY OF HEALTH CARE NATIONALLY. AFTER 35 YEARS OF EXPERIENCE IN ADMINISTERING THE FEHB PROGRAM, OPM HAS DEVELOPED A GOOD UNDERSTANDING OF THE KEY FEATURES THAT HAVE CONTRIBUTED TO THE SUCCESS OF THIS PROGRAM -- MARKET COMPETITION, INFORMED CONSUMER CHOICE, AND, MORE RECENTLY, STRONG COMMITMENT TO COST-CONTAINMENT INITIATIVES, SUCH AS MANAGED-CARE FOR THE DELIVERY OF HEALTH SERVICES. WE ARE ALWAYS WILLING TO RESPOND TO REQUESTS,

SUCH AS THAT FROM THIS SUBCOMMITTEE, TO DISCUSS POTENTIAL SOLUTIONS TO HEALTH CARE ISSUES IN THE CONTEXT OF OUR FEHB EXPERIENCE.

BUT, IT IS VERY IMPORTANT TO UNDERSTAND THAT, AS A FIRST PRINCIPLE IN ANY COOPERATIVE UNDERTAKING FOR PURPOSES OF HELPING OTHERS MOVE IN THE DIRECTION WE HAVE, OPM'S POLICY MUST BE TO AVOID ANY CHANGE WHICH WOULD HARM THE FEDERAL FEHB POPULATION. THE FEHB PROGRAM IS AN ESSENTIAL PART OF THE GOVERNMENT'S OVERALL EMPLOYEE COMPENSATION PACKAGE DESIGNED TO RECRUIT AND RETAIN A WELL-QUALIFIED WORKFORCE TO CONDUCT THE GOVERNMENT'S FUNCTIONS. FURTHERMORE, THE GOVERNMENT, AS AN EMPLOYER, MUST BE ABLE TO IDENTIFY ITS HEALTH INSURANCE COSTS AS A COMPONENT OF TOTAL COMPENSATION IN ORDER TO EFFECTIVELY MANAGE ITS HUMAN RESOURCES.

BY WAY OF EXAMPLE, THE PRESIDENT'S ECONOMIC PLAN FOR A BALANCED BUDGET DID NOT "FOLD" OTHERS INTO THE FEHB PROGRAM. HE PROPOSED THAT SMALL EMPLOYERS COULD GET COVERAGE FROM PLANS THAT ALSO PROVIDE COVERAGE TO FEDERAL EMPLOYEES THROUGH THE FEHB PROGRAM, BUT THE COVERAGE WOULD BE SEPARATELY RATED IN EACH STATE, LEAVING PREMIUMS FOR FEDERAL EMPLOYEES UNAFFECTED.

THE FEHBP IS THE COUNTRY'S LARGEST EMPLOYER-BASED HEALTH INSURANCE PROGRAM, WITH $16.1 BILLION IN ANNUAL REVENUES. UNDER THE PROGRAM, OPM CONTRACTS ANNUALLY WITH NEARLY 400 TRADITIONAL INSURANCE PLANS AND HEALTH MAINTENANCE ORGANIZATIONS (HMO'S) ON BEHALF OF 9 MILLION-PLUS INSUREDS -- 2.3 MILLION FEDERAL EMPLOYEES, 1.8 MILLION

ANNUITANTS, AND ELIGIBLE DEPENDENTS. OPM ALSO PROVIDES COMPARATIVE INFORMATION TO ASSIST INDIVIDUALS IN MAKING INFORMED CHOICES AMONG THE PLANS AVAILABLE IN THEIR AREA AND IS AVAILABLE TO RESOLVE DISPUTES BETWEEN ENROLLEES AND THEIR HEALTH PLANS. OPM'S ADMINISTRATIVE EXPENSES ARE ABOUT $23 MILLION A YEAR, LESS THAN TWO TENTHS OF ONE PERCENT OF PREMIUM. A GOVERNMENT CONTRIBUTION, DERIVED FROM A FORMULA WHICH IS BASED ON THE AVERAGE PREMIUM CHARGES UNDER A SET OF PLANS DESIGNATED BY LAW, PAYS UP TO 75 PERCENT OF PREMIUM COSTS FOR MOST ENROLLEES (SOME INDIVIDUALS WHO LOSE GROUP ELIGIBILITY MAY CONTINUE COVERAGE TEMPORARILY ON A SELF-PAID BASIS AND POSTAL SERVICE EMPLOYEES RECEIVE A HIGHER EMPLOYER CONTRIBUTION UNDER COLLECTIVE BARGAINING). OPM'S INCREASED EMPHASIS ON MANAGED CARE AND OTHER COST-CONTAINMENT INITIATIVES OVER THE LAST 5 YEARS HAVE BEEN VERY SUCCESSFUL IN CONSTRAINING FEHBP COSTS COMPARED TO HEALTH INSURANCE PROGRAMS AVAILABLE TO MANY OTHER POPULATIONS. MOREOVER, OPM SURVEYS CONFIRM THAT PROGRAM SATISFACTION AMONG ENROLLEES IS HIGH, A FACT THAT IS FURTHER SUPPORTED BY A LOW PERCENTAGE OF ANNUAL OPEN SEASON ENROLLMENT CHANGES.

THERE ARE MANY REASONS THE PROGRAM HAS BEEN LOOKED TO AS A MODEL FOR EXPANDING HEALTH CARE COVERAGE. IT OFFERS ELIGIBLE INDIVIDUALS MANY HEALTH CARE OPTIONS, YET IS RELATIVELY SIMPLE IN STRUCTURE. ALTHOUGH THE PROGRAM IS MANAGED BY A FEDERAL AGENCY, SERVICES ARE PERFORMED EXCLUSIVELY IN THE PRIVATE SECTOR. THE PROGRAM COULD OFFER GREAT POTENTIAL FOR CAPITALIZING ON ECONOMIES OF SCALE,

PARTICULARLY IF THE CURRENT CONTRACTING PROCESS, BENEFIT STRUCTURE, AND INFORMATIONAL MATERIALS CAN BE USED FOR NEW GROUPS. MOREOVER, ALL FEHB PLANS ARE REQUIRED TO INCLUDE COST CONTROL INCENTIVES AND THE PROGRAM PROVIDES UNIFORM ACCESS TO ALL BENEFICIARIES.

IF OPM WERE INVITED TO CONSULT ON BRINGING NEW POPULATIONS INTO THE FEHB PROGRAM, SUCH AS NON-ACTIVE-DUTY MILITARY HEALTH CARE BENEFICIARIES, IT WOULD BE NECESSARY TO CONSIDER CERTAIN ACCOMMODATIONS ON BEHALF OF THE NEW ENTRANTS TO MAINTAIN THE MOST ATTRACTIVE FEATURES OF THE CURRENT FEHB PROGRAM. FIRST, FOR RATE-SETTING PURPOSES, WE BELIEVE AN ELIGIBLE POPULATION MUST BE CLEARLY COMMITTED TO THE FEHB PROGRAM, THAT IS, THE FEHB PROGRAM MUST BE THE EXCLUSIVE VEHICLE FOR HEALTH CARE COVERAGE FOR A SUFFICIENTLY BROAD CLASS OF INDIVIDUALS, AND INDIVIDUALS MUST BE REQUIRED TO POSITIVELY ENROLL IN THE PROGRAM DURING PRESCRIBED PERIODS. GROUP INSURANCE PRINCIPLES RELY ON ACHIEVING A BROAD MIX OF INDIVIDUALS TO MAINTAIN ATTRACTIVE RATES. AS WELL, FOR PROGRAM PLANNING AND ADMINISTRATIVE PURPOSES, IT IS ESSENTIAL TO KNOW THE POTENTIAL BENEFICIARIES IN ADVANCE. MOREOVER, NEW POPULATIONS MUST BE CONSIDERED AS A SEPARATE RISK POOL FOR PURPOSES OF ESTABLISHING PREMIUM CHARGES -- AT LEAST UNTIL THERE IS SUFFICIENT EXPERIENCE TO DETERMINE ANY DIFFERENCES FROM THE CURRENT FEHB POPULATION. THE SPONSORING ORGANIZATION FOR THE NEW POPULATION MUST HAVE THE CAPABILITY TO COUNSEL ELIGIBLE BENEFICIARIES AND PROCESS ENROLLMENTS, COLLECT ALL SUBSCRIPTION CHARGES, AND OTHERWISE ADMINISTER PROGRAM FINANCING MATTERS. AND, BEFORE ADDING ANY NEW

GROUP, CONSIDERATION WOULD HAVE TO BE GIVEN TO THE POTENTIAL AFFECTS ON SERVICE DELIVERY FOR THOSE PLANS THAT MIGHT BE ADVERSELY AFFECTED BY A SUDDEN INFLUX OF NEW ENROLLEES. MANY PLANS NOW USE MANAGED CARE APPROACHES TO ENCOURAGE ENROLLEES TO OBTAIN CARE FROM APPROVED PROVIDERS; THIS MAY REQUIRE PRESCRIBING A DELAYED OR PHASED-IN EFFECTIVE DATE TO PERMIT ADEQUATE PLANNING FOR NEW POPULATIONS. FINALLY, OPENING THE FEHB PROGRAM TO CHAMPUS BENEFICIARIES WOULD ALSO OPEN THE PROGRAM TO BENEFICIARIES OF THE CIVILIAN HEALTH AND MEDICAL PROGRAM OF THE DEPARTMENT OF VETERANS AFFAIRS (CHAMPVA).

BEFORE CLOSING, I WILL BRIEFLY ADDRESS THE SPECIFIC QUESTIONS POSED IN YOUR INVITATION TO TODAY'S HEARING.

WHAT WOULD BE THE IMPACT ON THE FEHB PROGRAM OF ALLOWING MILITARY BENEFICIARIES, INCLUDING THOSE ELIGIBLE FOR CHAMPUS, TO ENROLL?

THIS COULD INCREASE CURRENT FEHB ENROLLMENT LEVELS BY TWO-THIRDS, OR APPROXIMATELY 7 MILLION LIVES. TO ACCURATELY ESTIMATE THE IMPACT, WE WOULD NEED TO DEVELOP DATA FOR PURPOSES OF COMPARING VARIABLES SUCH AS (1) UTILIZATION PATTERNS, (2) SOCIO-ECONOMIC FACTORS, AND (3) GEOGRAPHIC DISTRIBUTION. DIFFERING FAMILY COMPOSITION AMONG MILITARY AND FEHB ENROLLEES WOULD NEED TO BE CONSIDERED SINCE ACTIVE DUTY PERSONNEL WOULD CONTINUE TO BE ELIGIBLE FOR FREE CARE IN MILITARY FACILITIES. ALSO, WHILE 50 PERCENT OF FEHB ANNUITANT BENEFICIARIES ARE MEDICARE ELIGIBLE, ONLY 36 PERCENT OF MILITARY RETIREES ARE.

WOULD IT BE NECESSARY TO MAINTAIN SEPARATE RISK POOLS FOR MILITARY BENEFICIARIES AND OTHER FEHB ENROLLEES?

THIS WOULD CERTAINLY BE NECESSARY AT LEAST UNTIL THERE IS SUFFICIENT PROGRAM EXPERIENCE FOR COMPARING RESPECTIVE UTILIZATION PATTERNS. FEDERAL CIVILIAN ENROLLEES SHOULD NOT BE ASKED TO SUBSIDIZE INSURANCE COSTS OF OTHER GROUPS AS PART OF THEIR EMPLOYEE COMPENSATION PACKAGE, NOR SHOULD OTHER GROUPS SUBSIDIZE FEDERAL CIVILIAN ENROLLEES, AS A MATTER OF EQUITY.

WOULD FREQUENT RELOCATION OF MILITARY EMPLOYEES PRESENT PROBLEMS IN FEHB ENROLLMENT?

OPM WOULD NEED TO FURTHER EXPLORE THE POTENTIAL IMPACT OF SIGNIFICANT ENROLLMENT SHIFTS ON PARTICULAR FEHB PLANS, AS DISCUSSED EARLIER IN THIS STATEMENT. GENERALLY, MOBILITY IS NOT NOW A PROBLEM FOR ENROLLEES IN GOVERNMENTWIDE FEHB PLANS AND ALL OF OUR HMOS OFFER A SPECIAL ENROLLMENT OPPORTUNITY FOR ENROLLEES WHO MOVE BETWEEN HMO SERVICE AREAS.

ARE MEDICARE-ELIGIBLE MILITARY RETIREES LIKELY TO BE INTERESTED IN FEHB COVERAGE?

PAST EXPERIENCE HAS SHOWN THAT MILITARY RETIREES WHO SUBSEQUENTLY BECOME CIVILIAN FEDERAL EMPLOYEES HAVE BEEN VERY INTERESTED IN USING THE FEHB PROGRAM FOR MEDICARE SUPPLEMENTAL COVERAGE.

CAN YOU ESTIMATE THE INCREASE IN OPM'S ADMINISTRATIVE EXPENSES THAT WOULD ACCOMPANY A MERGER OF THE MILITARY HEALTH CARE SYSTEM AND THE FEHB PROGRAM?

IT IS VERY DIFFICULT TO ESTIMATE POTENTIAL ADMINISTRATIVE EXPENSES

WITHOUT KNOWING SPECIFIC DETAILS. SUCH AN ESTIMATE WOULD HAVE TO BE GENERAL AT BEST. AS I MENTIONED EARLIER, OPM'S CURRENT FEHB ADMINISTRATIVE EXPENSES ARE ABOUT $23 MILLION A YEAR OR TWO TENTHS OF ONE PERCENT OF REVENUE. ABOUT DOUBLE THAT AMOUNT, OR AROUND $40 TO $50 MILLION, WOULD BE A REASONABLE ESTIMATION OF THE OUTSIDE RANGE OF THE COST OF PROVIDING THE ACTUARIAL, FINANCIAL MANAGEMENT, CONTRACT ADMINISTRATION, AND INFORMATIONAL SERVICES NEEDED TO HANDLE THE PROGRAM WITH A TWO-THIRDS INCREASE IN PARTICIPATION. BUT THE ACTUAL COST WOULD BE A FUNCTION OF THE DESIGN AND STRUCTURE OF THE PROGRAM.

THIS CONCLUDES MY STATEMENT. I WILL GLADLY TRY TO ANSWER ANY ADDITIONAL QUESTIONS YOU MAY HAVE AT THIS TIME.

Mr. MICA. I thank you and Mr. Singer, and I have a couple of quick questions.

Mr. Singer, your report, I believe, on page 55, details some of the potential cost savings, and you say that under certain scenarios it could save on the order of about $1.7 billion. You also say that in other scenarios it could end up having a net cost to the Federal Government.

I don't know if you were paying attention to the proposals by the former panel that certain percentages, I think they said 4 percent, be paid by active participants, and I guess around 28 percent would be paid by others participating. I don't want to hold your feet to the fire because I think this would require some calculations, but do you think a point could be reached where there could be some savings and draw these folks into the system and provide not only access but also the quality and availability of care in some savings pattern?

If we added $3 or $4 billion more, I am sure we could provide the coverage, but what we are trying to do is bring the costs down. Do you think that scenario could be developed?

Mr. SINGER. I think you can come close to playing that scenario on the basis of the table on page 56 of our report if you take some of the numbers in there apart. Let me do that with you, and then if it turns out I am doing it wrong, when I get back to my office my staff will correct me and I will correct the answer for the record.

Mr. MICA. We won't hold your feet to the fire. Go right ahead.

Mr. SINGER. I think you could come close to the proposal that Ms. Chescavage was offering you by taking the $3.8 billion in Option 3, in Table 9 on page 56, as the cost for dependents of active-duty personnel, assuming payment of 100 percent of the premiums by the Government, and adding that to the costs in Option 1 for retirees both under and over 65 in the same table. And that, if I am doing the numbers in my head correctly, would add about $1.9 billion to the $7.3 billion at the bottom of the Option 1 column, making the total about $9.2 billion, or close to what we project as the steady-state savings from downsizing the military system.

Mr. MICA. You didn't factor in the 4 percent that they recommended?

Mr. SINGER. I haven't got the 96 percent option. I have a 100-percent option, so I did that.

Mr. MICA. If we did the four.

Mr. SINGER. It would cost a little less.

Mr. MICA. So we could even be a little bit more in the positive?

Mr. SINGER. It would be closer, yes.

I want to stress that this calculation is a steady-state calculation. It doesn't talk about how long it would take to get there or what the costs of getting there would be in terms of closing bases and hospitals and that sort of thing.

Mr. MICA. The other question is, I think that your report cited about a $16, $15 to $16 billion cost; is that a general estimate on what we are providing medical services for military and dependents? Do you think that is a real cost? Is that pretty accurate?

Mr. SINGER. The $15.2 billion, if I was listening correctly, was Mr. Moran's figure in his opening remarks for the budgetary cost

of DOD's medical care. I think that is a budgetary number. There may be a few items that are not counted in that total: for example, accession programs for medical professionals, initial training, things of that sort, which would add slightly to that total.

Mr. MICA. Capital facilities, things of that nature?

Mr. SINGER. No, I think capital facilities are included. I believe the $15 billion includes personnel costs and acquisition costs for equipment and facilities and also operating costs. There would be some ancillary expenditures of the sort that I mentioned that might be added, which I think DOD does not capture in its budgeting, but you might ask that question of the DOD witnesses.

Mr. MICA. Well, I was just trying to see if we had fairly accurate figures on the cost of current services.

Mr. SINGER. We based our $9 billion steady-state savings estimate on the $15 billion total that DOD counts as its cost of medical care.

Mr. MICA. Thank you.

Mr. Flynn, one of the areas where we see some particular problems is in the retiree area and, possibly, in expanding the pool of those eligible for FEHB benefits to those who are in a retirement stage of life. They are also, I guess, higher users and have a higher risk. Has there been any instance where we have taken in and expanded FEHBP eligibility in the past with a similar group? I am not certain.

Mr. FLYNN. Not that I am aware of, Mr. Chairman.

Mr. MICA. Or any expansion of the program that we could go back and look at that might give us some evidence as to the impact? Has there been any instance?

Mr. FLYNN. I think since the program was originally started, the total membership base or the total number of people eligible to participate in the program has stayed essentially the same with just a little bit of change around on the margins. I will double-check that, but I don't think we have anything——

Mr. MICA. If you find anything, I would be interested in knowing that. And do you think that what we are proposing can be done? We might have to separate these folks out into a separate risk pool to gain some experience and some additional knowledge as to costing and things of that sort, is that correct?

Mr. FLYNN. Absolutely, Mr. Chairman. We have tried to do some rough estimating of the differences in terms of the populations we are talking about with some very rough data that is available, but part of what we think is very important here is to be able to know exactly what the experience of that group would be for rate-setting purposes.

Mr. MICA. You do a fairly admirable job in administering the program. What are your total number of programs personnel for FEHBP? Is it 170?

Mr. FLYNN. At the Office of Personnel Management we are currently financing about 153 people to administer this program for almost 10 million, yes, sir.

Mr. MICA. You probably wouldn't have to expand that too much because your providers and your insurers would feel the brunt of most of this, most of your personnel and activities are in place.

There may be some additional burden and expense to your agency if we did expand this pool. Would that be correct?

Mr. FLYNN. I think that is a fair estimate, Mr. Chairman. In fact, you had asked specifically what the impact on OPM's administrative costs would be, and our view is that is always a function of program design and structure, but at the outside you would be looking at doubling what we invest currently, which means you would go to maybe 300 people and perhaps $40 million at the outside. Now, we would expect that you would, as you mentioned, see some economies of scale. We are essentially dealing with the same private health care delivery system and things of that nature, but just rough figuring, somewhere in that vicinity.

Mr. MICA. Do you see any red flags that we should be aware of or problems that you haven't mentioned, something that should be of particular concern if we did expand? We are doing very well now at fairly low costs and a fairly effective service. Is there anything you wanted to comment on?

Mr. FLYNN. I think the things that I have mentioned already—the distinction between CHAMPUS and the Federal Employee Health Benefits Program's role as part of the employer's compensation package and others like that. One thing I might point out, not because I think it is necessarily more important than any of the others, is that were one to move to the sudden expansion of the total population participating in this program, we would want to look, particularly in rural areas, at the availability of and the access to qualified medical care providers—physicians, hospital facilities, nurses, and others—to make sure that we either know what we were looking at in terms of what is available, or we can see the availability of those services expanding as the populations there demand new services.

Mr. MICA. Thank you.

Mr. Moran.

Mr. MORAN. Thank you, Mr. Chairman.

Your study was very interesting with regard to the military's medical system, and I think it does give anyone cause for reconsideration of the system because the mission is to prepare for wartime, to keep the facilities and the manpower, the men and women medical professionals or medical professionals that serve it ready to deal with the medical emergencies that arise in wartime.

The problem is that the medical care being delivered has virtually no relationship to the medical care that would be necessitated in wartime. In fact, the most typical operation is childbirth. And there is a clear implication that they would be far better off providing care for some of the emergency hospitals in inner cities if they really wanted to get wartime experience. D.C. General, for example, has more bullet wounds and people coming in than Vietnam, I understand did, so that is where the relevant experience is available. It is in the inner city, it is not in military medical facilities. And, in fact, the training that is most relevant is the rotation through the trauma centers, where they send people. But that doesn't mean that we ought to close down the military medical facilities. And the problem with the analysis, the savings that are available is that it really does mean closing down much of the system that we have now.

I would be very reticent to advocate that. I don't think adequate consideration has been given to the implications, not the least of which are of course the political implications. The Base Closure Commission is one thing, closing down our military facilities, medical facilities would be another. But your CBO paper needs to be read and seriously considered by a lot of people in decisionmaking capacities.

Can the TRICARE system really save much money? Is there any real savings in TRICARE by offering the PPO alternative, or is it really to provide better access? It is really not a cost-savings measure as much as it is updating the insurance options that are available to military families.

Mr. SINGER. Is it the PPO option you want to focus on, Mr. Moran, or the HMO option?

Mr. MORAN. Well, I am talking about the TRICARE system, where you have the three, you have got the HMO, the CHAMPUS, and you have got the PPO, but that seems to be more for the purpose of providing affordable access for active-duty personnel, and—well, active-duty personnel primarily than it is to save money. Is that a reasonable assumption?

Mr. SINGER. I think, as we understand it, the focus of TRICARE is really on TRICARE Prime, which is the HMO option. The PPO network of providers and the discounts for using them are available on a case-by-case basis as an incentive for those who elect not to enroll in Prime, so they nonetheless behave in their choice of physicians in a way that will be of some benefit to the Government. But, I think that the substantial changes in beneficiary behavior would be reflected in the Prime participants rather than the Extra participants.

As far as the costs go, we have looked at this periodically as TRICARE has been proposed for expansion in different regions, and our bottom line, as I mentioned in my testimony, is that we think that costs will increase by about 3 percent over what they are today. Now, that is a point in a range, and if you are more optimistic in your view of the way TRICARE's reforms will work out and the way beneficiaries will respond, then you might come up with modest or small savings, which we estimated at less than a percentage point.

If you are less optimistic, particularly about the ability of DOD to manage the care that beneficiaries receive, then the outcome could be substantially worse a 6-percent increase in costs, at the other end of the range. Where you end up depends on many factors, including the way the program is administered. As I mentioned, we are a little concerned that the management changes and administrative reforms that DOD has stipulated and put into place to this point don't really go far enough in terms of imposing the strictures of managed care on the system.

In my prepared statement, I describe TRICARE as a loose managed care, TRICARE Prime is a loose managed care system, and I think that it would have to be tighter to achieve some of these savings.

Mr. MORAN. Well, that makes sense. Of course, you would assume that TRICARE Prime would be the preference. In fact, military families would have much easier time adjusting to an HMO

than any other collective group of people, because essentially that is what they have now is an HMO. But the problem has been, as you cite, that there has not been an emphasis upon efficient use of resources, and in fact to some extent there has been an incentive to make greater use of the resources. The reward is in making the most use of the resources rather than the most efficient allocation of them.

Mr. SINGER. Yes, sir.

Mr. MORAN. If we were to have FEHBP as an option only for those over 65 where essentially it would be a supplement to Medicare to pick up the difference between Medicare and the actual cost of services, do we have an estimate of what the cost is? I know what DOD assumes it to be.

Do we, Mr. Singer, do you know?

Mr. SINGER. I was afraid you were looking at me. I don't have one off the top of my head, Mr. Moran. Maybe I could provide that estimate for the record, if we have one, and if not, then we will do our best to come up with one.

[The information referred to follows:]

The total cost to the government of providing military beneficiaries who are eligible for Medicare with coverage under the Federal Employees Health Benefits program would depend on many factors, including the specific terms of eligibility. For example, assuming that military beneficiaries were offered the option to enroll in a plan offered by the FEHB program as a supplement to their insurance coverage under Medicare, the total cost to the government in fiscal year 1996 could be about $3.8 billion, including an increase in Medicare costs of about $1.4 billion.

It is also important to note three key assumptions that underlie the estimate of costs to the government. First, consistent with current premium-sharing arrangements between the government and nonpostal federal civilian employees, the government is assumed to pay 72 percent of the average FEHB premium on behalf of Medicare-eligible military beneficiaries. CBO expects that about 95 percent of beneficiaries 65 years of age or older then would enroll in the FEHB program. Second, DoD is assumed to ensure that all Medicare-eligible military beneficiaries have full coverage under Medicare by paying for the enrollees' premiums under Medicare Part B, including fees for those beneficiaries who waived coverage when they first became eligible. Therefore, Medicare would serve as the primary payer. Third, CBO assumed that current levels of FEHB premiums would apply to providing coverage for Medicare-eligible military beneficiaries.

Changes in these assumptions would generate different costs to the government. For example, raising the government contribution to more than 72 percent of FEHB premiums would increase the number of Medicare-eligible military beneficiaries who enrolled in the FEHB program and thus would raise the total costs to the government. Alternatively, a less generous benefit option for Medicare-eligible military beneficiaries might lead to lower enrollment levels and lower government costs than estimated above.

Mr. MORAN. I think that would be useful to get.

And, Mr. Flynn, what would we—how would OPM feel about bringing in the over–65 Medicare-eligible people using FEHBP as essentially a Medigap policy?

Mr. FLYNN. As I said earlier, Mr. Chairman, I think that we would want to sit down and make sure we understood the ramifications of that. That is obviously a smaller subset of the universe of people that we have been talking about so far, and we could see what is doable here.

There are some complex matters of administration when you are dealing with Medicare retirees, such as how you collect premiums and how you distribute the cost of that premium, and so on, and

so forth. But in principle, we would certainly be more than willing to sit down and see what might be doable.

You had asked a moment ago about the cost of that. I don't know what the Medicare system costs would be. But I do know that if you look at, as I understand it, a little over a million Medicare eligibles, retired military Medicare eligibles, and you look at average premiums in the Federal Employee Health Benefits Program, in total it is about $2,100 a year for a self contract, and about $4,800 a year for a family contract, so you would want to look at the distribution of self and family in that population and do the multiplication, that would give a sense of FEHB Program costs. Then how that parcels out to the Government or to the individual is a function of another set of decisions.

Mr. MORAN. We are not going to have an opportunity to talk with representatives of the Retired Officers Association, are we, Mr. Chairman, but it would be interesting to get their view. I think they are providing an insurance policy that pretty well fulfills that function at this point. OK.

Well, we have got another panel. I don't want to delay.

I appreciate the receptivity of OPM to these possibilities. We clearly need to do just as you say, Mr. Flynn, we need to sit down and consider all the ramifications, both on the recipients and the organizations, the insurers and the like, and your administrative responsibilities.

And, Mr. Singer, I very much appreciate this report. I think this is going to be cited time and again for quite sometime and I suspect there are a lot of folks at the Pentagon reading it carefully.

Thank you.

Mr. SINGER. Thank you.

Mr. MICA. Thank you, Mr. Moran, and thank our panelists.

Mr. Singer, you have probably spent as much time as anyone studying the military health care system. Just a closing question; do you think it is efficient?

Mr. SINGER. How many people should I alienate with my answer?

Mr. MICA. Well, the reason I ask the question, I sent out a notice of the hearing to the press and said the Congressional Budget Office has found that the military health care system has a number of deficiencies in health care provided to active-duty military families, retirees, and their dependents. Beneficiaries of the military health care system are eligible to receive medical care at military facilities. However, depending on the level of demand and accessibility of facilities, this care is not always assured. Is that an accurate statement?

Mr. SINGER. That is absolutely accurate, Mr. Chairman.

Mr. MICA. Then I went on to say, "Treating wives and children of those who serve this country so honorably in our military like second-class citizens when it comes to health care is unacceptable," for which I was severely chastised by the Pentagon.

Mr. SINGER. I hope you weren't citing CBO as the source of that, Mr. Chairman?

Mr. MICA. No, I cited some of the testimony and comments from some of those who had to experience and endure the service provided to them by the system.

Mr. SINGER. If I could give a semi-serious answer to the question. I think that we have found in our examination of the military health care system over the years a number of instances of poor incentive structure, of apparently excessive treatment practice, medical practice that certainly departs from the norm in civilian facilities. This does not mean that it is unprofessional, simply that it doesn't use resources in the same way, and that is the sense in which I would respond to the question of efficiency or inefficiency of the military's own system. As we said, maybe obliquely, in our paper, we think there is ample opportunity for improvement in that regard.

Mr. MICA. Well, I thank you both. I thank you for the extensive work you have done and the efforts that CBO has made to assist us.

And also, Mr. Flynn, OPM, we thank you for your participation. We may have additional questions that we will submit to you both from both sides of the aisle. We will leave the record open.

Mr. Moran, if you would like to get something on record from any of those additional groups, we would invite that to be part of the record.

Thank you, and we will excuse this panel.

Our third and last panel will review certain aspects of the military health care system and also study of the cost-effectiveness of different sizing options.

We have two panelists: Mr. William Lynn, Director of the Office of Program Analysis and Evaluation of the Department of Defense, and Dr. Stephen Joseph, Assistant Secretary of Defense for Health Affairs at the Department of Defense.

I want to welcome both of you gentlemen, ask that you stand to be sworn in, please.

[Witnesses sworn.]

Mr. MICA. The record will reflect they answered in the affirmative.

We again, extend a welcome to you.

Was it Dr. Joseph that wanted to lead?

Dr. JOSEPH. I think Mr. Lynn is going to lead.

Mr. MICA. All right.

Mr. William Lynn, Director of the Office of Program Analysis and Evaluation of the Department of Defense.

Welcome.

STATEMENTS OF WILLIAM J. LYNN, DIRECTOR, OFFICE OF PROGRAM ANALYSIS AND EVALUATION, DEPARTMENT OF DEFENSE; AND STEPHEN C. JOSEPH, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Mr. LYNN. Thank you, Mr. Chairman.

Like the other witnesses, I have a prepared statement that you should have in front of you, and I will put that——

Mr. MICA. Without objection, it will be a part of the record.

Mr. LYNN. I will summarize it, turn it over to Dr. Joseph, then be happy to answer any questions you might have.

I am pleased to be here today to testify on the results of the Defense Department's 2-year study of the military medical care sys-

tem. Congress directed that study in section 733 of the Fiscal 1992–1993 National Defense Authorization Act.

The Department was directed to do two things: One, determine the wartime medical requirement in the post-cold war era, and two, evaluate what adjustments could be made to enhance the peacetime cost-effectiveness of the medical system.

We completed the study in April 1994. We submitted a series of reports to Congress at that time. Since that time, the Assistant Secretary of Defense for Health Affairs, Dr. Joseph, has begun to implement the TRICARE program that he will describe in more detail in his testimony. But let me briefly summarize the results of what is known as the "733 Study."

First, with regard to the wartime requirements, the study first examined the current size of the military medical system in light of the projected wartime requirements of U.S. forces for medical care. The central conclusion of this portion of the study is that wartime requirements for medical care have declined from the levels that prevailed in the cold war era. The decline has occurred not only because of reductions in the number of active-duty and reserve forces, but also because of changes in the presumed nature of conflicts that we may face in the future.

To treat casualties evacuated to the United States as a result of two nearly simultaneous major regional conflicts, which is the current planning assumption of the Department, the United States would require approximately 9,000 beds in the Continental United States, that is, in military medical facilities in the Continental United States.

To man these beds we would need about 4,100 active-duty and reserve physicians in the hospitals, as well as in the conflict theaters. Another 4,900 active-duty and reserve physicians would serve outside the hospital system, working with combat units, outpatient clinics, and the medical evacuation system. Accordingly, the total base-case wartime requirement calls for approximately 9,000 active-duty and reserve physicians. To support that wartime requirement, the United States may need to augment the force with as many as 5,500 additional active-duty and reserve physicians for training, rotation base, and other support functions.

The table on page 4 of my written statement compares the wartime requirements generated by the 733 Study with the resources provided in the fiscal year 1999 Defense program as described in last year's Defense Budget Request, the fiscal year 1995–1999 Defense Budget Request.

As you can see, the CONUS medical facilities and active-duty personnel then programmed for fiscal year 1999, exceeded the projected wartime needs of a two-theater conflict in Southwest Asia and Korea. The analysis conducted for this study indicated that medical demands in the United States could be met by about one-third of the 30,000-bed capacity at the military treatment facilities then planned to be operating in 1999. Similarly, only about half to three-quarters of the active-duty and reserve physicians projected to be available in fiscal year 1999 would be needed to meet wartime requirements.

This estimate of the wartime requirements formed the basis for our assessment of the peacetime medical benefit, which I will turn to next. That was the second part of the study.

The central question in that part of the study was whether DOD should reduce its medical establishment to support the much smaller wartime mission now envisioned, or whether it should maintain some of the excess capacity in order to provide peacetime care to the nonactive duty beneficiaries it currently serves in CHAMPUS and elsewhere.

On one hand, if the medical establishment were sized strictly against wartime requirements, substantially fewer hospitals, doctors and other medical personnel would be needed than the defense program currently provides.

On the other hand, maintaining a larger DOD medical structure than what's adequate for the wartime requirement would allow us to treat more beneficiaries in-house during peacetime.

These issues have many implications for DOD beneficiaries, including the impact on quality of care and convenience to the beneficiary population. But the threshold issue we addressed in the study was the impact on DOD health care costs overall.

Let me turn to that issue. Whether greater access to the MTF system, the military treatment facility system, would cause DOD health care costs to rise or fall turns primarily on two factors: whether, for identical workloads, military treatment facility costs are higher or lower than CHAMPUS; and, second, whether greater access to military treatment facilities will attract new users into the DOD health care system.

The first factor is the relative costs of providing a given amount of care in military treatment facilities versus obtaining that care through CHAMPUS. The issue here is the cost of a given workload, 10 cases from CHAMPUS becoming 10 cases in a military treatment facility, for example.

Our study concluded that MTF's can provide care less expensively on a case-by-case basis than CHAMPUS. We found a cost savings of 10 to 24 percent on the margin. But although DOD could provide care more cost-effectively in military treatment facilities than in CHAMPUS, that cost advantage is balanced, indeed overwhelmed, by a second factor: the increased demand for care that greater access to military treatment facilities produces.

This so-called demand effect arises because transfers from CHAMPUS are not the only source of new workload in an expanded military treatment system. An expanded system would also pull beneficiaries who had previously been getting care outside the DOD system. In many instances, the individuals would come from households in which a family member was employed outside the military and was enrolled in a health plan sponsored by his or her employer.

According to the survey of beneficiaries conducted for the 733 study, about 60 percent of retired military families and 11 percent of active duty families have such third-party insurance coverage. These individuals form a large pool of "ghosts" who could be drawn into the MTF system if greater access were made available.

Why such individuals would attempt to receive care in military treatment facilities is clear. Treatment obtained through third-

party insurance ordinarily involves cost-sharing. In contrast, treatment in military treatment facilities generally involves few or no copays or deductibles. Hence, especially for very costly procedures, those with third-party insurance have a large financial incentive to seek treatment in a military treatment facility.

Shifts from insurance to MTF's are the dominant source for the cost increases that we found, but there is a second source and that would be increased utilization. People already within our system may use that system more if they had greater access to it. That would add an additional 3 cases to the example I gave, so that, in total, for every 10 cases attracted from CHAMPUS through an expansion of MTF capacity, DOD would see an additional increase of approximately 9 cases. These additional cases constitute the demand effect associated with military treatment facilities.

This effect is very important in terms of its implications for costs. While it might be less expensive to treat in military treatment facilities the 10 cases that come from CHAMPUS, DOD would be treating a total of 19 new cases in military facilities, while saving the CHAMPUS costs of only 10.

This demand effect produces a near doubling of the CHAMPUS workload transferred to military treatment facilities and thus dominates the 10 to 24 percent cost savings on a marginal cost basis.

Let me just sum up. I see my time is expired.

The three central findings of the 733 study were as follows: First, the central conclusion of the study with regard to wartime requirements was that the wartime requirements for medical care have declined significantly from the levels planned for during the cold war. Sized to the expected casualties and the conflict scenarios that are the basis for the bottom-up and other strategic reviews by the Department, the military medical system would require approximately 9,000 hospital beds in continental U.S. military facilities and would need 9,000 active duty and reserve physicians, plus as many as an additional 5,500 physicians to support the training, rotation base and other support functions. That means a total of about 14,500 physicians.

Second, in peacetime, despite lower marginal costs at military treatment facilities, expanding access by retaining excess capacity as space available for nonactive duty beneficiaries does not necessarily reduce DOD's overall medical costs.

Third, the study suggests two approaches for achieving a more cost-effective military medical system in view of the first two conclusions. One approach would be to reduce the size of the military treatment facility system to that required for the wartime mission only, a policy that implies a substantially smaller in-house medical structure and thus significantly more buying of medical care for DOD's beneficiaries. The other approach would be to reform the system by addressing the demand effect on overall costs.

Together with quantifying the wartime requirement for medical care, identifying management of the demand effect as the key to controlling DOD's medical costs is the primary contribution of this study. DOD can cost-effectively size to its peacetime requirements only if it manages utilization through some combination of single plan enrollment, collection of payments from third-party insurers,

and managed care and capitation budgeting. If DOD is unable to implement these initiatives effectively, then sizing to wartime requirements would be the most cost-effective alternative.

That concludes my prepared statement. I'd be happy to answer any questions.

Mr. MICA. I thank you, Mr. Lynn.

[The prepared statement of Mr. Lynn follows:]

PREPARED STATEMENT OF WILLIAM J. LYNN, DIRECTOR, OFFICE OF PROGRAM ANALYSIS AND EVALUATION, DEPARTMENT OF DEFENSE

1

I am pleased to be here today to testify on the results of the Defense Department's two-year study of the military medical care system. Congress directed this study in Section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993. Further direction was provided in Section 723 of the fiscal year 1993 National Defense Authorization Act. The thrust of these directions was to:

- Determine the size and composition of the medical system needed to support the armed forces during a war or lesser conflict in the post-Cold War era;
- Determine what adjustments should be made in the medical system in order to enhance the cost-effectiveness of the medical benefits provided during peacetime; and
- Respond to other, more detailed requests concerning military medical issues.

We completed all of the study requirements in April 1994, and submitted to Congress a series of reports, including:

- An Executive Report presenting the primary conclusions of the study, which I will discuss today;
- A report describing wartime medical requirements, the unclassified findings of which I will summarize for the committee;
- A report addressing several other medical issues on which the Congress requested information; and
- Three supporting papers prepared by the RAND Corporation and the Institute for Defense Analyses (IDA).

Since that study was completed, the ASD(HA) has begun to implement the TRICARE program, described in Dr. Joseph's testimony.

Current Military Medical Care System

Let me begin by briefly describing salient aspects of the military medical care system. This will provide a basis for my subsequent comments on wartime requirements and peacetime medical care issues.

Approximately 8.7 million people were eligible for DoD health benefits during fiscal year 1993. Active-duty personnel (1.9 million) and their dependents (2.7 million), including the active reserves, accounted for 53 percent of the DoD beneficiary population. The remaining 47 percent (or 4.1 million beneficiaries) was made up of retired military personnel and their dependents and survivors.

Health care services for DoD beneficiaries are provided by "military treatment facilities" (MTFs) operated by the military departments. There are three main categories of MTFs: clinics, community hospitals, and medical centers. During the period of the study, DoD operated eighteen facilities classified as medical centers, 99 community hospitals, and 29 independent clinics. The eighteen medical centers in the DoD system account for the largest share of the MTF workload. In 1992, about 57 percent of MTF inpatient care (adjusted for case-mix severity) and 34 percent of outpatient visits were handled in medical centers. The 99 DoD community hospitals handled 43 percent of the MTF inpatient workload and 60 percent of the MTF outpatient workload. The 29 clinics that reported their workload separately from other medical facilities accounted for the remaining 6 percent of outpatient workload. (There were more than 400 clinics in the United States; all but 29 of these, however, report through community hospitals or medical centers.) Overall, the medical centers provided the greatest share of their care to retirees and their family members, while the community hospitals and clinics served primarily active-duty members and their dependents.

First priority in MTFs is given to active-duty personnel, who are required to use military facilities for their medical care. All other DoD beneficiaries are provided treatment in MTFs only on a space-available basis. Prior to 1966, if MTFs could not provide the treatment these beneficiaries required, they had to arrange and pay for their own medical care. That changed with the inauguration of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in 1966. In broad terms, CHAMPUS provides supplemental health care coverage, available automatically to qualified DoD beneficiaries.

CHAMPUS does not cover active-duty personnel because, apart from emergency situations, they are required to obtain medical care from (or through) MTFs. CHAMPUS also is not available to retirees over age 65, or to their dependents or survivors over age 65, because these individuals are eligible for Medicare. CHAMPUS, then, is a program for the families of active-duty personnel, and for retirees and their dependents and survivors under age 65. CHAMPUS is an important component of the care received by DoD beneficiaries. In fiscal year 1992, CHAMPUS expenditures stood at about $3.5 billion (including the costs to beneficiaries). This was nearly as large as the approximately $3.9 billion DoD spent on non-active-duty beneficiaries in the direct care system. Thus, CHAMPUS accounts for almost half of the costs of medical care delivered to non-active-duty beneficiaries through the DoD system.

Wartime Requirements

Section 733 of the 1992 authorization act directed DoD to examine the current size of the military medical system in light of the projected requirements of U.S. forces for medical care in a conflict. This study represents the first comprehensive examination of this issue undertaken by the department since the end of the Cold War.

To assess wartime demands for medical care, the study drew on hypothetical conflict scenarios developed by the Joint Staff for use in preparing the FY 1994-99 defense program. The scenarios posited nearly simultaneous conflicts in Southwest Asia and Korea. Wargames and other well-established techniques were used to estimate the number and types of casualties that could result from the conflicts, and to determine the medical structure and personnel that would be needed in theater and in the continental United States (CONUS) to care for wounded and ill personnel. While the details of the analysis are classified, I would like to share with you this afternoon an unclassified summary of the principal results.

The central conclusion of this portion of the study is that wartime requirements for medical care have declined significantly from the levels that prevailed in the Cold War era. The decline has occurred not only because of reductions in the number of active-duty and reserve forces presumed to be committed to a conflict, but also because of changes in the expected nature of conflicts.

To treat casualties evacuated to the United States as a result of two nearly-simultaneous major regional conflicts, the United States would require approximately 9,000 hospital beds in CONUS military medical facilities. About 4,100 active-duty and reserve physicians would be needed to staff the hospitals in both CONUS and the conflict theaters. Another 4,900 active-duty and reserve physicians would serve outside the hospital system, working with combat units, outpatient clinics, and the medical evacuation system. Accordingly, the total base-case wartime requirement calls for approximately 9,000 active-duty and reserve physicians. To support this wartime requirement, the United States may need to augment the force with as many as 5,500 additional active-duty and reserve physicians for training, rotation base, and other support functions.

The table below compares the wartime requirements generated by the study with the resources provided in the FY 1999 defense program, as described in the President's FY 1995 budget request. As you can see, the CONUS medical facilities and active-duty personnel currently programmed for fiscal year 1999 exceed the projected wartime needs of a two-theater conflict in Southwest Asia and Korea. The analysis conducted for this study indicated that medical demands in CONUS could be met by about one-third of the 30,000-bed capacity of the MTFs planned to be operating in FY 1999. Similarly, about half of the active-duty physicians projected to be available in FY 1999 would be needed to meet wartime requirements.

Table 1.
Medical Requirements Comparison:
FY 1999 Program versus Concurrent Scenario*

	CONUS Beds	Active-Duty Physicians	Reserve Physicians	Total Physicians
FY 1999 Program	30,000	12,600	6,500	19,100
Concurrent Scenario (Base Case)	9,000	4,000	5,000	9,000
Concurrent Scenario (Augmented)	N/A	6,300	8,200	14,500
Percentage of FY 1999 Programmed Level	30	33-50	75-125	50-75

* Figures show approximate requirements, all numbers rounded.

In conducting this analysis, every effort was made not to reduce the medical force below the levels needed to provide ample support to military forces in combat. Modeling assumptions were made that tended to increase rather than decrease requirements. The result was a conservative estimate of wartime medical requirements. The estimate provided more beds per deployed soldier, airman, marine, and sailor than were provided in Korea and Vietnam, and about two times more physicians per bed than were available in Korea, Vietnam, or the Persian Gulf war.

Peacetime Medical Care

The estimate of wartime requirements formed the basis for our assessment of the peacetime medical benefit. The central question considered in the analysis was: Should DoD reduce its medical establishment to support the much smaller wartime mission now envisioned, or should it maintain some of the excess capacity

in order to provide peacetime care to non-active-duty beneficiaries? If the medical establishment were sized strictly against wartime requirements, substantially fewer hospitals, doctors, and other military medical personnel would be needed than the defense program provided. A reduction in peacetime medical care, however, would push many beneficiaries from MTFs onto CHAMPUS. Thus, reducing the MTF system implies an expansion of the CHAMPUS program. A shift of workload from MTFs to CHAMPUS would have had many implications for DoD beneficiaries, including the impact on quality of care and convenience to the beneficiary population. But the threshold issue was whether such a shift would reduce or increase DoD health care costs overall. This was the question addressed in the study, and it is the central issue that I would like to discuss today.

To assess whether total DoD health care costs would rise or fall with changes in the capacity of the MTF system, the Department investigated the effect of a hypothetical increase in MTF capacity on the demand for MTFs and CHAMPUS care. The simulation was based on data from DoD databases, a survey of beneficiaries conducted as part of this study, and other sources. RAND built a model of beneficiary behavior that captured the effects of various factors on beneficiary demand for health care--including the relative availability of military treatment facilities. IDA built a cost model for the MTF system that included a number of costs not captured in previous models. These costs were included in an effort to create an "apples-to-apples" comparison between the price of care provided through MTFs and that provided through CHAMPUS. Together, these models enabled us to estimate changes in MTF and CHAMPUS utilization and the costs to DoD and its beneficiaries.

Whether greater access to the MTF system would cause DoD health care costs to rise or fall turns on two questions: First, for identical workloads, are MTF costs higher or lower than CHAMPUS costs? Second, would an expanded MTF system (or one made more accessible as active-duty populations fall) pull in only CHAMPUS users or would it attract other DoD beneficiaries as well, and would all users increase their utilization because of the lower beneficiary cost share in MTFs? I will discuss each of these factors in turn.

The first factor is the relative cost of providing a given amount of care in MTFs versus obtaining that care through CHAMPUS. I must stress that the issue is the cost of a *given* workload--ten cases from CHAMPUS becoming ten cases in an MTF, for example. Our study concluded that MTFs can provide care less expensively on a case-by-case basis than can CHAMPUS. For a given workload,

we found a price advantage of 10 to 24 percent for MTFs relative to CHAMPUS. These savings are shared between the Defense Department and the beneficiaries themselves. Previous studies have attributed a somewhat larger cost advantage to MTFs. Those studies did not fully account for all relevant costs, however. In particular, they omitted facilities costs. Our study employed a much more comprehensive measure of costs that lowered, but did not eliminate, the MTF cost advantage.

Several qualitative points supported the conclusion that MTFs should be able to provide care more cheaply than CHAMPUS. First, MTFs provide care in what are usually more austere settings than are found in civilian facilities--fewer private rooms, simpler amenities, and so on. Second, with notable exceptions, the military system is under less pressure to adopt unproven technologies, thereby slowing the pace of technology-induced cost growth. Third, DoD is relieved from financial responsibility when malpractice claims are upheld in court. Fourth, DoD is responsible for almost no indigent care. Finally, because our physicians are in essence salaried employees and not contractors within the hospital system, there is far less economic incentive for DoD doctors to prescribe greater amounts of testing and treatment.

Although, for these reasons, the Defense Department could provide care more cost-effectively in MTFs than CHAMPUS, this cost advantage is balanced by a second factor--the increased demand for care that greater access to MTFs produces. This so-called "demand effect" arises because transfers from CHAMPUS are not the only source of new workload in an expanded MTF system. An expanded system would also pull in beneficiaries who had previously been getting care outside the DoD system. In many instances, the individuals would come from households in which a family member was employed outside the military and was enrolled in a health plan sponsored by his or her employer. According to the survey of beneficiaries conducted for this study, about 60 percent of retired military families and 11 percent of active-duty families have such third-party insurance coverage. These individuals form a large pool of "ghosts" who could be drawn into the MTF system if greater access were made available.

Why such individuals would attempt to receive care in an expanded MTF system is clear. Treatment obtained through third-party insurance ordinarily involves cost-sharing. In contrast, treatment in MTFs is essentially free. Hence, especially for very costly procedures, those with third-party insurance may have a large financial incentive to seek treatment in an MTF. They have less incentive to

shift from private insurance plans to CHAMPUS, however, since CHAMPUS (like most private plans) incorporates copayments and deductibles.

Shifts from private insurance plans to MTF care are the dominant source for the cost increases generated by increased MTF access. Overall--considering both inpatient and outpatient care--RAND found that for every ten patients pulled into MTFs from CHAMPUS, the MTFs would also see about six patients who otherwise would have sought treatment through third-party insurance or would have deferred care. This result is very important in terms of its implications for costs. While it might be less expensive to treat in MTFs the ten cases that come from CHAMPUS, DoD would be treating a total of 16 new cases in military facilities, while saving the CHAMPUS costs of only ten.

A secondary aspect of the increase in utilization arises because expanding the free care offered by MTFs tends to increase the rate of utilization of medical services by those who seek care in the DoD system. Increased rates of utilization add about three cases for every ten pulled from CHAMPUS.

In total, then, for every ten cases attracted from CHAMPUS through an expansion of MTF capacity, DoD would see an additional increase of approximately nine cases. These additional cases constitute the demand effect associated with increased MTF capacity. This demand effect produces a near doubling of the CHAMPUS workload transferred to MTFs, and thus dominates the 10 to 24 percent case-by-case cost advantage of MTFs.

An important potential offset for this increased demand for MTF care is the assignment of financial responsibility for those with a civilian employee in the household who has private insurance and for those beneficiaries eligible for Medicare. If DoD shifts ten cases from CHAMPUS to MTFs, costs are reduced to the extent that the cost of treatment in MTFs is less than the price paid for care obtained through CHAMPUS. If DoD cares for additional beneficiaries with third-party insurance, and their insurance covers the cost of care in MTFs, there would be a smaller additional financial burden on DoD.

Currently, we collect relatively little from those with third-party insurance who obtain treatment in MTFs. There appears to be adequate statutory authority to make the appropriate collections. The problem is execution. DoD is making progress in this regard, but still has a long way to go. Thus, the large portion of the demand effect due to those with third-party insurance remains a major cost

consideration.

DoD is not today in a position to exploit the MTF cost advantage by retaining work in the MTF system. When we pull cases from CHAMPUS into MTFs, the sum of DoD and beneficiary costs for the transferred workload falls by 10 to 24 percent. But a significant number of new cases would simultaneously be attracted into the system, adding to MTF costs without generating commensurate reductions in other DoD costs. The net result is a significant increase in the costs of the DoD health program.

Conclusion

In conclusion, I would like to summarize the three key findings of the 733 study.

First, the central conclusion of the study is that wartime requirements for medical care have declined significantly from the levels planned for during the Cold War. Sized to the expected casualties in the conflict scenarios that are the basis for the Bottom-Up Review, the military medical system would require approximately 9,000 hospital beds in CONUS military medical facilities and 9,000 active-duty and reserve physicians, plus as many as 5,500 physicians for training, rotation base, and other support functions.

Second, in peacetime, despite lower marginal costs at MTFs, expanding access by retaining this excess capacity as space available for non-active duty beneficiaries does not reduce DoD's overall health care costs. With respect to marginal costs alone, the study found that for a given workload, MTFs can provide care 10 to 24 percent less expensively than CHAMPUS. However, as the pool of active duty beneficiaries draws down making space available at MTFs, these facilities attract new utilization both from beneficiaries who otherwise would have used CHAMPUS as well as from those who would have sought treatment through third-party insurers or deferred treatment altogether. In addition, the availability at MTFs of care requiring no co-payments or deductibles would tend to increase these beneficiaries' utilization of MTFs. In sum, for every ten former-CHAMPUS cases that fill the space available in MTFs, at a somewhat lower cost to DoD, nine cases arise from this demand effect, the additional cost of which dominates the lower marginal costs at MTFs.

Third, the study suggests two approaches for achieving a more cost-effective military medical system in view of the first two conclusions. One approach would be to reduce the size of the MTF system to that required for the wartime mission only, a policy that implies a substantially smaller in-house medical structure and significantly more "buying" of medical care for DoD's beneficiaries. The other approach, one that attempts to take advantage of the cost advantage in MTFs, would reform the system by addressing the demand effect on overall costs. Together with quantifying the wartime requirement for medical care, identifying management of the demand effect as the key to controlling DoD's medical costs is the primary contribution of this study. DoD can cost-effectively size to its peacetime requirements only if it manages utilization through some combination of:

- Single-plan enrollment and assignment of responsibility for the employer share of health care costs
- Collection of payments from third-party insurers
- Managed care and capitation budgeting, possibly including copayments and deductibles for care received in MTFs.

If DoD is unable to implement these initiatives effectively, then sizing to wartime requirements becomes the cost-effective alternative.

This concludes my prepared statement. I would be happy to take your questions.

Mr. MICA. And we will turn now to Dr. Stephen Joseph.

Dr. JOSEPH. Thank you, Mr. Chairman. I welcome this opportunity to present some of the elements of our complex system to you. Like the others, I would ask that my more extensive prepared remarks be inserted in the record.

Mr. MICA. Without objection.

Dr. JOSEPH. And I've chopped down my verbal remarks. If I leave out any of the meat, such as the details of the structure of TRICARE that you are not familiar with, we can go back into those on the questions.

Mr. MICA. Mr. Moran and I are prepared go after the meat with a cleaver if you should leave any out. Go ahead.

Dr. JOSEPH. Well, then, at the outset, let me say that a major conversion of military health care to FEHBP is not a good idea. It would be disastrous to readiness and unacceptably expensive for our beneficiaries. It would increase the risks to the health of our troops whom we send into harm's way.

Furthermore, to continue patient benefits at the same level we provide within the Military Health Services System, which we believe to be an obligation, the recent CBO report states would cost the Government an additional $3.1 billion annually.

Mr. Chairman, there is a single mission for the Military Health Services System. Let me quote it.

"We are ready to provide top-quality health services whenever and wherever needed in support of military operations and to the members of the Armed Forces, their families, and others entitled to DOD health care."

This mission weaves together the care provided to our active duty personnel with the care provided to all other beneficiaries. These responsibilities are not separable. To actually provide top-quality health services, we must have the means to practice professional skills, not only those of our physicians but also our nurses, technicians, physician's assistants, nurse clinicians, hospital corpsmen, and others who may be faced with saving the life of a wounded or seriously ill soldier, sailor, marine, or airman.

Uniquely critical to military medicine is the professional medical training for enlisted medics, hospital corpsmen and independent duty corpsmen. These individuals must be able to recognize critical signs and symptoms, administer correct lifesaving techniques and to stabilize patients sufficiently well to get to the physician.

On the front lines and ships at sea, our medics and independent duty corpsmen are the initial and sometimes the only medical professionals our military men and women have to advise and indeed save them. These medics cannot gain the full required measure of their training anywhere, I repeat, anywhere except in military medical facilities.

Sustaining professional skills also requires training on how to lead a convoy, command a hospital, run a hospital ship, how to set up in a field environment, how to evacuate patients and to where, how to decontaminate chemical casualties, what the echelons of care are where you and your ship or unit are located, how to gain supplies and resupply, how to communicate with the next echelon, where to contact a specialist, how to call in the MEDEVAC chopper and so much more. These are professional military skills our medi-

cal personnel, physician and combat medic alike, must know in order to provide top-quality health services to deployed forces.

In the President's fiscal year 1996 budget, the military medical system seeks $15.5 billion. This includes just over $10 billion in the Defense Health Program appropriation and $5 billion in the three military departments' military personnel appropriations.

Of the $10 billion DHP, more than $6 billion is for the direct care system, that is our own military hospitals and clinics; and about $4 billion is for the CHAMPUS program, including the new TRICARE Managed Care Support Contracts.

The quality of care provided in military medical facilities is better than that provided in nonmilitary medical facilities. I do not say this idly, but I'm happy to provide some supporting documentation.

On the two charts, you can see that DOD hospitals have outscored all other hospitals in the Nation in their accreditation by the Joint Commission on Accreditation of Health Care Organizations. In fact, last year military hospitals outscored nonmilitary hospitals in all 17 patient categories, and four of our hospitals received accreditation with commendation, as shown in the second chart.

I would be happy to provide the committee with other specific indications of the quality of this system.

Our fiscal year 1996 budget request includes funding for 104,000 military and 45,000 civilian health care personnel. We operate 124 military centers and hospitals and 504 ambulatory care clinics in support of our 8.2 million eligible beneficiaries worldwide.

But active duty personnel are usually healthy and fit. The question is, who will military medical personnel provide everyday care to in order to retain their professional technical medical skills? It is the population which is eligible for care in military medical facilities, our family members and retirees.

If the Military Health Services System did not exist, the U.S. Armed Forces would not have well-trained, experienced military medical professionals to support them in their everyday activities, their exercises and operational deployments, and in times of war. Bluntly, but not as an overstatement, significant numbers of our soldiers, sailors, airmen and marines would die unnecessarily. That, in my view and I believe in the view of their families, is totally unacceptable.

Faced with the challenge of maintaining a top-quality medical system in these times of restraint and downsizing, ready to deploy at any time and to provide care to more people than possible within the military medical infrastructure, we have found smarter ways to organize, to plan, to budget, and to manage health care. In a word, our challenges are met in TRICARE, which brings together the three military systems of health care in a collaborative way, both for the readiness mission and for the so-called peacetime health care mission, and changes our budgeting basis from one that is workload driven to one that is capitation driven.

I'm going to skip a description of the triple option and the various structural elements of TRICARE because of time. But I, of course, would be happy to respond to your questions about them.

Mr. Chairman, to have a fully prepared, skilled, and trained military medical capability to support the Armed Forces, there must be a functioning military health care delivery system. Consequently, it is unclear what savings, if any, would be realized by downsizing the Military Health Services System to, "purely," wartime requirements.

If our medical personnel do not practice their professional medical skills in our medical facilities, the only other alternative is to send them to civilian hospitals. This has been advocated by some; however, it is an option that has not been proven to be cost-effective. It omits entirely military professional training and certainly would not be able to fulfill the necessary training for our corpsmen, our combat medics and our frontline personnel.

I would be happy to go further into some of the issues that have been thrown around about trauma training in inner city hospitals. The recent CBO paper that has been discussed suggested downsizing the direct care system from 120 to 11 military hospitals and shifting all but 35 percent of active duty care to the civilian sector.

I have a chart with some of the CBO findings. You've seen the CBO's three options, for downsizing this system, eliminating CHAMPUS, going to the outside market, and providing all non-active duty beneficiary health care through the FEHBP program.

My concerns with this paper include the following: First, CBO does not include the closure costs to downsize the direct care system but stated it would take 5 to 10 years before the Department could realize projected savings from downsizing the direct care system.

Next, only the first of CBO's three options produces a savings for the Department and that is achieved by shifting a significant amount of the Department's costs to its beneficiaries. This cost shift is demonstrated on the other chart.

You can see that, under TRICARE, active duty families have an annual out-of-pocket cost of about $160 and retirees and their families have an annual out-of-pocket cost of about $800. Under FEHBP HMO options, these costs would range from $1,700 to $2,500 annually, and that's without the increase in the beneficiary costs that I read about in the Washington Post this morning.

Again, let me point out that if DOD were to maintain a benefit level comparable to what our beneficiaries enjoy under TRICARE Prime, the cost to the Government would be an additional $3 billion annually.

Finally, nowhere in the CBO paper is the necessity of professional skills maintenance, both medical and military, addressed for all military medical personnel. It is unclear how the military would be supported medically during extended cruises, operational commitments around the globe, et cetera.

Savings generated by downsizing the military health services to its wartime requirements remain questionable, and if such savings could be identified they should not be accrued at the expense of either medical readiness or the beneficiaries.

I would be happy in the question period to talk about the fact that we have actually come down to about half the national rate of inflation in medical care costs in the Military Health Services

System. I think that's the most telling indicator about whether we are efficient or not.

In our efforts to consider all possible alternatives for readiness, cost-effectiveness and beneficiary health care, we have in progress an analysis to determine the advantages and disadvantages of including the FEHBP as a fourth option of TRICARE for those beneficiaries who might wish it.

On the surface, such an option would seem to offer two advantages: First, it would continue to cover retirees beyond the age of 65, which our military medical facilities also do, but which, as you know, CHAMPUS does not; and, second, FEHBP might be available in a number of locations where only standard CHAMPUS is available. But counters to these advantages include the hefty cost borne by beneficiaries and the fact that FEHBP is not available everywhere either, particularly in remote and isolated areas where the problem of coverage is at its greatest.

Our analysis of the FEHBP as an option is in its formative stages with a projected completion date of March 1996; and we will be happy to furnish it to the committee when it's available.

In closing, Mr. Chairman, it's my belief that TRICARE is the most cost-effective delivery system and is the only system which can ensure that the men and women of the Armed Forces have top quality health care wherever and whenever they and their families may need it.

In good conscience, I cannot support a Military Health Services System that does not fulfill our obligations to our troops, those who serve today and those who have served so well in years past.

If I can beg just a minute's additional indulgence, Mr. Chairman, I heard before coming over here the testimony of Mrs. Jones. I want to be clear that was not a good episode of medical care. We believe it was the kind of exception that proves the rule.

And at the pleasure of the committee, I would like to provide to you and enter into the record the letter that Mrs. Jones was sent by the Inspector General, 89th Airlift of the Air Force apologizing for that episode of care and discussing some of the factors that led to her situation.

Thank you. I'd be happy to answer your questions.

Mr. MICA. Thank you, Dr. Joseph, for your testimony.

[The prepared statement of Dr. Joseph follows:]

PREPARED STATEMENT OF STEPHEN C. JOSEPH, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Mr. Chairman, Distinguished Members of the Committee, it is a privilege and my honor to appear before you today. I welcome this opportunity to present the Military Health Services System and our initiatives to cost-effectively ensure the health of our troops, our retirees and their families. Our task is unique in that we are the only U. S. health care system that goes to war. And, that is the foremost responsibility entrusted to military medicine.

I want to respond in some detail to the questions you posed, Mr. Chairman, but first I will briefly summarize my view of military medicine and the FEHBP issue at hand.

* Military medicine's primary responsibility is readiness and today it "ain't broke!"
* TRICARE is essential to readiness, a fact clearly misunderstood!
* TRICARE enhances cost-effectiveness, high quality care, and patient satisfaction.
* FEHBP is undergoing our review as an option with results due in March 1996.

Wholesale conversion of military health care to FEHBP is not a good idea. It would be disastrous to readiness and unacceptably expensive for our beneficiaries. Very important to us, and I am sure to you, it would increase the risk to the health of our troops who we send into harm's way. Furthermore, to continue the patient benefit at the same level we provide within the Military Health Services System, which we believe to be an obligation, the recent CBO report states it will cost the government an additional $3.1 billion.

Now, let me turn to details of military medicine and answer the questions posed in your letter, Mr. Chairman.

There is a single mission for the Military Health Services System. It is that:

We are ready to provide top quality health services, whenever and wherever needed in support of military operations, and to members of the Armed Forces, their families, and others entitled to DoD health care.

This mission weaves together the care provided to our active duty personnel with the care provided to all other beneficiaries. These responsibilities are not separable. Separability is a misconception of some who analyze and report on the military medical system of health care delivery. To provide top quality health services we must have the means to practice professional skills, not only our physicians, but also our nurses, technicians, physician assistants, nurse clinicians, hospital corpsmen, and others who may be faced with saving the life of a wounded or seriously ill soldier, sailor, marine or airman.

To maintain professional skills means taking care of patients, sick and injured patients who need extensive evaluation and detailed lab work, patients who need bones set, patients who need delicate or restorative surgery. Uniquely critical to military medicine is the professional medical training for enlisted medics, hospital corpsmen, and independent duty corpsmen. These individuals must be able to recognize critical signs and symptoms, to administer correct life-saving

techniques, and to stabilize patients sufficiently well to await a physician. On the front lines and in ships at sea, our medics and our independent duty corpsmen are the initial, and sometimes the only, medical professionals our military men and women have to advise, counsel, treat, and indeed save them. These medics cannot gain the full required measure of their training anywhere, I repeat: **anywhere**, except in military medical facilities.

Sustaining professional skills also requires training on how to lead a convoy, command a hospital or run a hospital ship, how to set up in a field environment, how to evacuate patients and to where, what the echelons of care are and where you and your unit or ship are located, how to gain supplies and resupply, how to communicate with the next echelon, where to contact a specialist, and so much more. These are the professional military skills our medical personnel -- physician and medic alike -- must know in order to provide top quality health services to deployed forces. These deployments may be for any of a continuum of military operations: humanitarian support, disaster assistance, quelling civil unrest, peacekeeping operations, as well as conflict and war. Military medical personnel must be prepared today and everyday.

Military Medical System & Readiness (Includes CHAMPUS Operations and Financing)

The Military Health Services System is an extensive system with tremendous capabilities. In the President's FY 96 Budget, the military medical system seeks $15.5 billion. This includes just over $10 billion in the Defense Health Program (DHP) appropriation and $5 billion in the three military departments' military personnel appropriations.

The $10 billion DHP amount includes a little more than $6 billion for the direct care system, that is, our own military hospitals and clinics, where over 70 percent of our beneficiaries care is provided.

For the CHAMPUS program, which is also included in the $10 billion DHP, we requested almost $4 billion which includes funding for the TRICARE Managed Care Support Contracts as well as the standard fee-for-service CHAMPUS program.

The quality of care provided in military medical facilities is better than that provided in non-military medical facilities. Measures supporting this statement include higher accreditation scores from the Joint Commission on Accreditation of Healthcare Organizations, maximum licensure of physicians and dentists, and board certification of the majority of physicians.

The FY 96 Budget request includes funding for 104,500 military and 45,200 civilian health care personnel. The Military Health Services System operates 124 medical centers and hospitals and 504 ambulatory care clinics worldwide. The 8.2 million beneficiaries eligible for care in these facilities include:

* 1.7 million active duty,
* 2.4 million active duty family members,
* 1.1 million retirees under age 65,
* 1.8 million retiree family members under age 65, and

* 1.2 million Medicare-eligible military beneficiaries.

Military medical personnel must be prepared to deploy in support of our Armed Forces with little notice to any location in the world. Their skills, both medical and military, must be sharp and well-practiced. We can be certain of that only if they are doing military medical activities on a regular and routine basis. Active duty personnel are usually healthy and fit; they too must be prepared to deploy at a moment's notice. The question then is who will military medical personnel provide everyday care to in order to retain their professional technical medical skills. It is the population which is eligible for care in military medical facilities, our family members and retirees. If the Military Health Services System did not exist, the United States Armed Forces would not have well-trained, experienced military medical professionals to support them in their everyday activities, their exercises, in operational deployments, or in war. Bluntly, significant numbers of our soldiers, sailors, airmen and marines would die unnecessarily. That, in my view and I believe in their families' views, is totally unacceptable.

With the unprecedented changes in world politics, the national security strategy and objectives have been rewritten. The size of the Armed Forces has been reduced; the roles and missions of the military services have been evaluated and re-evaluated in light of the new strategy and objectives. In this whirlwind of change for the U. S. Armed Forces, military medicine also must change -- and it is.

The Military Health Services System, by the year 1997, will have closed 58 hospitals or 35 percent since fiscal year 1988, due to management initiatives, including the Base Realignment and Closure Act decisions. Military and civilian medical manpower has been reduced, deployable medical systems for field operations have been cut back, and the military medical budget has not kept pace with inflation, despite annual increases. Additionally, medicine in this country is grappling with significant change driven, in large measure, by the spiraling increases in health care expenditures. This change has impacts on the delivery of health care to military medical beneficiaries and on the Military Health Services System itself.

Military medicine, while declining in size, structure and manpower, has deployed medical units in support of our national interests to Haiti, Somalia, Rwanda, Kuwait, Croatia and Macedonia. Plus, military medicine continues to provide everyday health care...and everyday professional skills maintenance...for as many of its eligible population as is possible. And, that health care is of the highest quality: the military hospitals surveyed by the Joint Commission on Accreditation of Healthcare Organizations last year outscored non-military hospitals in all 17 patient care categories and four of our hospitals received accreditation **with commendation**.

TRICARE Program

Faced with the challenge of maintaining a top quality medical system to deploy at any time and to provide care to more people than possible within the military medical infrastructure, we found smarter ways to organize, to plan, to budget, and to deliver health care. In a word, our challenges are met in TRICARE.

Organizationally, TRICARE brings together the three military systems of health care in a joint and collaborative way to better support military operations and to better care for the whole beneficiary population. The United States has been divided by geographic regions, each administered by a military medical center commander who is known as the Lead Agent. All military hospital commanders within a region joined their Lead Agent in developing a comprehensive health care delivery plan for the entire region based on military support missions and on beneficiary profiles.

Analyses of our system of health care delivery have led to a significant modification in how we fund our health care operations. We changed from a workload driven system of budgeting to one of capitation. This initiative has the ability to alter provider incentives so that our patients receive the timely care they need in the most appropriate setting.

We brought the CHAMPUS program into the organizational structure of TRICARE, building on its authorities to purchase care from civilian sources for most categories of our beneficiaries. Seeking and awarding competitive managed care contracts for the TRICARE regions brings in supplemental support to round out health care capabilities to meet the needs of our beneficiaries in the event of a major deployment as well as in the everyday delivery of patient care.

TRICARE is a joint and collaborative effort which relies on Lead Agents, capitation funding and competitive managed care support contracts.

Let me turn to a brief description of TRICARE as a health care delivery plan. First, it is centered in the military medical facilities so that wherever there is a military hospital, a triple option benefit will be available to beneficiaries. Included in the triple option are a Health Maintenance Organization (HMO) called TRICARE Prime, a Preferred Provider Organization (PPO) called TRICARE Extra, and a fee-for-service option called TRICARE Standard.

The uniformity and stability of benefit is built into TRICARE. Both the scope of coverage and the beneficiary cost of coverage is the same for the three options anywhere those options are available. Access to care has been standardized across the entire system in terms of wait times and availability of some preventive examinations and their results. And, with the supplemental capability of the managed care support contractor, the majority of patients will be able to receive all the care they need in the vicinity of their residence.

The organization and budgeting initiatives inherent in TRICARE will result in a more effective health care delivery system. Unnecessary duplication of programs is being eliminated, consolidations of training programs, logistics, and support services are being accomplished. Each of these measures furthers our efforts to work jointly and to bring about an environment of interservice cooperation that will enhance the medical support capability in joint military operational deployments.

Of the TRICARE benefit options, only Prime is an enrollment option. As the option centered in the military medical facilities, Prime assists in identifying the majority of patients to

receive care within that facility or group of facilities. Further, each Prime enrollee will have a primary care manager to be the source for most of the enrollee's health care needs. Primary care managers offer beneficiaries continuity of care as well as familiarity and comfort with the system. Having non-enrollment options extends the ability of military medicine to offer coverage to beneficiaries not within an easy commute of a Prime plan and satisfies the issue of choice which is important to some of our beneficiaries.

TRICARE is a transformation of the Military Health Services System, a transformation in its implementation stages. Many of the management initiatives, organizational arrangements, and design elements have been accomplished, but the operational activities involving beneficiaries are just beginning. TRICARE is in the early stages of full implementation in our first region, Region 11, which includes the states of Washington and Oregon. Using the enrollment figures in that region as one measure beneficiary knowledge of TRICARE, we have over 100,000 beneficiaries enrolled after only six months and our projected enrollment for the first year was less than a third of that number.

As the full implementation of TRICARE draws near within a Region, the tempo of educational activities for both beneficiaries and providers increases dramatically. In the interim, we continue to speak with beneficiary groups, advocacy organizations and representatives of the media to let military medical beneficiaries know that TRICARE is a major change to military health care delivery and it will be implemented across the United States by fiscal year 1997. Any health care plan is detailed and can be rather complex. It is our intent to continue to pursue all opportunities to talk about TRICARE and what it means to the military, to individual service members, to health care providers, to corporate health care, and especially to our beneficiaries.

TRICARE supports our readiness requirements, it sustains the skills of our medical personnel, it realigns our organizational structures, it introduces appropriate incentives, it has appeal to the majority of our beneficiaries, it is a partnership between public and private health care systems, and it affords military medicine flexibility to meet its range of responsibilities.

TRICARE Prime today does not include, and under the proposed TRICARE regulation would not include, our Medicare eligible beneficiaries

At present we estimate that military medical facilities provide care to the equivalent of 320,000 Medicare-eligible military beneficiaries at a cost of about $1.4 billion annually. The cost of caring for all military Medicare-eligible beneficiaries who might want to participate in TRICARE Prime is more than the Department can afford. In an effort to fix this problem, we have begun working with the Health Care Financing Administration (HCFA) to setup a demonstration project wehre DoD could continue to care for its Medicare-eligible beneficiaries.

Costs/Savings

Mr. Chairman, you asked what savings could be realized from downsizing the military health care system to its wartime mission only. As I have indicated, to have a fully prepared, skilled and trained military medical capability to support the Armed Forces in all of its mission

responsibilities, there must be a functioning health care delivery system. Consequently, it is unclear what savings, if any, would be realized by downsizing the Military Health Services System to "purely" wartime requirements.

The total wartime and operational support requirements are currently being refined, updated, and quantified by the Department. This analysis will be used to update the results of the April 1994, Section 733 Study of the Military Medical Care System, which was directed by section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993.

Once the total wartime and operational support requirements of active duty military medical personnel are determined, we must ensure that they are properly trained and continue to maintain their medical proficiency and required wartime skills. The best and most cost effective way, and for some the **only** way, to achieve this objective is by having our personnel deliver health care services to our eligible beneficiary population in our direct care system of military medical facilities. An important point to note is that the 733 Study found that care provided in military medical facilities is the most cost-effective care provided.

If our medical personnel do not practice their professional medical skills in our medical facilities, the only other alternative is to send them to civilian hospitals. This has been advocated by some; however, it is an option that has not been proven to be more cost effective, it omits entirely military professional training, and it is filled with many unresolved obstacles and potentially serious problems.

The 733 study recommended several steps to eliminate potential military medical cost increases due to military medicine having a more attractive health plan. We are implementing these recommendations.

The recent Report by the Commission on the Roles and Missions (CORM) of the Armed Forces, dated May 24, 1995, also contained recommendations related to the DoD medical program which we are pursuing. Unlike early staff drafts of this report, the final document contained no recommendation to downsize the direct care system and move that care to the FEHBP. The cost effectiveness of such a recommendation could not be demonstrated.

The recent CBO paper "Restructuring Military Medical Care" (July 1995) suggested downsizing the direct care system from 120 to 11 military hospitals and shifting all but 33% of active duty care to the civilian sector. CBO developed three options for downsizing the direct care system, eliminating CHAMPUS, obtaining 67% of active duty health care from civilian sources, and providing all non-active duty beneficiary health care through the Federal Employees Health Benefits Program (FEHBP). My concerns with this paper include the following:

First, CBO did not include the closure cost to downsize the direct care system, but stated it would take 5 to 10 years before the Department could realize projected savings from downsizing the direct care system.

Next, only the first of CBO's three options produced a savings for the Department and that is achieved by shifting a significant amount of the Department's costs to its beneficiaries. And, the beneficiary costs would further increase if the proposed legislation is passed to increase the employee share of FEHBP premium contributions.

Finally, no where in the CBO paper is the necessity of professional skills maintenance, both medical and military, addressed for all military medical personnel. It is unclear how the military would be supported medically during extended cruises, operational commitments around the globe, field training exercises, and periods where military requirements are centered on the installations in the United States.

It remains unclear to me that there would be a savings generated by downsizing the Military Health Services System to its wartime requirements. In the first instance, wartime requirements must be clearly defined, then mechanisms must be in place to ensure continuous military and medical professional training, the process for identifying operational medical support requirements must be established, and saving should not be accrued at the expense of either medical readiness or beneficiaries.

I think it is very important that the Committee know something about the trend of DoD's health care expenditures. Prior to the Defense Health Program appropriation, from 1985 through 1990, DoD health care per capita rates, in constant FY 94 dollars, reflected the national annual increase. With the establishment of the Defense Health Program appropriation, from 1991 through the present time, that per capita rate has remained constant and is projected to **decline** through our program years. Additionally, the DoD rate of inflation for health care is half that of the nation and one-third that of HMOs. Clearly, the Military Health Services System is operating more cost-effectively than most health care systems in the country today.

Mandatory enrollment in FEHBP will not satisfy our medical readiness requirements, nor will it be willingly accepted by a significant number of our beneficiaries, nor will it produce savings. The FEHBP would seem to offer two advantages for some military beneficiaries. First, it continues to cover retirees beyond the age of 65, which our military medical facilities also do, but CHAMPUS does not. And, second, it is available in a number of locations where only standard CHAMPUS is (and standard TRICARE will be) available.

Some military Medicare-eligible beneficiaries may be interested in the FEHBP. However, those who reside near a military medical facility would choose the military facility as long as they could gain access. The FEHBP is significantly more expensive than TRICARE, and the strongest statements from our military retirees regarding their health care are about costs. Let me be clear on this point. By our estimates and without a significant infusion of new Federal funds, military retirees face significantly increased out-of-pocket costs under FEHBP.

In our efforts to consider all possible alternatives, we have in progress an analysis to determine the advantages and disadvantages of including the FEHBP as a fourth option of TRICARE for those beneficiaries who might wish it. This analysis is in its formative stages with a projected completion date of March 1996.

In closing, Mr. Chairman, it is my belief that TRICARE is the most cost-effective delivery system, and is the only system which can ensure that the men and women of the Armed Forces have top quality health care wherever and whenever they, and their families, may need it. It is the system that ensures we are ready, no matter what the military mission, to support that mission and to protect the health of our troops. In good conscience, I cannot support a Military Health Services System that does not fulfill our obligation to our troops...those who serve today and those who have served so well in years past.

Thank you. I would be happy to respond to your questions at your convenience.

Mr. MICA. I have a couple of questions. First, if I could ask the Lieutenant Colonel to put the first chart up there.

Dr. JOSEPH. You have those also in your packets.

Mr. MICA. I appreciate your bringing this chart which shows the performance and standing of the DOD hospitals and survey and accreditation. But, the problem appears to be access.

And you have heard just a couple of examples. Since we started getting into this, we have heard dozens, hundreds of examples of dependents and retirees—I mean, horror stories of people that are caught up in a system that is inefficient, that is treating them, as I said, in my opinion, as second-class citizens. That is the problem, is access, and the thing isn't working.

Do you want to comment?

Dr. JOSEPH. I certainly do. I certainly do.

The problem is access. In most of my hearings, appearances, I say that our top three problems in the system are access, access, and access. In managing medical care, you are always trying to balance to an optimum three things: cost, quality, and access.

In the current conditions of downsizing and budgetary restraint, access is our greatest problem. The way to remediate that problem is by the advantages of managed care, improving access while not sacrificing quality and cost.

I often also say I know how to satisfy my banker over here by driving down the cost of the system, and that's to close all the hospitals Wednesdays and Fridays, but that would be disastrous in terms of our access. So we are trying to balance those three efforts.

I don't believe that our system treats people as second-class citizens. I acknowledge that we have a significant access problem, and I would state that the way to solve the access problem is by improving the efficiencies of care through the sort of managed care systems that we are implementing.

Mr. MICA. Well, you heard what I have had to say. The Chairman of the Joint Chiefs of Staff said in the Navy Times, December 12, 1994, that DOD should consider alternatives to its health care system which is, "headed toward a cliff." I could also give you the rest of his statements where he said we should look at some of the options.

Mr. Moran, myself, and other members of this panel don't have the ability to go in and analyze what you are doing, what you have proposed for remedial changes, but we rely on folks like CBO. CBO has stated that the administrative changes DOD is introducing in TRICARE will fall short of what is needed to improve the delivery of peacetime health care.

Now, these are our experts, and this is the Chairman of the Joint Chiefs of Staff saying that we should consider options. And CBO, who has looked at this rather extensively, questions your cost estimates.

So how do you respond to that?

Dr. JOSEPH. Well, I respond to that by saying we think CBO is flat-out wrong. We think that there is ample support for what we're doing: one, from the GAO; two, from the committees of jurisdiction in the Congress for the TRICARE program. We are proceeding with this program basically under congressional mandate.

Three, I wouldn't put words in General Shali's mouth.

I know about that statement he made. I would suggest if you had him or any of the other chiefs up here, or any of the Surgeons General of the three services up here, what you would hear from them would be a strong endorsement of the managed care direction of the TRICARE process. Now, we can argue about whether I'm correct or you're correct, but that's my assertion of what they would tell you.

Mr. MICA. I'm not looking to put words into anybody's mouth, but I have comments from the Chairman of the Joint Chiefs of Staff saying specifically that it is no secret to you that with every year it is getting more and more difficult to get entry into the military health care system. He goes on and I would be glad to share his comments.

Dr. JOSEPH. I agree with that statement. I agree with that statement. I think what he would also say is that the approach that we're taking is the way to remediate that problem.

Mr. MICA. Again, our experts disagree with both your solution and the potential costs. And we are hearing from some of the dependent family organizations and others that they are even willing to pay to gain access.

Now, this is the Civil Service Subcommittee, so we don't have jurisdiction over all of DOD and the other things, but we do have jurisdiction over this particular Federal Employee Health Benefits Program. They have said that they are willing to even pay to participate and to have access.

We have heard from OPM, who manages it. We are looking at options. Our role here is that we see people who are crying out for some assistance. They say the system falls short of delivering what they need.

So do you object to us opening this up?

Dr. JOSEPH. Absolutely not.

Mr. MICA. We also have questions now being raised—I have the exhibit here, and I think Senator Stevens is overlooking the TRICARE system from the other side and has raised some questions. In fact, I believe he is going to put some of this program on hold while they examine it. I don't have the jurisdiction to do that.

But I have people, some of them sitting behind you, and hundreds have written to us and thousands out there that are looking for some solution to this, and we have 8 million people who are affected by the program. If we can take some of the pressure off, and they are willing to provide some of the costs—and you said, you know, there is a $3 billion solution. That is not necessarily what we want. If it takes more money to solve the problem, maybe that is it, but we are looking for some options.

So do you still object to our making this alternative available?

Dr. JOSEPH. Absolutely not, to your inquiry about it. And I hope I made that clear by saying we are now looking at an FEHBP option ourselves, and we are anxious to share that with the committee.

My cautions, which are in my printed statement, are that although it's early days yet, we're going to need to recognize that an additional FEHBP option, A, would be costly; and B, would not solve the greatest problem which—for the people in East Overshoe, MT, is their access. I think I heard some of that in the last panel.

The other thing I would say is that if you talk to the Military Coalition, the collection of 27 or 28 organizations of military beneficiaries, I think the very large majority, 80 or 90 percent of the organizations in the military coalition are not nearly as enthusiastic about the FEHBP option as has been proposed here. I think you might want to get a broader range of statements from the coalition.

Mr. MICA. Well, sir, I do submit that the problem isn't solely the access in Montana. I know there are a lot of folks in Montana who need the care, but when I have individuals like Ms. Jones, who is close to probably as many military facilities as you could find, and Mrs. Gildersleeve, who came up here at her own expense, and is also close to facilities in Florida. They have the problems they related to this subcommittee, and so we have a serious problem.

We do have jurisdiction over this program; and it appears from the testimony we have heard today that this problem could be handled in some cost-effective manner. These people are crying out for some access, so we are looking for a solution, and we will work with you. I don't want to be combative with the Department of Defense on the issue. But that is our purpose in holding this hearing and looking at these options.

Dr. JOSEPH. May I take 30 seconds back?

I certainly hope you didn't hear me say, Mr. Chairman, that I thought the only problem was in, let's say, Wyoming. That's clearly not the case. And I don't mean to denigrate at all the issues that have been raised by Mrs. Jones and others.

My statement there is I think it is important to look at the FEHBP option. I agree with you and the committee on that point. We are looking at it. It may turn out that it has some useful applicability for some of our beneficiaries.

My caution is that both on the basis of cost, on the basis of access in some areas and, most importantly, on the basis of the wholeness and health of our military readiness medical posture, we should not rush off the end of the cliff in thinking that this is the answer to the access problem, pure and simple. That's the only point I'm trying to make, sir.

Mr. MICA. Well, I get the final word. But, again, this is not the solution to all the access problems. It provides some alternative to people who are looking for that, and they have even expressed their willingness to pay for some of it.

So, with that final word, and I won't give you another opportunity to respond to me, I yield to Mr. Moran.

Mr. MORAN. Well, thanks a lot, Mr. Chairman. I think it is obvious that the chairman and myself, although we represent different parties and come from different parts of the country and really didn't come into this issue with any big ax to grind, although we are concerned about retiree families and so on, you know, we have a very similar perspective, probably identical perspective on this, issue. And we want to remain open-minded, but there are some questions that have been raised the more we delve into it.

First place, I am glad to hear you say that you are apparently open-minded about the possibility of FEHBP and you are studying it and I guess you will have a report due next spring.

Dr. JOSEPH. Yes, sir.

Mr. MORAN. Another 6 months. How long have you been working on the analysis?

Dr. JOSEPH. We began to look at the FEHBP option 2 or 3 months ago seriously. It was after the discussions of last spring and the CBO report of early summer.

Mr. MORAN. May I ask you why, when you were developing the TRICARE program, that you did not consider the situation that confronts people over the age of 65 and a possibility such as FEHBP being available to them?

Dr. JOSEPH. Yes, sir, I really welcome that question.

First of all, we were mandated by the Congress to construct a triple option managed care program with, as you've described to the earlier panel, the standard CHAMPUS, a preferred provider option, which is a kind of icing on the cake. It is not a major element in the system. And, the key to the system, the HMO option.

I left out of my testimony, second only to our access problem is the problem of financing the care of our Medicare-eligible retirees.

We currently provide about $1.4 billion a year in services to Medicare-eligible retirees, and we are not reimbursed at all by HCFA or the Medicare Trust Fund for that care. That is an enormous looming fiscal problem in the future of the Military Health Services System.

We have been working very hard within the administration and with Congress to find a solution whereby, from my point of view, there would be an equitable transfer of funds from Medicare to the DOD for those particular services. That was envisioned when TRICARE was being developed, when the structure was being developed, as the solution to the problem of the over–65-years retirees.

And I believe it would be the reason why we went in that direction, triple option plus a solution to Medicare reimbursement, rather than FEHBP or some other program.

Mr. MORAN. OK. Since you are both here representing the Department of Defense, what is the Department's official position with regard to the position that active duty military families, their dependents, and retirees—upon being recruited and entering the military services, were told that one of the benefits of entering the military service was lifetime free medical care?

What is the Department's official position on that?

Dr. JOSEPH. I think it is unquestioned that people believe that virtually every recruiter who—who has worked the field—that they promised that. I don't think the answer to that argument rests in the reality that the fine print both in the legislation and in Department policy never really said that.

I wouldn't rest my answer on that. My answer on that rests on the fact that, as we're seeing in many, many areas not restricted to DOD, the times and the requirements have changed. It is no longer possible for things to be available in the sense they were available 30 or 25 years ago.

And what we've been trying to do, sometimes with somewhat different perspectives, whether it is from the money side of the house or the program side of the house, is to find the best balance between the realities of these times and the requirements. This is reflected as we put in the benefit some forms of copayment while try-

ing to hew as close as possible to what people believe they were promised.

So, the Department will not deny that people believe that, and that there's a basis for that belief. But, the realities of today, and certainly the realities of 10 years from now, are quite different. And, we see that in the civilian sector with health care as well.

Mr. MORAN. So you are saying that, in fact, they are not all wrong that——

Dr. JOSEPH. Absolutely not.

Mr. MORAN [continuing]. Recruiters did tell them——

Dr. JOSEPH. Absolutely.

Mr. MORAN [continuing]. That and that there was a guarantee of free medical care?

Dr. JOSEPH. The guarantee, I believe, was somewhat different in the actual legislative language than it was in what the recruiters told them.

Mr. MORAN. I understand. But there was the assumption—in law, there is consideration given and people act according to a promise. And that, in effect, creates a contractual obligation. And DOD, you're saying, recognizes that contractual obligation?

Dr. JOSEPH. DOD is trying as——

Mr. MORAN. Since it was——

Dr. JOSEPH [continuing]. Carefully as it can to come as close to those beliefs and understandings as we can, given the realities of the situation.

Mr. MORAN. Let me just ask you on a—well, first of all, have you ever had any customer satisfaction surveys done?

Dr. JOSEPH. Yes, sir. I'd be happy to provide those.

Mr. MORAN. What do they show?

Dr. JOSEPH. They show generally very high customer satisfaction. Lowest marks, of course, on access. Highest marks on quality.

Our people also vote with their feet. One of the reasons for the ghosting that Mr. Lynn talked about may be financial advantage, but when our beneficiaries, particularly our retirees, are really sick, they want to be in the military hospital if they can get in. And, again, I think if we can solve the access problem, that one and the Medicare subvention are our two greatest ones.

We would be happy to provide the committee with some of our more recent customer satisfaction reports.

Mr. MORAN. That might be useful just to see them generally. I think it would be appropriate for the record here to have it included.

[The information referred to follows:]

Customer Satisfaction Survey

Satisfaction Category	Active Duty	Active Duty Family Members	Retirees. Family Members	Retirees and Family Members Age 65 and Over
Overall	3.2	3.2	3.6	4.0
Technical quality	2.8	2.9	3.3	3.7
Interpersonal concern	2.8	2.8	3.3	3.7
Communications	2.9	2.8	3.3	3.6
Finances	3.0	3.0	3.0	3.4
Access	2.7	2.7	3.0	3.3

Customer Satisfaction Survey—Continued

Satisfaction Category	Active Duty	Active Duty Family Members	Retirees, Family Members	Retirees and Family Members Age 65 and Over
Choice and continuity	2.2	2.2	2.7	3.2

This table shows both overall satisfaction and satisfaction with specific aspects of health care in military hospitals and clinics. Method used to calculate these numbers: The survey contains 34 related questions on satisfaction with care received in military facilities. For each question, the beneficiary rated their care on a scale from one to five where "1" is "poor", 2 is "fair", 3 is "good", 4 is "very good" and a 5 is "excellent". The values for related questions were averaged together to determine the values for the categories shown on the table. These numbers are based on preliminary analysis of the survey data and may be re-weighted so that the values better represent the DoD population. Highlights from the table include the following:

• Retirees and their family members are most satisfied on average. Active duty and their family members tend to be less satisfied. This pattern is consistent with past surveys of military personnel and may be related to age.

• On average, beneficiaries rate their care overall as "good" or better. Retirees and their family members age 65 and over rate their care overall as "very good."

• In terms of specific aspects of care, active duty households are most satisfied with technical quality and finances at military treatment facilities while retirees are most satisfied with technical quality and interpersonal concern.

• Beneficiaries are least satisfied with access and choice and continuity.

The information in this table comes from the 88,000 responses to the 1994/1995 Health Care Survey for DoD Beneficiaries. The survey went out during winter and spring of 1995 and achieved an overall response rate of about 53 percent. The survey asked about health care in the past 12 months.

Mr. MORAN. On a scale of 1 to 10, one being the least efficient, 10 being the most efficient use of medical resources possible, how would you rate the efficiency of the military medical facilities?

Dr. JOSEPH. I'll give you a straight answer if you will tell me whether you want me to do that relative to the rest of the American health care system or on an absolute scale?

Mr. MORAN. Let's try absolute.

Dr. JOSEPH. Absolute scale, I would say about seven. Relative to the rest of the American health care system, eight, eight and a half.

Mr. MORAN. OK. What would you consider the first one or two things that could be done to make it more efficient?

Dr. JOSEPH. The benefits in quality assurance and efficiency that come to a system with managed care, the access that improves with advocates and network providers, the kinds of advantages that come when you can share resources among three different color uniform facilities in the same geographic area, the kinds of benefits patients have when they can call an advice nurse 24 hours a day and save a trip to the emergency room.

I think, without question, that appropriately managed care, balancing costs, quality, and access offers not only dollar savings and better patient satisfaction, but it really improves quality of care.

Mr. MORAN. OK. So, essentially, managed care and finding some way to better integrate the fact that you have three separate medical systems now for all three different Armed Services.

Dr. JOSEPH. Well, except that I would not——

Mr. MORAN. You would include that in——

Dr. JOSEPH. I think the latter one we have working well, it is well in hand. The great achievement of the Congress in 1992 in

putting all the money into the Defense Health Program, centralizing that budget and moving into TRICARE where we pull together the three services for those purposes, has gone a long way to solve that problem.

Mr. MORAN. OK. In terms of military readiness, which is the mission of the military treatment facility——

Dr. JOSEPH. Yes, sir.

Mr. MORAN [continuing]. Give me again that 1 to 10 analysis.

Dr. JOSEPH. Well, of course, there is nothing that we can compare it to. I guess I would give us about a nine.

Mr. MORAN. About a nine in terms of——

Dr. JOSEPH. I mean, every time we have been tested, whether it's in the small deployments of the last couple of years or the big ones, we have done very well. But, it takes an enormous effort—and sir, for me, that's the thing I think you can't put at risk.

We could argue for a long time about to what extent we need the full spectrum of beneficiary care in the system to keep our surgeons sharp. But, you always have to buffer against putting at risk that ability in our people to respond to deployment.

Mr. MORAN. Let me ask, what are the three most common medical procedures that are performed in military treatment facilities?

Dr. JOSEPH. Well, childbirth, live birth is the first. The second is an orthopedic procedure. Your point taken in the last panel was true but not really relevant to the issue. It is true that childbirth is not a highly military trauma-relevant issue.

It is also true that to keep your chest surgeons and your internists and your pediatricians, who are going to be primary care providers in time of deployment, sharp, they have to see a broad spectrum of pathology in a broad range of patients.

It is also true that two-thirds of all hospitalizations during the Vietnam war were for infectious diseases.

And it is also true that particularly for medics who crawl under the wire and provide care in that first hour of combat casualty—you cannot train those people anywhere but in a military environment.

I'd be happy, at as great a length as you would like, to pursue privately or in another hearing, to talk about how that broad spectrum of care, though it doesn't seem to be like D.C. General on a Saturday night, really is the environment you need to keep military medical readiness. And I'd be happy to bring the three Surgeons General with me for that discussion.

Mr. MORAN. We probably ought to bring in the CBO people, too. Your rating of a 9 on a scale of 1 to 10 doesn't seem to comport with some of the observations that have been made with regard to the most typical medical procedures performed currently in medical treatment facilities versus those most common medical procedures if you are at a time of war. And that, in fact, it seems like the rotation through the trauma care is the one thing that really does give them relevant experience.

But, as John says, we have a kind of a tradition of having the last word here, and I just took it. So I will conclude my comments.

We have gotten some good information on the record here, and that's what we wanted to do, and we do appreciate your time and

your willingness to testify before us, Mr. Lynn, Dr. Joseph. Thank you.

Mr. LYNN. Thank you.

Dr. JOSEPH. Thank you.

Mr. MICA. I thank our panelists.

I am not going to belabor the panelists at this time, but I will submit some additional questions for your response. And we will include in the record any additional statements and leave the record open for an appropriate period of time for comments.

If there is no further business to come before the subcommittee, then I declare this meeting adjourned.

[Whereupon, at 11:38 a.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF HMCS JOHN NICKOLAS LIBERT, USN RETIRED

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STATEMENT OF
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by

HMCS JOHN NICKOLAS LIBERT, USN RETIRED
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REHABILITATION
THE AMERICAN LEGION, SPRINGFIELD POST 176

before the

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT
UNITED STATES HOUSE OF REPRESENTATIVES

on

The Option of Enrollment in The Federal Employees
Health Benefit Program (FEHBP) by All Non Active Duty Military Beneficiaries
(including Medicare-eligibles over 65)

September 12, 1995

Mr. Chairman and distinguished members of the committee, The American Legion, Springfield Post 176, would like to express its appreciation for holding these important hearings and the opportunity to provide testimony, representing the collective views of our members on this issue.

The end of the Cold War brought about reduced wartime medical requirements, reductions in personnel, and base closures and realignments. It also produced adverse effects on military personnel, active and retired, and their families as well as budgetary constraints in all areas, including health care. This concern was instrumental for The American Legion, Springfield Post 176, as a community service project, to sponsor several grassroots medical forums, "Military Health Care, At the Crossroads of Change." Approximately 1,000 military retirees and their families, including Congressional Staffers and Virginia State Delegates turned out to hear speakers from the Department of Defense, the National Association of Uniformed Services, National Military Family Association, and DeWitt Army Hospital.

The current military health care delivery system is, at best, tenuous. With the health care budget decreasing and the continued pressure to reduce the number of physicians, it will definitely impact the readiness of the military medical establishment. Although the quality of care is deemed good too excellent, the availability of care has become increasingly uncertain and inaccessible in many cases, forcing many, if not most, retirees to seek health care in the private sector. Significant problems encountered by most retirees are the increasing number of civilian providers who refuse to participate in the CHAMPUS and/or MEDICARE programs.

Commander K. C. Avery, USN Retired and his family was just beginning to enjoy the "good life" of a retiree. He bought a new home, automobile, and motorcycle and began his second career with a new company. He elected not to participate with the corporate group health care package offered so the company provided him with a CHAMPUS supplement. On September 15, 1994, their life was shattered when Commander Avery was struck by a hit-and-run vehicle that pushed him into the oncoming traffic lane and again was hit head on. He suffered multiple head traumas that left him totally disabled, requiring extensive rehabilitation, physical and occupational therapy, and speech therapy. Most of his hospitalization was taken care of through CHAMPUS and the supplemental coverage. During the course of treatment, he underwent two MRI's. CHAMPUS approved payment for one; however, questioned the medical necessity of the second. After 30 sessions of speech therapy, Commander Avery and his family were informed that the therapy should continue but payment from the beneficiary must be made at the time of service. This requirement was necessitated because of nonpayment from CHAMPUS. The Avery's attended our first health care forum in May 1995 and brought this issue up with a DOD staffer from Dr. Joseph's office. He assured the Avery's that this would be looked into and corrected. To this date, after numerous correspondence and telephone calls to OCHAMPUS in Aurora, Colorado, their claims have not been approved. The break in Commander Avery's rehabilitative care has caused him a severe setback.

Another Legionnaire was badly wounded while conducting a live-fire exercise at the Army's National Training Center in April 1993. The gunner in one of the Bradley fighting

vehicles fired on his position, mistaking it for one of his targets. Eight of the 25mm rounds struck the armored vehicle and debris damaged his eyes and face. One round broke in half and penetrated his skull. Since the wounds were too severe for the post hospital to handle, he was flown by helicopter to Loma Linda University Medical Center. He was classified as "death imminent." The Army expected death to occur within 72 hours and retired him the next day. He survived and remained at Loma Linda through three brain surgeries and rehabilitation. The Army soon tired of the high cost of health care for him. As soon as it was medically feasible he was transferred to James A. Haley VA Hospital in Tampa, Florida. This facility specializes in treatment for head injury cases; however, he was contracted out to the private sector. The reality of paying the CHAMPUS cost-share greeted him, since retirement took place while an inpatient in a civilian hospital.

This family originally would have transferred to New Jersey, near his wife's family home. They were informed that they must stay in Tampa for continued treatment and rehabilitation. Today, his left side remains paralyzed and continued treatment is ongoing. He being forced out of CHAMPUS and required to rely on MEDICARE because of this disability.

Another Legionnaire retired after serving 22 years in the Army and afterwards went to work for the Postal Service. During this period he was receiving treatment on a continuous basis at Walter Reed Army Medical Center for diabetes and cardiovascular problems. On his retirement from the Postal Service he opted not to participate in the health plan that was offered. He could not understand why an additional healthcare expense was needed when the

military was going to provide care for him and his wife. After 42 years of receiving military health care at Walter Reed, he was denied access. Now at ages 74 and 72, their only coverage is MEDICARE. His current medical bills are mounting due to two recent strokes and his wife requiring surgery.

Mr. Chairman, these cases are just the tip of the iceberg. There are many retirees that have, or are currently experiencing, difficulty in receiving proper health care delivery through military treatment facilities (MTFs). Most all retirees understand and expect mission readiness to be the number one priority. However, faced with long waits for doctors' appointments in MTFs, refusal of many private physicians to accept CHAMPUS, and loss of CHAMPUS at age 65, leaves most military beneficiaries increasingly frightened about health care.

DOD's solution is TRICARE; a triple option plan with managed health care, which presumably will provide both access and quality. Unfortunately, the fee structure is not uniform for all beneficiaries and those over age 65 are ineligible to enroll in TRICARE Prime.

Mr. Chairman, the Federal Employees Health Benefit Plan (FEHBP) provides the widest range of choice of any alternative. Seven national plans and approximately 400 local health plans are available. No preexisting restrictions are permitted in any plan offered. Currently military beneficiaries are the only federal employees or retirees who are not allowed to participate. All Federal civilian employees, retirees, survivors, including the U.S. Postal Service are eligible to participate. FEHBP beneficiaries retain coverage as they

become MEDICARE eligible, generally at age 65. Beneficiaries in this age group can combine MEDICARE with an FEHBP plan and obtain 100 percent coverage. including prescription drugs for as little as $100 a month. FEHBP national plans are available to beneficiaries no matter where they maintain a domicile, even at an overseas location.

FEHBP can also co-exist with a Military Health Plan. TRICARE Prime. as well as the U.S. Family Health Plan, can function as Military Health Plans. Beneficiaries will have an annual choice of a Military Health Plan or a plan selected from the FEHBP during "Open Season."

A Congressional Budget Office study on inclusion of military beneficiaries in the FEHBP, cited by a speaker at our health care forum, indicated that FEHBP could actually be the only viable alternative with the upcoming major reductions in the medical force structure, along with enormous fiscal shortfalls.

Therefore, Mr. Chairman, The American Legion, Springfield Post 176, believes that all non-active duty military beneficiaries should be afforded the opportunity to participate in FEHBP. We would like to thank you and the Committee for allowing us to present our views on this important issue.

This concludes our testimony and we are prepared to answer any questions that you or any other member of the Committee might have at this time.

PREPARED STATEMENT OF MICHAEL A. NELSON, LIEUTENANT GENERAL, USAF

THE RETIRED OFFICERS ASSOCIATION

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Michael A. Nelson, Lieutenant General, USAF (Ret)
President

September 8, 1995

The Honorable John Mica
Chairman, Subcommittee on Civil Service
House Government Reform and Oversight Committee
RHOB B-371C
United States House of Representatives
Washington D.C. 20515

Dear Mr. Chairman:

We appreciate your leadership in holding these important hearings to consider the viability of extending the Federal Employees Health Benefits Program (FEHBP) to uniformed services retirees and their families. FEHBP may be an appropriate alternative and, therefore, deserves serious consideration and debate.

The greatest problem facing all uniformed services retirees and their families who primarily rely on military medicine for their health care is the increasing decline of access to care in military treatment facilities (MTFs). This situation is exacerbated by base closures which have closed or will close 39 MTFs and downsize many others. From the perspective of retirees, these cutbacks are breaking the promise of lifetime health care and will leave them worse off than most of their civilian counterparts.

From the day they were recruited through retirement, service members were advised by the government, commanders and recruiters that they would have a right to medical care in military hospitals for themselves and their families following their retirement from active duty. Those assurances were an important factor that induced service members to endure the extraordinary conditions of service for 20 or more years.

Clearly improvements need to be made to the Military Health Service System (MHSS) to assure retirees have a health benefit no less than what is available to retired federal employees. A group of associations is studying FEHBP as an alternative, but has not drawn any final conclusions. Based on our early review, we see some possible pluses and minuses:

- The pluses include providing a defined benefit plan for all members of the uniformed services; and filling the significant health care void that now

exists when beneficiaries turn 65 and are essentially locked out of the military health care system.

• The minuses include the potential deterrent effect of FEHBP premiums on service retirees' participation, particularly enlisted retirees, given the job/income security concerns they face during their forced mid-life career change -- a circumstance not faced by Federal civilian employees; and the potential resentment retirees would feel because of having to pay health care premiums in contradiction with what they believe was a commitment to free health care for life.

Unfortunately, the American public -- and many in Congress -- have the misperception that uniformed services retirees have better-than-average health care benefits. This is a myth. The uniformed services are virtually the only large employer that terminates their retirees' health coverage when they turn 65.

In contrast, nearly all of the largest U.S. corporate and government employers provide their retirees substantial employer-paid supplemental health coverage in addition to Medicare. For example, the five largest U.S. corporations either fund virtually the entire supplemental health care premium (including heavily subsidized prescription drug benefits) or cap their retirees' out-of-pocket medical expenses at modest levels. In a similar vein, the United States government provides significantly subsidized Medicare supplemental coverage for retired Federal civilian employees and their families -- including retired members of Congress and retired Congressional staffers. Yet, successive Administrations and Congresses over the years have progressively stripped older military retirees of nearly all DoD-funded health benefits.

For generations, military health care has been touted as second to none. It is past time to recognize that, compared to what is provided by other large employers, Medicare-eligible military retirees' health care has become second to almost everyone. Members who have given their country decades of service and sacrifice deserve better.

In closing, we believe time has come for Congress to restore the health benefits older retirees thought would always be there for them. We would welcome the opportunity to discuss our recommendations, including an evaluation of FEHBP, when we complete our study of health care options later this year.

Sincerely,

Michael A. Nelson

PREPARED STATEMENT OF MARY ELLEN MULHERN

Last year I lost my husband in an inexplicable, unjustifiable, and tragic accident. My husband, Col. Richard A. Mulhern, was killed on active duty by friendly fire. A six month assignment which "wouldn't be too long" will now be for our three children and for me, a lifetime.

My husband had 22 years, 10 1/2 months in service at the time of his death. Rich had a successful career, one we both viewed with immense pride. We were married for 16 years and in those years I had to deal with innumerable difficulties, including eleven moves, several separations, and an evacuation from Jordan during the Gulf Crisis. One can never be prepared to deal with the tragic and senseless death of a loved one, and I was certainly not prepared to deal with the tragic condition of my military health care benefit.

Although my husband was on active duty at the time of his death, my children and I were immediately placed into the retired category for medical benefits. This meant that now my family would receive lower priority in the military treatment facilities almost ensuring that we could not get care in any of the medical centers in the area. My Champus option would now cost me more in cost shares, and the catastrophic cap went from $1,000 to $7,500. Our dental benefit fared even worse - it was immediately cut off! I had to face all of these changes at a time when I no longer received my husband's salary and the value of my survivor's benefit and children's social security was still undefined.

More shocks were in store when I had to deal with our immediate health concerns. Shortly after my husband's death my son injured his leg playing football. I took him to the Primus clinic where he was x-rayed. Since there is no radiologist at the clinic the report had to be sent out and an evaluation was received 36 hours later. It was determined that my son had a broken growth plate for which a specialist needed to be consulted. Despite many phone calls and pleas an appointment at any of the three local military medical centers was denied. The Primus clinic would not refer me to a specialist.

Fortunately a friend recommended an orthopedic surgeon and my son received four treatments for a total cost of $650. Champus only allowed $152.00 of the fee and I received only $122.00. It took a full five months for Champus to reimburse this inadequate amount.

My son was scheduled for dental work the day after we buried my husband. Our dental benefit was cut off immediately, so I was left to find care on my own.

I am finding that my husband's Social Security and survivor's benefit do not adequately cover the increased costs of my

diminished health care benefit, and I am afraid that there will be a further erosion of my benefits. I am now carrying two costly supplementary insurance policies. Because of my reduced status and the military wide reduction in health care, I don't know of any other way to ensure coverage for my children. I still can't buy dental coverage for my children!

I know that my husband fully expected his family to be cared for in the event of his death. He paid in-full with his life for quality medical and dental coverage and it should be delivered.

PREPARED STATEMENT OF LAURA COLBERT

My name is Laura Colbert. My husband was Specialist Jeffrey C. Colbert. He was killed on April 14, 1994 when two F-15 pilots mistakenly identified two Black Hawk helicopters for Iraqi Hinds and shot them down. Jeff was the crew chief on the lead helicopter. We have two children, ages 5 and 6.

On May 1, 1995, our 5 year old daughter, Beth, was flown from Frederick Memorial Hospital to Johns Hopkins Hospital and diagnosed with acute lymphocytic leukemia. She spent 7 weeks there undergoing practically every test and procedure they have and beginning chemotherapy. After her discharge, she must now return every other week for 48-72 hours of chemotherapy for the nest 6 months. After that, her treatments will be monthly. During this time frame, if she runs a fever over 100 degrees, or her blood counts fall too low, she must be admitted to Johns Hopkins. As you can see, she will be admitted to Johns Hopkins quite a few times over the next 2 1/2 years, which is the length of her treatments. Her prognosis is good. Her chances for a full recovery are in the 80-85% range. Apparently she was "lucky" to have developed this type of leukemia when she did, it is easiest to treat between the ages of 2 and 6.

Now, up until April 14, 1995, we were covered with full medical benefits. Once the anniversary of Jeff's death passed, our benefits were reduced to "retiree" benefits. My responsibility for Beth's medical bills is 25% of <u>each</u> bill, with a cap of $7,500. If Jeff had not been killed, our cap would have been $1,000. Beth's medical bills to date are: $198,000 to Johns Hopkins Hospital, $22,000 for 16 of the 48 doctors she has seen, and there are many more treatments and bills yet to come.

These bills have been submitted to CHAMPUS insurance and they have paid their portion, however, my part is now due. I am being faced with a collection company for the doctors' bills. Johns Hopkins Hospital has been working with me to set up monthly payments, but with two children to provide a home for, expenses of food, clothing, medications, travel to and from Johns Hopkins, etc., I cannot afford the payments in excess of $500.00 per month they would like. I am receiving travel and medication assistance from the Leukemia Society ($125.00 every 3 months), however, I feel the manner in which my husband lost his life plays a part in this. As you are aware, this was not a war time incident of "friendly fire." It was a beautiful, clear day. There were large American flags on the helicopters. I feel, along with the other widows and family members,

that special considerations must be made for this special circumstance. All widows and children's benefits should be extended past the first year, perhaps to the length of service each victim would have been able to serve, had their life not been taken. At the time they would have retired, then retiree benefits would be acceptable.

This concludes my immediate concerns, thank you for your interest and help. I appreciate anything you can do for me and the other families.

PREPARED STATEMENT OF TAMI LITTLETON

I would like to bring your attention to a serious problem facing many military families who need health care. My husband is an active duty Army officer stationed at the Pentagon and our family is eligible for health care at military treatment facilities (military hospitals) on a space available basis or under the CHAMPUS health benefits program. Medical treatment is increasingly difficult to obtain in a military hospital and we must rely more and more on the CHAMPUS program. However, because CHAMPUS reimbursements are so low, all military families are now encouraged to purchase supplemental insurance policies to provide adequate coverage for medical expenses. For supplemental coverage for myself and two young children, we pay almost $250 a year. This partially covers the annual CHAMPUS deductible of $300 per year per family but does not cover any vision, or dental care. Most supplemental plans cover co-payments and some cover "balance billing". The CHAMPUS catastrophic cap of $1,000 per year does not include balance billing. I've been told by doctors that CHAMPUS payments have been reduced twice in the last year and are considered second only to Medicare for lowest reimbursements. In fact, the fee schedules are so low that doctors who have agreed to participate with CHAMPUS also have the right to refuse treatment on a case by case basis. Our family recently faced a problem with balance billing that I believe will highlight the seriousness of this problem.

In the spring of 1994, our son, Patrick, then seven years old and in the second grade, had suffered for several years from recurrent sinus infections that left him with chronic headaches, sinus pain, fatigue, and difficulty breathing. A string of PCS moves also meant that Patrick was coping with the stresses of fitting into his third school. Because of the headaches and fatigue, Patrick had difficulty keeping up with the work load in his new class and spent many afternoon recesses inside the classroom trying to catch up on daily classwork. On those days when he got to go outside, Patrick had trouble keeping up with his new classmates on the playground because his breathing problems made it so difficult for him to join in the activities of the other second graders.

Having exhausted all possible treatments with Primus pediatricians, we were referred to a civilian allergist (It was a six month wait to see a military allergist.) Patrick quickly exhausted the allergist's therapies and so he referred us on to an Ear, Nose, and Throat specialist (ENT). The Ear, Nose and Throat doctor did participate in several common civilian insurance plans but did not participate in CHAMPUS because their reimbursement was too low. We decided to see her anyway and pay the extra cost for consultations out of our pocket because she was so highly recommended. The diagnosis: Patrick required surgery to drain and repair his sinuses, and to remove his adenoids, which were obstructing most of his airway. We had developed a relationship with our civilian ENT by this point and would have preferred that she do the surgery but we

were willing to have a military doctor perform the surgery as long as it could be done soon.

The Health Benefits Adviser at Ft. Belvoir told us to fax in the information so that they could review it for a Non-Availability Statement (NAS). If you live within 40 miles of a military hospital you must get a Non-Availability Statement (NAS) from that hospital before CHAMPUS will cover inpatient care. We were told that we would have a decision within 10 days. It was a struggle for Patrick to get out of bed in the morning now. He cried everyday. We anxiously counted the ten days on our calendar but heard nothing from the hospital. On the eleventh day I called the Health Benefits Advisor who told us that she had never received our fax (something she said was not uncommon, still she had not called us back to let us know) and so nothing had been done yet. Patrick was now struggling for breath even when sitting to read a book. We scrambled to get the information to the Health Benefits Adviser and then she told us that since there were no military ENT's available for several months it would almost certainly be approved for a NAS. We received verbal approval 3 days later and called CHAMPUS to find out their fee schedule so that we would know beforehand what our portion of the medical bills would be.

We were shocked to find that CHAMPUS would pay a total of $697.44 to cover procedures for which local doctors charge between $2,000 and $3,000! As this was a pre-existing condition, our supplemental insurance policy would not pay on this bill. Somewhat embarrassed, we told our ENT that we could not afford her fee and would have to find a surgeon who would accept CHAMPUS. Calling the list of "CHAMPUS providers" only brought further humiliation. I was refused by the first one (they had left CHAMPUS 2 years ago because the fees were too low) and told by the second office, "We can't do it (the surgery) for that kind of money. And we won't. I don't care what our contract says!" The third office said they would see Patrick and would abide by their contractual obligations to CHAMPUS. The office manager was clearly shocked at the fee, but very kindly told me that the doctor wouldn't turn away patients in need of care, no matter how little their insurance paid. One doctor, a Naval Reservist, even insisted that the military had lied to me about the non-availability of military surgeons and advised me to have my husband call Bethesda and demand they find us one immediately!

Patrick's doctor was not a CHAMPUS provider but, after discussions with her billing staff, agreed to accept a greatly reduced fee. We paid the balance, some $700.00 from money saved in our children's college fund. Patrick's surgery was successful and produced almost immediate improvements. However, neither my husband nor I felt particularly good about having been reduced to a charity case to obtain the care our son needed. This time we were able to handle the problem ourselves, but what about the next major medical problem we encounter?

After 15 years of service to this country, we are angry, hurt, and resentful at such poor treatment. We are tired of hearing talk about the military's "overly generous" benefits and retirement package. The perception exists that military members receive so many "free" benefits, but, in reality, these benefits are hollow. Service members work very hard and their families make many sacrifices. We are not asking for an entitlement program, only reasonable compensation for our efforts. We understand that our government needs to control spending and that sacrifices have to be made. The question that continues to haunt us is one of equity. Why is it that my husband's secretary (a federal employee who has FEHBP) has a better family medical plan than he does?

PREPARED STATEMENT OF DEANN D. SHAW

DeAnn D. Shaw - My Experiences with Military Medicine.

My husband was a 2ndLt in flight school when I came down with the shingles in 1979. I was seen at the Navy Hospital in Pensacola. The Doctor on duty that night was a Psychiatrist. All he did was prescribe antihistamines. My pain grew worse and my husband took me to the emergency room after several days. Of course, I was seen by a different Doctor and had to explain the situation from scratch. This was my introduction to the frustration of having to see different Doctors for each visit, and having to "reinvent the wheel" each time.

We moved to Kingsville, TX in 1980 for advanced jet flight training. I began to feel unusual and extreme fatigue. I went to the branch clinic on base. The Navy doctor on duty (GP) patronized me and suggested that I was a depressed aviator's wife and that I should seek family counseling. I was never examined. No blood work was done. Two weeks later, I returned to the clinic. My fatigue was now accompanied by a severe kidney infection and high fevers. This time I was seen by a Physician's Assistant. He suspected that I might be seriously ill, so he began a series of blood tests and x-rays. The x-rays showed a mass in my chest. I was sent to the Navy Hospital in Corpus Christi where I was examined further and given extensive x-rays. They confirmed that I had a tumor and sent me to Brooke Army Medical Center in San Antonio.

I was admitted to Brooke Army Medical Center in 1980. Two biopsies were done on lymph nodes (the first one was lost by a laboratory technician before it could be analyzed). the second biopsy confirmed Hodgkins Lymphoma. I then underwent staging procedures including a laparotomy. Then I began radiation treatments. My husband had been with me for a couple of weeks but he then had to return to Kingsville for his training. He commuted on weekends (6 hour drive round trip). At the time we understood this to be our only option. Nobody told us we had any other alternatives.

We arrived in Yuma, AZ in 1981 where my husband received further flight training. There was only a small branch clinic on base. I had to travel 6 hours round trip to Balboa Hospital in San Diego once a month (sometimes more). We still understood this to be our only choice for the critical follow up observation of the Hodgkin's disease.

We were stationed in Kaneohe, HI from 1982-1985. I received my medical care at Tripler hospital. Although the care by Doctors was good, I experienced occasional rude treatment by other staff. Having no choice of Doctors and the lack of continuity was still a worry and a concern. I had to become an expert on my own case in order to bring new Doctors up to speed because they didn't communicate with each other.

My husband requested orders to Pensacola specifically because we wanted to be near a military hospital due to the critical nature of the remission time-frame. We were there from 1985-1988. When I arrived, I found out that there was no Oncology Dept. at

the Naval Hospital. My cancer care was provided by an internal medicine Doctor at the Navy Hospital. I became pregnant with second child and was referred to a high risk pregnancy specialist (civilian) due to the Hodgkin's history. This was the first time we were given the opportunity to use CHAMPUS. We still felt "safe" financially because we did not fully understand the "fine print" issues of CHAMPUS such as "participation" and the 20% co-payment. In 1986, when my youngest son was 3 months old, I was seeing a family practice Doctor at the Naval Hospital for my regular care. I mentioned that I was fatigued, and that I didn't feel well. I also showed him a rash which was developing on my elbow and ankles. He stated that I might have pulled a muscle during child birth. Because of the nature of the family practice program, this was the only Doctor I could see in order to stay enrolled in family practice and gain its benefits for my children. One night, very fatigued, I went to the Navy Hospital emergency room. X-rays were taken. My Hodgkin's Disease was active again. I was told that I could not be treated at the Naval Hospital because they had no Oncology department. I was "CHAMPUSed out" to West Florida Hospital. I was able to choose my Doctor there. This began a year of chemotherapy, inpatient stays, and other procedures. We soon found out about the mountain of paperwork, filing problems, and incompetence at various levels of the CHAMPUS administration system. We also found out that we faced serious money problems due to the potentially huge bill, and the 20% that we would be forced to pay. At this time we became aware, for the first time, of CHAMPUS supplemental insurance and we quickly signed up with a good plan. However, the plan required a 6-month grace period on preexisting conditions. Much of this year was spent writing letters, getting non-availability statements, sending in claim forms, and pleading with the hospital to wait for the painfully slow CHAMPUS payments to arrive. We were upset to see other people, with better health care plans, able to undergo similar situations with much less trouble and expense. It was particularly painful for my husband to know that civil servants that he worked with had a better health care plan. After my Chemotherapy regimen, there was concern that I was not improving. Under CHAMPUS, I was able to seek second opinions from a specialist at Yale Hospital in New Haven. The CHAMPUS system allowed me to make that choice. My concern is that the TRICARE system might not allow me that choice.

When stationed in Quantico, VA in 1988-1989, I became very ill with the Flu. My husband took me to the branch clinic at Quantico. My Hodgkin's disease was being followed at this time by an Oncologist at Bethesda. I was finally told, after 4 hours of waiting, that Quantico could not get in touch with my Oncologist at Bethesda and that they couldn't do anything until they checked with him. I was told to go home and come back in the morning. The next morning, I waited an additional 2 hours. The Oncologist was finally reached and he told them to put me in an ambulance and send me to Bethesda. My husband had to remain behind with my 2 small children (5 and 2). At Bethesda, I was left in a room for about an hour. A nurse came and asked me about my medications. She realized that I was toxic due to excessive amount of medication that had previously been prescribed. I was also dehydrated. They began to hydrate me intravenously. They also began several procedures which might not have been undertaken had my husband been able to be at my side consistently to

explain my unusual situation. But, unfortunately, I was considered to be in the catchment area so I had to be at Bethesda while my family was in Dumfries, VA.

We were stationed in El Toro, CA from 1989-1993. One week after we arrived, both of my sons became ill with viral meningitis. They were both admitted to Childrens Hospital of Orange County. Again, like the situation in Pensacola, there were payment problems and mountains of paperwork before the billing was finally resolved two years later. Although California had CHAMPUS Prime and CHAMPUS Extra at the time, my particular medical problems made it necessary for us to remain with standard CHAMPUS. Also, we did not want to upset the delicate balance we had finally managed to achieve between CHAMPUS and our supplemental carrier by joining these new programs which only served California and Hawaii. We knew that we would have to come back to regular CHAMPUS eventually. During this time, another administrative headache came about. Congress enacted the Catastrophic Cap which is designed to limit out-of-pocket expenses to $1000 per family per year. Unfortunately, these costs were tabulated differently by CHAMPUS and the supplemental carrier. The result was that my supplemental insurance refused to pay when their records showed that the CAP had been met. It now fell to me to prove to CHAMPUS that the CAP had been met so that they would increase their payments. I had to write many letters in order to finally get reimbursed by CHAMPUS. This was a nightmare which could be avoided with the FEHBP system.

Since 1993, we have been stationed at Quantico, VA. After my previous experiences with military hospitals, and particularly Bethesda, I was determined to have my own Doctors so that continuity could be maintained. However, upon arriving in Virginia, I found that very few local Doctors accepted CHAMPUS assignment. By now my oldest son was diagnosed with Attention Deficit Disorder and my youngest son had a partial loss of hearing caused by the meningitis. I investigated the branch clinic on base to see if it could meet some of our needs. I found that it would take months to get my oldest son an appointment to see a Doctor about getting medication for his ADD. As far as my youngest sons hearing loss was concerned, Quantico only had hearing test equipment for adults. When I checked with Fort Belvoir, I found that there were similar problems with long waiting periods, and lack of personnel and equipment. Through persistence and dedication, I was finally able to line up an acceptable network of Physicians who took CHAMPUS assignment, and who were close to home. In Virginia, I found that I was confronted with a problem I had first noticed in El Toro. I could no longer get my two major prescribed medications at military pharmacies. This forced me to resort to civilian pharmacies and CHAMPUS.

My circumstances are unique but the frustration I feel is shared by all military families. My husband was told, at the outset of his career, that the military would take care of his family's health care. Yet over the years, he and I have had to struggle to protect ourselves. We became educated and informed and had enough "rank" to be listened to if we made enough noise. Perhaps this would not be an issue if all of our Federal employees shared the same system. Yet, our military families take a back seat to those of civil servants when it comes to a simple, fair and effective health care system.

PREPARED STATEMENT OF EDITH M. SMITH

Mrs. Vincent M. Smith
8008 Brompton Street
Springfield, VA., 22152
September 12, 1995

TESTIMONY RESPECTFULLY SUBMITTED AT A HEARING ON OPENING THE FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM TO NON-ACTIVE DUTY BENEFICIARIES ELIGIBLE FOR MILITARY HEALTH CARE

Department of Defense denies disabled Medicare-eligible beneficiaries under age 65 equal coverage under The Uniformed Services Health Benefit Program

The Honorable John Mica, Chairman
Subcommittee on Civil Service
Committee on Government Reform and Oversight
U. S. House of Representatives
Washington, D. C., 20515-6143

Mr. Chairman and Members of the Subcommittee:

My name is Edith Smith from Springfield, Virginia. I consider myself to be a traditional military wife and a volunteer citizen advocate for disabled military retirees, family members, survivors, and certain former spouses. I represent no organization. I appreciate the opportunity to express my views before this committee concerning the unequal healthcare benefit provided by the Department of Defense to disabled military beneficiaries under age 65 solely because they suffer the misfortune of serious disability or End Stage Renal Disease (ESRD.)

The Uniformed Services Health Benefit Program provided to military employees and their families by the Department of Defense consists of two parts: 1.) Health care at Military Treatment Facilities which (except for the active duty member) is subject to the availability of space and personnel for all eligible beneficiaries. 2.) In 1966, Congress established The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as the guaranteed part of the health care delivery program provided to all military retirees as an entitlement of their retirement. Initially, Congress mandated that the coverage provided by CHAMPUS would equate to the coverage provided by the Federal Employee Health Benefits Plan, Hi-Option BC/BS. (In compliance with Federal Law regulating health insurance, FEHBP does not "dump" their disabled from primary coverage.) CHAMPUS, a federally funded program rather than an insurance, escapes the mandates of these laws.

The Department of Defense has testified before Congress that cost is the only barrier to providing equal CHAMPUS entitlement to disabled military beneficiaries.

Medical care for the disabled is cost shifted to other agencies; resulting in "cost savings" for DOD and a significant loss of coverage with greater expense for these individuals with severe disabilities From 1972 until 1980, as a "cost saving" administrative action, eligibility for CHAMPUS entitlement was terminated under CHAMPUS regulation when a beneficiary became entitled to Medicare Part A due to disability or ESRD. This termination of CHAMPUS eligibility for the disabled "Medicare eligibles" was not official under law until 1980. In 1991, Congress restored a partial CHAMPUS entitlement as second payer to Medicare for eligible beneficiaries under age 65.

A basic principle of Healthcare Reform is to expand employer-provided coverage to all workers. How can we even think of requiring small business employers to provide health insurance equally to all workers when a government agency is still allowed to "cherry pick" certain beneficiaries solely because they are disabled?

There are 6.6 million CHAMPUS beneficiaries. In September, 1993, The Defense Eligibility Enrollment System reported that 14,206 individuals are listed as under 65 and eligible for Medicare Part A. The unjust loss of more generous CHAMPUS coverage is an insult to the already injured. DoD abandons their responsibility to provide equal access to all benefits of retirement for all retirees. Why is the Department of Defense allowed to "cost shift" this employer responsibility of the sickest retiree to Medicare and Medicaid? Why does DoD fund premium subsidies of the Federal Employees Health Benefits Program for their disabled civilian retirees and not be similarly responsible for their military retirees?

President Clinton, Members of Congress, and the majority of American citizens endorse universal health coverage; seeking an end to discrimination of individuals with pre-existing condition and disabilities by insurance companies. I encourage this committee to support legislation which provides equal access to adequate health care coverage by all Americans. Begin this endeavor by legislating changes in the law that will require the Department of Defense, to provide opportunity for disabled military beneficiaries to equal eligibility for their earned retired medical entitlements. THE DISABLED MILITARY BENEFICIARIES. ARE DISMAYED WITH THE SECOND CLASS TREATMENT FROM CHAMPUS AND WANT THE EQUAL TREATMENT OFFERED BY THE FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM.

Very Respectfully,

Edith G. Smith

Edith G. Smith
(Mrs. Vincent M.)

PREPARED STATEMENT OF MICHAEL F. OUELLETTE

Non Commissioned Officers Association of the United States of America

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STATEMENT OF

SERGEANT MAJOR MICHAEL F. OUELLETTE, USA, (RET)

DIRECTOR OF LEGISLATIVE AFFAIRS

TO THE

SUBCOMMITTEE ON CIVIL SERVICE

COMMITTEE ON GOVERNMENT REFORM AND OVERSIGHT

ON

FEDERAL EMPLOYEES HEALTH BENEFIT PLAN (FEHBP) ELIGIBILITY EXPANSION

FIRST SESSION, 104TH CONGRESS

HOUSE OF REPRESENTATIVES

SEPTEMBER 12, 1995

Chartered by the United States Congress

Mr. Chairman. The Non Commissioned Officers Association of the USA (NCOA) appreciates the opportunity to present testimony to the subcommittee concerning the expansion of Federal Employees Health Benefit Plan (FEHBP) eligibility to beneficiaries of the Military Health Care System and those who lose Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) when reaching age 65. NCOA is a federally-chartered organization with a membership in excess of 160,000 noncommissioned and petty officers serving in every component of the five Armed Forces of the United States; active, national guard, reserve, retired and veterans.

NCOA members believe they were "promised" free life-time medical care benefits as a result of military service and NCOA has always opposed any health care alternative or option that would cause the eligible military beneficiary population to pay premiums for the same medical care protection "promised" for life. The Association does, however, appreciate the pro-activity demonstrated by your subcommittee to hold hearing in an effort to explore all avenues in a search for an answer or alternative that would provide adequate and dependable health care protection to those who earned the benefit for themselves and eligible family members as a result of military service. In this statement, NCOA does not intend to oppose any options being considered by the subcommittee, but wants only to present a number of concerns the Association believes must be considered during subcommittee deliberations.

BACKGROUND

For many years the military health care benefit was easily understood by virtually all eligible

beneficiaries who simply went to an available Military Treatment Facility (MTF) for cost-free medical treatment and prescription drugs. Today, military beneficiaries are confused with the numerous health care programs either in effect or being implemented world-wide. For whatever reasons these many programs have been or will be put in place, the only achievement has been to thoroughly confuse and disorient virtually every category of eligible beneficiary. The military health care system at this time consists of an ill-defined benefit with procedural and various program inconsistencies that leave all eligibles searching for information and answers at the worst possible time, when ill and in need of medical treatment. In essence, a free life-time medical benefit has little value if the system put in place to support it cannot be accessed or the alternative to MTF access is not understood. Therefore, NCOA is committed to obtaining a well-defined, uniformed health care benefits plan for its members that can be relied on when needed and subsequently used.

In the area of health care availability, Base Realignment and Closure Commission (BRAC) actions have totally eliminated access to military medical care for many military retirees. Consequently, many have only been left with a CHAMPUS benefit they do not completely understand or Medicare coverage with it's late Part-B enrollment penalties and coverage shortfalls.

ITEMIZED LISTING OF CONCERNS

CONCERN #1 - - - NCOA suggests that offering FEHBP enrollment to military beneficiaries, if only as an option, gives credence to the perception

that the quality of health care one can receive is directly proportionate to whatever one can afford to pay. Although there may be many military beneficiaries who may be financially able to take on the costs of a premium based health care protection plan, there remain many enlisted retirees who are not. The only alternative for this group of retirees could be access to a health care delivery system that falls short of meeting quality care or accessibility expectations.

CONCERN #2 - - - Virtually all NCOA members either are serving or have served careers in the uniformed services believing that as a benefit of that service they would be provided "free" life-time medical care. Upon retirement, military retirees quickly realized they had become second-class citizens when it came to accessing this earned cost-free benefit. It did not take them long to realize that a free lifetime medical benefit has no value when they could not gain access to the Military Treatment Facility (MTF). For the most part, all they really have is an empty promise. Eligible beneficiaries will not take kindly to any suggestion that they now must or may pay premiums for a benefit they have already paid for in terms of military service.

CONCERN #3 - - - Medicare eligible military retirees (age 65) currently lose their military health benefit and must pay monthly Medicare Part B premiums to receive medical care coverage which is less comprehensive than their earned military benefit. For instance, there is no prescription drug benefit under

Medicare. NCOA is concerned that offering Medicare-eligible beneficiaries an option to enroll in FEHBP, in order to improve their level of health care cost protection, will require them to pay an additional premium, besides Medicare Part B, to cover shortfalls in the Medicare program.

CONCERN #4 - - - NCOA is concerned that in the rush to offer FEHBP to military beneficiaries in order to extend a health care protection benefit that can be relied upon, many will lose sight of the fact that the average military retiree is an E6 or E7 and financially incapable of taking on the additional deductions from their retired paycheck. Many of these retirees receive a significantly reduced amount of monthly retired pay and possess military job skills that do not translate into compatible civilian jobs. Consequently, many military retirees depend totally on their retiree paychecks for their financial livelihood. Under the proposed FEHBP enrollment opportunity, many would have to make a decision as to whether to buy food for the month or purchase health care protection. The point is that all military retirees qualified for the same medical care benefit and the comprehensiveness of that benefit must not be dependent on the level of income received and what one is able to pay for health care coverage.

CONCERN #5 - - - NCOA is concerned that the actual premium costs associated with FEHBP enrollment appear to be an avoided subject. From an experience standpoint, NCOA is certain the premium requirements for the

FEHBP enrollment of active-duty families would be substantially subsidized by the Department of Defense (DoD); however, the Association is not convinced that DoD would be inclined to subsidize military retiree FEHBP premiums at the same level. This is an obvious assumption since failure to subsidize is precisely the reason military retirees are left without a DoD sponsored dental protection program. As a side note, DoD currently pays 60 percent of the premiums associated with active-duty family dental plan.

In conclusion, NCOA appreciates the efforts of the subcommittee to address the health care needs of the various categories of military beneficiaries; however, care must be taken to insure all those eligible are treated fairly and provided equal opportunity to obtain a standard, uniform and consistent health care benefit that meets the "promised" benefit earned as a result of service.

Thank you.

PREPARED STATEMENT OF BOB MANHAN

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT FOR THE RECORD

BOB MANHAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON CIVIL SERVICE
HOUSE GOVERNMENT REFORM AND OVERSIGHT COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

PROVIDING ACCESS TO THE FEDERAL EMPLOYEE HEALTH BENEFIT PROGRAM (FEHBP) FOR PARTICIPANTS OF THE MILITARY HEALTH CARE SYSTEM

WASHINGTON, DC SEPTEMBER 19, 1995

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

At this point in time all uniformed service retirees and their families who primarily rely on military medicine for their health care are finding it very difficult, if not impossible, to receive this service. Historically, military retirees were told from the day they were recruited, through 20 or more years of active duty service and indeed at the time of their retirement briefings, that they would have the benefit of receiving medical care in military treatment facilities (MTF). This entitlement included their dependents, too. Of course once a retiree reaches age 65 he is denied all further military medical services and must enter the Medicare program.

Today, with the ongoing efforts to reduce the size and strength of the armed services fewer doctors and nurses will be on active duty. At the same time, base closures have or

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will have closed almost 40 MTFs and further reduced the mission and size of many other clinics. All this has taken place while successive Administrations and Congresses have continued to reduce older military retirees and their dependents of almost all Department of Defense (DoD) funded health care support.

The VFW is aware of the fact our government does significantly subsidize Medicare supplemental coverage for retired Federal employees and their dependents. We believe military retirees certainly deserve better health care service than is currently available to them. In fact, I cannot think of any other group of federal employees who receive fewer medical benefits as they get older than does the military retiree.

In conclusion, the VFW is working in conjunction with other like-minded associations to restore the health care entitlement for older retirees. One of the options under consideration is an evaluation of FEHBP. Once a decision is reached by the group the VFW, along with others, will discuss our recommendations with this committee.

Thank you and all the committee members for sharing our concerns that military retirees are relegated to second or possibly third-class status by our country when it comes to receiving life-long health care benefits.

Congress of the United States
House of Representatives

MAC THORNBERRY
13TH DISTRICT, TEXAS

COMMITTEE ON NATIONAL SECURITY
COMMITTEE ON RESOURCES
JOINT ECONOMIC COMMITTEE

September 12, 1995

The Honorable John L. Mica
Chairman
Subcommittee on Civil Service
Committee on Government Reform and Oversight
B371C Rayburn HOB
Washington, D.C. 20515

Re: Congressional hearing regarding the option of enrollment in the Federal Employees Health Benefit Program (FEHBP) for military beneficiaries.

Dear Chairman Mica:

Our country's active duty military families and military retirees continue to experience a serious deterioration of the health care benefits they deserve. I commend you and your subcommittee for conducting this important hearing today to examine this issue. In that regard, I respectfully submit this letter and request that it be included in the official record of the hearing.

For some time, I have been concerned about the growing population of military retirees who are unable to access the military health care system largely as a result of the closure of military medical treatment facilities. As the military health care system continues its drawdown, I believe it is imperative that the Congress and the Department of Defense work together to ensure that we address the needs of military families and retirees.

I believe the Congress should review all available options to remedy this problem. One of the more promising possibilities involves making the FEHBP available to some or all military beneficiaries. FEHBP is a model program. This cost effective health care benefit system provides its civilian beneficiaries choice, market competition and unique cost containment incentives.

I support a thorough analysis of whether the savings achieved through downsizing could be used to make FEHBP available to military families and retirees. Furthermore, I support a full examination of all other implications of opening FEHBP to military families and retirees.

As a member of the Personnel Subcommittee of the Committee on National Security, which has primary jurisdiction over military health care, I am very interested in your committee's pursuit of alternatives to make sure the government meets its obligations to military service members and retirees.

Congress must continue to work towards a solution to the military health care crisis. Once again, I look forward to the continuation of your committee's work and await your conclusions and recommendations.

Sincerely,

Mac Thornberry
Member of Congress

WMT:cs

JOHN N. STURDIVANT, NATIONAL PRESIDENT, AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO

Mr. Chairman and Members of the Subcommittee: My name is John Sturdivant, and I am the National President of the American Federation of Government Employees, AFL–CIO (AFGE). On behalf of the more than 700,000 federal and District of Columbia employees our union represents, I thank you for the invitation to submit our views on the possibility of extending to a segment of the military health care beneficiary population the opportunity to participate in the Federal Employees Health Benefits Program (FEHBP).

AFGE's interest in this subject is profound. Our members and their families are among the 9 million current participants in the FEHBP. AFGE has also been at the forefront of efforts to reform our nation's health care system, advocating provision of more comprehensive and affordable health insurance benefits for all Americans. In particular, we have advocated more rational allocations of the federal government's own expenditures on health care.

Toward the end of the ill-fated 1993 Congressional debates on reform of our nation's health care system, the idea of opening the FEHBP up to all uninsured Americans was briefly considered. On principle, there was no reason for AFGE to object to expansion of access to the plans within the FEHBP. But we felt strongly that before others were brought into the system, its serious structural flaws would need to be addressed. That position remains, as time and the profound changes occurring in the health care industry have exacerbated the FEHBP's problems.

Furthermore, while AFGE does not consider expansion of access to FEHBP to be, in itself, the answer to our nation's crisis of coverage and affordability of health care, we do not see any reason to deny access to the FEHBP if that marks some level of improvement in overall access to health insurance coverage.

AFGE's first concern is that the federal employees, retirees and their families who now participate in the FEHBP are not adversely affected by the expansion of eligibility to military dependents, retirees and survivors. It is also important to us that those who consider participation in FEHBP are made aware of its very serious shortcomings. The FEHBP is often held up as a model of "managed competition" which offers participants a wide array of choices among fee-for-service, managed care, and prepaid or HMO-style plans. Yet the government's premium-sharing formula for federal employees is so inadequate that it leaves almost 400,000 eligible workers uninsured. These are federal workers who decline participation in FEHBP, but do not receive health insurance from another source. When asked by OPM to explain their non-participation, most replied that they could not afford it.

The FEHBP fails to require its plans to offer a minimum or standard set of benefits. Consequently, plans compete against one another for the lowest risk enrollees by continually changing their benefit packages. Thus, rather than offering peace of mind to enrollees that their health care costs will be insured, "come what may," there is always a worry that the category of health care excluded from one's chosen plan will be the category of health care one needs. There is also considerable evidence that the competition among plans within FEHBP has led to risk segmentation, rather than low cost and high quality for enrollees. In fact, the Congressional Research Service has found that the risk segmentation in FEHBP is so great that the variance between the actuarial value of benefits and the premiums charged is as high as 200 percent in some plans.

The FEHBP also fails miserably in the area of offering quality assurances to its participants. OPM requires only the most minimal standards for a plan's admission to the program, insisting the mere existence of an annual opportunity to switch plans constitutes adequate quality assurance for enrollees. Since there is no standardization of benefit packages, and OPM places no requirements on plans to submit to outside quality accreditation standards, FEHBP participants are forced to judge plans based on price, word of mouth, and the plans own advertisements. OPM can and should initiate a quality assurance program for the plans which are given the privilege of participating in FEHBP.

These are only a few of the ways that the FEHBP fails as an "ideal" model for health care reform. Indeed, it is in dire need of reform itself. At an absolute minimum, the federal government should improve its premium-sharing formula so that it resembles the more generous cost-sharing rates which prevail in typical large private sector firms. In so doing, the 400,000 uninsured federal employees could begin to receive health insurance through their employer. The OPM should also require plans to offer a set package of benefits. Only then could competition among plans work to the advantage of enrollees.

THE CONGRESSIONAL BUDGET OFFICE REPORT ON MILITARY MEDICAL CARE

The July 1995 report, *Restructuring Military Medical Care,* from the Congressional Budget Office, sets forth a compelling argument for focusing the Department of Defense's declining resources on preparation for wartime responsibilities. As part of that effort, the CBO posits a possible scenario in which all those now eligible for health care at military health care facilities and all those eligible for health benefits through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), with the exception of active-duty military personnel, become eligible instead to participate in the FEHBP on a voluntary basis.

Under the scenarios elaborated by the CBO, CHAMPUS would be ended, military retirees, survivors and their dependents, as well as the dependents of active duty personnel would no longer be eligible to receive care from military sources. Their options would become: government subsidized voluntary participation in FEHBP, Medicare coverage after age 65, or any other civilian option open to them.

EFFECTS ON FEHBP OF EXTENDING ELIGIBILITY TO MILITARY DEPENDENTS

There are two major factors to consider when setting up safeguards to assure that federal employee participants in FEHBP suffer no adverse effects from the inclusion of segments of the military population into the FEHBP. The first is the impact on the risk pools of the various plans. Second is the increased administrative costs of adding a new population.

The CBO study claimed that there was good reason to believe that the health risk profile of the military beneficiary population was almost identical to that of the federal employee population. Based on this assumption, CBO asserted that merging the military beneficiaries with the existing FEHBP risk pool would be unlikely to create any significant impact on FEHBP premiums.

To consider material health risks separately from the multitude of other factors which impact premiums is misleading. Perhaps the most critical factor would be the choice of FEHBP health plans in which the military population might choose to enroll. The government's repeated threats to lower its share of premiums for federal employee and retiree participants are always cast as a means of providing an incentive for enrollment in the lowest cost "prepaid" or "managed care" plans. If the Defense Department chose to subsidize participation in FEHBP for the military beneficiaries at a different rate from the government's subsidy for federal employees, the incentives, and thus the choices would be different. This would create differential impacts on the risk pools, experiences, and ultimately the premiums, for various types of plans throughout the FEHBP.

The rate of premium subsidy by the government for the military beneficiaries would also have an impact on other variables that affect premiums. If the premium subsidy were 100 percent, as it is with CHAMPUS, enrollment could be expected to be nearly universal for the eligible population. The CBO also made cost estimates for two other premium-sharing possibilities which would likely lead to different outcomes. The examples were subsidies of either 86 percent, as specified in the current collective bargaining agreements in the Postal Service, or the roughly 72 percent which federal employees and retirees receive. Under either of these latter premium-sharing arrangements, the participation rates would be very different.

One danger is that with the less generous funding, only high risk individuals would enroll. The fact that FEHBP plans are prohibited from refusing enrollment to anyone on the basis of pre-existing conditions make this scenario a possibility. A demographic factor which makes the "high risk only" scenario a likelihood is that among the retired military beneficiaries, a high proportion continues to work and have access to health insurance through an employer. But unlike the FEHBP, many private sector health plans can and do discriminate on the basis of pre-existing conditions. These individuals could be expected to take advantage of access to FEHBP, and would likely cause premiums to rise.

If the relatively high-risk portion of the military beneficiary population chooses to participate in FEHBP, but is not joined by the lower-risk portion of that group, CBO notes that "FEHBP premiums would probably rise to reflect the change in the underlying risk pool." (CBO Report, July 1995, page 58.) AFGE members, retirees and their families must be protected from this eventuality.

The only way that the existing FEHBP participant population can be adequately protected from potential adverse effects of allowing the military beneficiary population to join FEHBP is for separate risk pools to be maintained indefinitely. This separation should include administrative costs as well as other insurance costs. In this way, the premiums for the military population will reflect the true costs of providing its health insurance. After several years of experience, when utilization rates

and enrollment patterns are well established, the decision can be made whether to merge the two risk pools.

The importance of separating the two groups for administrative functions as well as premium-setting cannot be overstated. If CHAMPUS were eliminated entirely and the military medical system downsized to the extent that its capacity were limited to serving only the needs of active duty personnel, we believe that military beneficiary participation in FEHBP would be significant. The fact that the military beneficiary population is so mobile, and relative to the civilian federal workforce, military retirement is so variable, administrative costs for this group can be expected to be extraordinary by current FEHBP standards.

Another potential problem for existing FEHBP enrollees is the prospect of overcrowding in some plans. Although plans may expand their provider networks or administrative staffs to accommodate the influx of new enrollees, it is also possible that they will simply stretch existing resources. The fear is that this could result in longer waits for appointments and slower processing of claims. Consequently, we believe that OPM should consider imposing some restrictions such as enrollment limits in prepaid plans, and minimal standards of quality (measured, for example, by speed of access to providers and speed of claims reimbursements) to forestall such problems.

CONCLUSION

AFGE has always believed in the benefits of bringing the largest group possible into a single government plan. As long as federal employees and retirees suffer no adverse effects of the inclusion of the military beneficiary population, AFGE sees no reason to oppose their participation in the program.

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