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001. list	meeting attendees (partial) (1 page)	nd	P6/b(6)

COLLECTION:

Clinton Presidential Records
Domestic Policy Council
Molly Brostrom
OA/Box Number: 8398

FOLDER TITLE:

DOD [Department of Defense] Medicare Subvention

2012-0326-S

kc782

RESTRICTION CODES

Presidential Records Act - [44 U.S.C. 2204(a)]

- P1 National Security Classified Information [(a)(1) of the PRA]
- P2 Relating to the appointment to Federal office [(a)(2) of the PRA]
- P3 Release would violate a Federal statute [(a)(3) of the PRA]
- P4 Release would disclose trade secrets or confidential commercial or financial information [(a)(4) of the PRA]
- P5 Release would disclose confidential advice between the President and his advisors, or between such advisors [(a)(5) of the PRA]
- P6 Release would constitute a clearly unwarranted invasion of personal privacy [(a)(6) of the PRA]

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PRM. Personal record misfile defined in accordance with 44 U.S.C. 2201(3).

RR. Document will be reviewed upon request.

Freedom of Information Act - [5 U.S.C. 552(b)]

- b(1) National security classified information [(b)(1) of the FOIA]
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- b(7) Release would disclose information compiled for law enforcement purposes [(b)(7) of the FOIA]
- b(8) Release would disclose information concerning the regulation of financial institutions [(b)(8) of the FOIA]
- b(9) Release would disclose geological or geophysical information concerning wells [(b)(9) of the FOIA]

Gordon

Adams

5-4657

Jim Fish

5-3776

Δ Don Fessenden
5-3884

SIMULATION OF MILITARY HEALTH SERVICES SYSTEM AS A MEDICARE AT-RISK HMO

The Department of Defense (DoD) will be conducting a simulation in which selected sites within the Military Health Services System (MHSS) will operate similarly to Medicare at-risk health maintenance organizations (HMOs) for dual-eligible Medicare/DoD beneficiaries. While this effort will not include actual Medicare reimbursement, it will attempt to simulate what would happen if DoD maintained its current level of effort and there was actual Medicare reimbursement. The goal of this simulation is to test a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries that would not increase the total federal cost for either agency.

DESCRIPTION OF SIMULATION PROJECT

1. **LEGAL AUTHORITY.** This simulation project is conducted under the existing authority of DoD.
2. **POPULATION COVERED.** The simulation covers six geographic areas (San Antonio (TX; two medical centers as well as freestanding clinics), Fort Sill (OK), Madigan (WA), Keesler (MS), Eisenhower (GA) and San Diego (CA)) and three comparison sites. Eligibility for participation is people who (during the project):
 - Are eligible for care from DoD and through Medicare's aged program (i.e., the simulation does not include Medicare's disabled or ESRD beneficiaries),
 - Enroll in TRICARE Prime, agree to receive covered services through TRICARE, and are residents of the geographic areas covered by the simulation and where enrollment in the simulation is offered,
 - Are covered by Medicare Part B,
 - Are not enrolled in a Medicare HMO, and
 - Are a dual-eligible who used a Military Treatment Facility (MTF), as a dual-eligible, before October 1, 1996 or became dual-eligible starting after June 30, 1996.
3. **SERVICES COVERED AND PATIENT COPAYMENTS.** Services covered include the services available on a space available basis through DoD for dual-eligible beneficiaries and do not include services covered only by Medicare. Patient copayments are also as currently defined for space available care for dual-eligible beneficiaries. Over age 65 enrollees in this simulation project will be given the same priority as retired enrollees under age 65. DoD will not require premiums or enrollment fees in this simulation but will require Medicare Part B coverage.
4. **SERVICES PROVIDED.** Services covered under the simulation project and covered by DoD as space available care are the responsibility of DoD and are provided directly by DoD. The provision of services not available as space available care will be arranged for by DoD with Medicare-approved providers and covered by Medicare as authorized under current law. HCFA will be asked to assist with tracking these latter costs.
5. **ENROLLMENT.** DoD will offer enrollment to dual-eligible beneficiaries eligible under this simulation as defined above under "Population Covered." Prime enrollees who turn 65 and have MTF primary care managers will have priority for becoming enrolled over other dual-eligibles. A dual-eligible, who has signed up for Part B but which is not yet effective, may enroll with the effective date tied to the Part B effective date. Enrollees must pay applicable cost shares and agree that TRICARE Prime will be the exclusive source of covered health care, except for care provided by non-DoD providers through a DoD referral. DoD will request HCFA's assistance in developing means to a) limit enrolled beneficiaries to using care either provided or arranged by DoD and b) track costs for services provided by non-DoD providers.

At each site, there will be an application mailed to all dual-eligibles who are eligible for the simulation. Applications for enrollment by dual-eligible beneficiaries will be accepted in the order in which they are received until demand for enrollment at any site exceeds the capacity for the simulation. For those received on the same day, a random selection process will be used to ensure that all applicants have an equal probability for selection.

6. **REQUIREMENTS APPLICABLE TO MEDICARE AT-RISK ORGANIZATIONS.** DoD will meet, for purposes of the simulation and to the extent feasible, the applicable requirements similar to a Medicare at-risk HMO.
7. **SIMULATION OF MEDICARE REIMBURSEMENT TO DOD.** Though Medicare reimbursement to DoD has not been authorized by HCFA, ^{congress} "simulated" Medicare reimbursement and end-of-year reconciliation will be carried out.
- Prior to being eligible for a simulated Medicare reimbursement under this simulation in a given year, DoD will commit to the expenditure of resources for dual-eligible beneficiaries at a level representing DoD's FY96 level of effort.
 - After DoD meets its level of effort in the particular geographic area(s) under the simulation project, a simulation will be run to show how Medicare would reimburse DoD on a capitated basis equal to a percentage of the Adjusted Average Per Capita Cost (AAPCC) applicable to the dual-eligible beneficiaries enrolled under the simulation. The simulated reimbursement will be run using two approaches. The first reimbursement approach would be that the reimbursement rate by Medicare to DoD is 93 percent of the applicable AAPCC rate as determined under Title XVIII of the Social Security Act. The second reimbursement approach is the same in the first year but for subsequent years is as follows. In the second year, the reimbursement rate is two percentage points less than the percentage rate (currently 95 percent) applicable to at-risk Health Maintenance Organizations under Medicare. In the third year, the reimbursement rate is 90.25 percent of the applicable AAPCC rate. In the second and third years, the applicable AAPCC rate will be the applicable AAPCC rate excluding: 100 percent of graduate medical education (GME) and disproportionate share hospital (DSH), 40 percent of indirect medical education (IME) and 67 percent of capital. Over the three years of the simulation, the evaluation will track the rate and evaluate it against the simulation's primary goal.
 - For this project, the simulation will assume that the maximum total Medicare reimbursement to DoD for any project year will not exceed \$65 million.
 - At the end of each simulation project year, DoD will conduct and invite HCFA to join in a simulated reconciliation process at the end of the year to correct for discrepancy between cost targets and actual spending, and to correct for any population selection effects.
8. **LEVEL OF EFFORT.** For the purposes of this simulation, DoD's level of effort is the estimated level of effort expended by DoD on dual-eligible beneficiaries for FY96 updated with an annual adjustment by the applicable inflation rates in the Defense Health Program.
9. **PROHIBITION AGAINST INCREASING AGENCY COST.** Since a Medicare demonstration project shall not increase the total cost of Medicare, the simulation project shall operate under the same requirement.
10. **JOINT ANALYSIS OF COST, UTILIZATION AND OTHER DATA.** DoD will request that HCFA join DoD in carrying out analyses of a merged data set of dual-eligibles based on questions (including utilization and cost prior to and during the simulation) developed jointly.
11. **EVALUATION.** The demonstration will be evaluated by an independent evaluator funded by DoD. The evaluation contractor will produce an semi-annual report.
12. **GENERAL ACCOUNTING OFFICE STUDY.** If the General Accounting Office (GAO) conducts a review as to whether or not the simulation indicates that a Medicare demonstration where Medicare actually reimburses DoD would likely increase the total cost of the MHSS or the total cost of Medicare, DoD will assist GAO with that review.
13. **DURATION.** The ^{simulation} demonstration begins May 1, 1997 and lasts three years.
14. **ASSISTANCE FROM THE HEALTH CARE FINANCING ADMINISTRATION.** In carrying out this simulation, DoD will request the assistance of HCFA in the following areas: a) tracking costs for enrollees receiving care outside the MHSS, b) ~~developing administrative means for limiting enrolled beneficiaries to using care either provided or arranged by DoD,~~ c) assessing the extent to which DoD meets the applicable requirements similar to a Medicare at-risk HMO, d) simulating the end-of-the-year reconciliation process, e) analyzing merged data set on dual-eligibles, and f) participate in the DoD evaluation of the simulation.

Subvention Status Report

10/7/96

VA

- . Administration submitted legislation August 8
- . Montgomery and Stump (House Veterans Affairs Committee) introduced HR 4068; at first very different from Admin. bill (reimb. for Cat. A's as well as C's). CBO scored at \$850 million. M&S worked out with CBO -- proposal became enrollee-specific. Did not move beyond committee.
- . No Action on Senate side.
- . Kizer is expected to stay; very interested in Subvention.

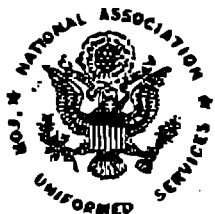
DoD

- . Administration submitted legislation mid-September.
- . House National Security Committee (Spence) introduced own bill; irritated others who thought issue was in their purview, particularly Ways & Means (Stark very opposed).
- . Senate process more collegial and coordinated; run mostly by Finance with Gramm's staff. Administration worked with them on their bill. Tried to get into Omnibus bill, but House disagreement reportedly prevented action (or, all Medicare provisions were dropped).
- . CBO scored the President's bill at \$25 million/year. Said DoD would have to receive 50% reimbursement from Medicare in order to make budget neutral. Agreement reached: 50% reimbursement from Medicare to DoD; Trust Fund created from sale of Palladium stockpile to cover rest (\$25 million).
- . DoD considering doing something internally -- i.e. somehow responding to military retirees clamoring for more access to military treatment facilities.

OCT-03-1996 12:46

NAUS

703 354 4380 P.02/03



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SOCIETY OF MILITARY WIDOWS
(Affiliated 1984)

NEWS RELEASE

FOR IMMEDIATE RELEASE

October 1, 1996

More information, contact:

Sharon Barnes 800-842-3451, ext. 3009

Partisan Politics Bargain Away Military Retirees Health Care

Major General Jim Pennington, USA (Ret), president of the National Association for Uniformed Services (NAUS), expressed disappointment that last minute partisan wrangling in the House of Representatives killed congressional action on the joint Department of Defense (DoD)/Medicare subvention demonstration project this year.

"Military retirees and veterans should not be used as pawns in partisan political maneuvering," Pennington said.

As late as mid-day Friday, September 27, Senate Majority Leader Trent Lott (R-MS), Sen. Phil Gramm (R-TX) and Rep. Joel Hefley (R-S-CO) had an agreement with House and Senate Committees of jurisdiction that the Medicare/DoD subvention project would be approved as part of the Continuing Resolution to provide federal spending for fiscal year 1997.

The agreement became unraveled when members of the House Ways and Means Committee including Representatives Pete Stark (D-13-CA), Charles Rangel (D-15-NY) and Bill Thomas (R-21-CA) engaged in political "one-up-man-ship" to hold Medicare subvention hostage in exchange for several other Medicare related amendments. House leaders sided with House Ways and Means Health Subcommittee Chairman Bill Thomas (R-21-CA), and pulled the demonstration out of the Continuing Resolution negotiations by late Friday afternoon.

NAUS political action team members reacted quickly to try to salvage support for the Medicare demonstration project, but at this late hour, there simply wasn't enough time. The House was in a hurry to finish business and go home to campaign.

NAUS had hoped to get White House Chief of Staff Leon Panetta to demand Medicare subvention be part of the Continuing Resolution during his negotiations with Congress.

The loss of this important health care issue was particularly disappointing because of winning President Clinton's personal intervention in support of subvention during Pennington's June 3rd White House meeting and the strong support of Senate Majority Leader Trent Lott, Sen.

Phil Gramm (R-TX), Sen. William Roth (R-DE) and Rep. Joel Hefley (R-5-CO) and the Senate and House Committees of jurisdiction except the House Ways and Means Committee. It is unfortunate that House Ways and Means Health Subcommittee undermined our efforts to give military retirees the health care they have earned and deserve.

We are confident that this DoD/Medicare Subvention Demonstration would prove care could be provided by DoD at a savings of up to 50% to the Medicare Trust Fund.

We believe the President has the authority to put this demonstration project in place by making DoD a Medicare provider. An agreement between Health and Human Services and DoD has already been approved.

On a positive note, hearings on Medicare subvention have been held for the first time before the subcommittees of three key House Committees: National Security, Ways and Means and Commerce. Also, the Congressional Budget Office scored the demonstration as budget neutral. Therefore, if Congress wants to, the issue could be moved quickly in the 105th Congress.

Medicare subvention was only one of our military health care initiatives. Another key initiative is the option of allowing all military retirees and their families to participate in the Federal Employees Health Benefits Program (FEHBP). We must focus on this issue early in the 105th Congress.

During the period before the election and before the beginning of the 105th Congress next year, we urge you to contact your members of Congress to gain their support for both of these initiatives.

###

[The National Association for Uniformed Services (NAUS) was founded in 1968 to support legislation to uphold the security of the United States, sustain the morale of the armed Forces, and provide fair and equitable consideration for all members of the uniformed services: active, reserve, National Guard, other veterans, retired and their spouses, widows and widowers. The Society of Military Widows (SMW) became affiliated with NAUS in 1984. Membership is now over 160,000 with over 500,000 additional family member and supporter voters. As a member of the National Military/Veterans Alliance with almost 3 million members, collectively, our organizations represent the 80 million Americans who directly serve and have served their country and their dependents. NAUS is the only association to represent all grades, ranks, components, and branches of the uniformed services: Army, Navy, Marines, Air Force, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration. For more information about the organization, write: NAUS 5535 Hempstead Way, Springfield, VA 22151, or call: 800-842-3451 or 703/750-1342.]

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release

September 10, 1996

STATEMENT BY THE PRESIDENT

Today, I am pleased to announce, on behalf of more than one million Medicare-eligible military retirees, a new demonstration that will expand health care options for our nation's military retirees.

This initiative moves forward an idea -- Medicare subvention, or Medicare reimbursement of Department of Defense health facilities -- that the military retiree community has sought for many years. This Administration first embraced the concept of Medicare subvention three years ago under health reform. More recently, the Administration moved the concept forward in a legislative proposal for the Department of Veterans Affairs.

The demonstration I am announcing today, the "Medicare Demonstration of Military Managed Care," is a partnership between the Departments of Health and Human Services and Defense that can generate multiple benefits: expanded health care options and improved access to military treatment facilities for Medicare-eligible military retirees; a better way for the Department of Defense to care for retired beneficiaries and support medical readiness; and savings for the Medicare Trust Fund by providing health care to Medicare-eligible military retirees at a lower cost in the DoD health care system.

Under this demonstration project, Medicare-eligible military retirees in five communities could enroll in Defense's new TRICARE Prime managed care system, and Medicare would reimburse DoD for these enrollees at a rate below what is traditionally paid to Medicare managed care plans. To protect the Medicare Trust Funds, Defense would receive Medicare payments only after meeting its current level of funding effort. The demonstration will test whether Medicare subvention is a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries.

We will submit legislation reflecting this agreement shortly. I am pleased that there is strong bipartisan support for this demonstration, and I look forward to working with Congress in quickly enacting enabling legislation this year.

We owe a great debt to those who have risked their lives defending our nation. This agreement is an important step toward repaying that debt.

-30-30-30-

11-48-10 11:55AM

SENT BY: JUL-30-1996 15:03



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

JUL 30 1996

Senator Trent Lott
United States Senate
Washington, D.C. 20510

Dear Senator Lott:

In response to your office's request, let me take this opportunity to update you on the progress with respect to the Medicare demonstration on reimbursing military medical facilities. Over the past month, the President has reiterated his support and has directed the Departments of Defense and Health and Human Services, working with the Office of Management and Budget, to quickly complete work on the demonstration. Given the President's direction, all three agencies have increased the pace of the negotiations.

As a result of this acceleration of efforts, the three agencies believe that we are near agreement on the demonstration. For that reason and the commitments made by both Departments and the Office of Management and Budget, there seems to be no reason why the two Departments would not be able to meet the September 6th reporting date specified in the current Defense authorization legislation.

I trust that this responds to your request. If you need further information, please feel free to call upon us. On behalf of our beneficiaries, let me thank you again for your interest and your strong support of this effort.

Sincerely,

Stephen C. Joseph, M.D., M.P.H.

cc

Bruce Viadeck, Administrator, Health Care Financing Administration
Gordon Adams, Associate Director, Executive Office of Management and Budget

NAME	AGENCY	PHONE
Bob Donnelly	OMB	395-7814
Bob Pellicci	OMB	395-4871
John Richardson	OMB	395-7816
Molly Brastrom	DPC	6-5561
Shawn Arnold	HCFA	690 5705
* Joel Slackman	HCFA	690-8258
* Dan Erman	HCFA	690 5856
Carl Taylor	HHS	690-5708
Gary Christopherson	DoD	(703) 697-2111
* Tom Leary	DoD	(703) 695-2504
JOHN CASCIOTTI	DoD	(703) 697-9657
* AL GIAMBORE	DoD	(703) 697-2111
Janet Murgusa	WH Leg. Affs	456-6620
Lisa Kountarpes	UMBLLA	395-4790
Gordon Adams	OMB	395-84657

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Tom Leary

DoD/Log Aff

P6/(b)(6)

Karen Pollitz HHS Legislation 301-587-2976

Patty Lewis

DoD/Health Affairs

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Dan Erman HCFA / legis. 301 6226288

Mark Miller

OMB/HHS

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Molly Brostrom

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202/483-9430

Pager of the signal
operator

Gordon Adams

301/681-0249



E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

23-Aug-1996 06:20pm

TO: BROSTROM_M
FROM: Nancy A. Min

SUBJECT: Re: DoD Subvention

Message Creation Date was at 23-AUG-1996 18:22:00

We said we would try to reach agreement on a Memorandum of Understanding by mid-August. We've been working very hard on this, but DOD has been very difficult to deal with. Last Friday, after everything else had been agreed to, Steve Joseph put a new item on the table--he wants the HHS Secretary to be mandated to change the reimbursement rates to DOD if the evaluation during the demo shows that the rates should be higher. That is a deal breaker. If DOD were a private company--which is what they have been arguing this will be like--we would tell them to take a hike. The HHS secretary is never going to cede her authority to set appropriate Medicare reimbursement rates. And if it turns out that DOD is more expensive than they thought or told the President (the 93 cents on the dollar comment that he keeps mentioning), then maybe this isn't a good idea for Medicare anyway.

Joseph also keeps trying to revisit the question of whether legislation is necessary. After a meeting with the DOD and HCFA counsels, Bob Damus, OMB's general counsel, concluded that it is.

Joseph is on vacation now, as is Vladeck. We've been working with their staffs this week to try to breathe life back into this. We think we have come up with a compromise, but won't know for sure until they both get back from vacation and take a look at what we've drafted.

Assuming they both agree, the next step is drafting legislative language, which HCFA thinks it can have a draft of in a week.

You should know, however, that the Senate Finance committee (other than Gramm) is furious about this whole thing, and thinks Medicare subvention is a bad idea. Therefore, unless this turns out to be budget neutral, I'm not sure it will happen anytime soon.



The Assistant Secretary of Defense (Health Affairs)

Facsimile Cover Sheet

To: Jeremy Benami / Molly Brostrum
Organization: White House Domestic Policy
Phone:
Fax: 202 -456-7028

From: Gary A. Christopherson,
Senior Advisor on Health Affairs
Organization: OASD(HA), RM3E346 Pentagon
Phone: 703-697-2111
Fax: 703-614-3537

Date: 8/13/96
Pages with cover
page: 9

Jeremy, Molly,

Attached is a letter which we have sent to Gordon Adams at OMB with copies to Bruce Vladeck and Jack Lew. In it is contained the one-page of amendments discussed in a staff negotiating session on Friday and a proposed final agreement with those amendments included. Give me a call if you have questions or want some background.

Gary



THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

HEALTH AFFAIRS

AUG 12 1996

Gordon Adams
Associate Director, National Security and International Affairs
Executive Office of Management and Budget
238 Old Executive Office Building
Washington, DC 20503

Dear Gordon:

In the interest of bringing the issue of a Medicare demonstration to a closure in a way that best serves the interests of the President, the beneficiaries and both agencies, the staffs of the Health Care Financing Administration and the Department of Defense have worked hard toward common ground. Some issues, however, remain unresolved. What I am forwarding as an enclosure is what I sincerely believe represents that common ground, a Medicare demonstration that fairly tests the concept of Medicare reimbursement to Military Treatment Facilities. The enclosed cover page, presented and discussed at last Friday's staff negotiating session, represents what we believe are a final set of amendments necessary for a signed agreement this week. The enclosed draft agreement incorporates those amendments.

It is very important that everyone understand that we are not presenting this as just another bargaining position. Some in the military beneficiary organizations and the Department of Defense argue that we have already given up too much. We believe that this draft agreement is fair for all parties. This agreement is ready to be signed on Tuesday. This agreement delivers on the President's commitment and allows him to announce that the Administration's efforts have been successful and that a demonstration will begin January 1, 1997.

We trust we can count upon you for support.

Sincerely,

A handwritten signature in dark ink, appearing to read "Steve", is written over the typed name.

Stephen C. Joseph, M.D., M.P.H.

Enclosures:
As Stated

cc: Jack Lew, Acting Director, Executive Office of Management and Budget
Bruce Vladeck, Administrator, Health Care Financing Administration

Draft 8/9/96

Final DHHS/DoD Agreement on Medicare Demonstration

The final DHHS/DoD Memorandum of Agreement to be signed by Dr. Vladeck and Dr. Joseph by August 15, 1996 is the 8/9/96 Draft Memorandum of Agreement (with technical revisions to the attachments in order to make them consistent with this final agreement) amended as follows:

<u>DoD</u>	<u>DHHS</u>
DHHS and DoD mutually agree to set reimbursement at 91 percent of the full Medicare AAPCC	
Accepts DHHS proposal for multi-site demo in Regions 6 and 11.	Accepts DoD proposal for eligibility of those who either used, as a dual-eligible, a Military Treatment Facility (i.e. inpatient or outpatient user) before July 1, 1996 or became dual-eligible after June 30, 1996.
Accepts DHHS proposal for not having a separate payment for SNF/HH but counting the amounts toward level of effort. To compensate for this, the number of enrollees beyond level of effort increases to offset the dollar value of no separate payment for SNF/HH.	Accepts DoD proposal for a January 1, 1997 start.
Accepts DHHS proposal for IDA adjustments and an IDA validation study within 18 months. DoD will estimate relevant "F" account costs directly and adjust the IDA "add-on" factor accordingly. DoD will validate IDA's findings regarding MEPRS cost factors and the size of the add-on.	Accepts DoD proposal: For the demonstration, the maximum total Medicare reimbursement to DoD for any demonstration years will not exceed \$__ million for the first year, \$__ for the second year, and \$__ million for the third year. The maximum is determined by estimating the expected Medicare reimbursement for a demonstration year and increasing that amount by one-half. This is designed to avoid creating an artificial limitation on the demonstration and limit the total risk to the Medicare Trust Fund.

8/10/96

MEDICARE DEMONSTRATION OF MILITARY MANAGED CARE

-- MEMORANDUM OF AGREEMENT --

The Department of Health and Human Services' (DHHS), the Health Care Financing Administration (HCFA), the Department of Defense (DoD) and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) agree to conduct a demonstration where the Medicare program will treat the DoD and its Military Health Services System (MHSS) similarly to a risk-type health maintenance organization (HMO) for dual-eligible Medicare/DoD beneficiaries. The demonstration will be operated under the terms of the agreement defined below. Under this agreement, Medicare will pay for dual-eligibles enrolled in the DoD managed care program after DoD meets its current level of effort, measured in terms of health care expenditures for the dual-eligible population

The goal of this demonstration is, through a joint effort by DHHS and DoD, to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries while ensuring that the demonstration does not increase the total federal cost for either agency.

TERMS OF THE AGREEMENT

The Department of Health and Human Services and the Department of Defense agree to carry out a Medicare demonstration of military managed care under the following terms:

1. LEGAL AUTHORITY.

This demonstration project is conducted under the authority of section 402(a) of the Social Security Amendments of 1967 (42 USC 1395b-1) (Medicare demonstration project authority), section 1092 of title 10, United States Code (DoD demonstration project authority), under the authority of an Executive Order (authorizing and directing demonstration projects with DHHS and DoD), and, if necessary, under the authority of new legislation jointly agreed to by DHHS and DoD and enacted into law.

2. POPULATION COVERED.

- a) The demonstration covers four sites in Region 6--San Antonio (because of its two medical centers as well as freestanding clinics), two outlying catchment areas (or overlapping catchment areas) served by community hospitals, and one "noncatchment" area with a large concentration of Medicare-eligible beneficiaries (e.g., Houston or Dallas)--and one site in Region 11--the Madigan-Bremerton region. In addition, we will prospectively designate three "comparison" sites, to include two outlying catchment areas and one noncatchment area in Region 6.
- b) Eligibility for participation in the demonstration consists of people who (during the demonstration):
 - Are eligible for care from DoD and through Medicare's aged program (i.e., the demonstration excludes Medicare beneficiaries who are disabled to eligible for ESRD benefits),
 - Enroll in TRICARE Prime,
 - Are covered by Medicare Part B,
 - Agree to receive covered services through TRICARE,
 - Are residents of the geographic areas covered by the demonstration and where enrollment in the demonstration is offered, and
 - Are a dual-eligible who, as a dual-eligible, used a Military Treatment Facility during the two years before July 1, 1996 or became dual-eligible starting after June 30, 1996 [Note: This provision may need to be part of a national Medicare subvention program].

3. SERVICES COVERED AND PATIENT COPAYMENTS.

Services covered include the standard Medicare benefit in addition to specific TRICARE Prime benefits defined in Attachment A -- "Benefits". Patient copayments are also defined in Attachment A.

Before final signature by the Secretaries, DoD will resolve two issues:

- (1) the extent of any premiums or enrollment fees; and
- (2) the availability of a point-of-service option.

4. SERVICES PROVIDED.

The provision of services covered under the demonstration is the responsibility of DoD and services are either provided directly by DoD or arranged and paid for by DoD.

5. ENROLLMENT.

- a) DHHS authorizes DoD to enroll dual-eligible beneficiaries, using TRICARE Prime, in the Medicare demonstration.
- b) DoD will offer enrollment to dual-eligible beneficiaries eligible under this demonstration as defined in Attachment B -- "Enrollment".
- c) Enrollees must pay applicable enrollment fees and cost shares and agree that TRICARE Prime will be the exclusive source of health care for enrolled beneficiaries. DHHS and DoD together will develop the means to "lock in" enrolled beneficiaries so that they do not continue using their fee-for-service Medicare benefits.

6. APPLICATION OF CONDITIONS OF PARTICIPATION APPLICABLE TO MEDICARE AT-RISK ORGANIZATIONS.

DoD will meet or be deemed to meet, the applicable and agreed upon requirements, as defined in Attachment C -- "Applicable Conditions of Participation", similar to a Medicare at-risk HMO.

7. MEDICARE REIMBURSEMENT TO DOD.

Medicare reimbursement and end-of-year reconciliation is based on the following provisions as defined further in Attachment D -- "Reimbursement"

- a) Prior to being eligible for Medicare reimbursement under this demonstration in a given year, DoD will commit to the expenditure of resources for dual-eligible beneficiaries at a level that represents the DoD's FY96 level of effort, as defined below, 1) in the particular geographic area(s) covered under the demonstration and 2) updated for the given year.
- b) Skilled nursing facility and home health costs, not a DoD benefit, paid by DoD for enrollees below the level of effort will be counted toward the level of effort. To compensate for this, the number of enrollees beyond level of effort increases to offset the dollar value of no separate payment for SNF/HH
- c) After DoD meets its level of effort in the particular geographic area(s) covered under the demonstration, Medicare will reimburse DoD on a capitated basis equal to a percentage of the Average Annual Per Capita Cost (AAPCC) applicable to the dual-eligible beneficiaries enrolled under the demonstration.
- d) The reimbursement by the Medicare to DoD is 91 percent of the applicable AAPCC rate as determined under Title XVIII of the Social Security Act, unless adjusted otherwise by mutual agreement of the Secretary of Health and Human Services and the Secretary of Defense. Over the three years of the demonstration, the evaluation will track the rate and evaluate it against the primary goal of the demonstration.
- e) For the demonstration, the maximum total Medicare reimbursement to DoD for any demonstration years will not exceed \$__ million for the first year, \$__ for the second year, and \$__ million for the third year. *[Note: Based on this final agreement and earlier discussion, these amounts will be included before the final agreement is signed by the Secretaries.]* The maximum is determined by estimating the expected Medicare reimbursement for a demonstration year and increasing that amount by one-half. This is designed to avoid creating an artificial limitation on the demonstration and limit the total risk to the Medicare Trust Fund.
- f) At the end of each demonstration year, DHHS and DoD will conduct a reconciliation process at the end of the year to correct for discrepancy between cost targets and actual spending, and to correct for any selection effects. The reconciliation will not adjust for "underpayments" or "overpayments" that result from inefficiency or efficiency.
 - Determine total spending, broken down between space available and enrollee care.

- If favorable or adverse selection into the DoD plan is detected and based on joint agreement by DHHS and DOD, recalculate what Medicare's payments should have been given the appropriate AAPCC adjustment and adjust payments accordingly.
- If DoD received capitation payments from Medicare and its actual costs were less than the level of effort, DoD reimburses Medicare up to its level of effort.
- HCFA auditors and the DHHS IG will have access to DoD's facilities and data--HCFA and DoD will develop some "grievance and appeals" process for settling any disputes that arise over the data.

8. LEVEL OF EFFORT.

For the purposes of this demonstration, DoD's level of effort is the estimated level of effort expended by DoD on dual-eligible beneficiaries for FY96 updated with an annual adjustment by the applicable inflation rates in the Defense Health Program.

- a) If for the base year or demonstration years, overall defense health spending (Category 3 of the Defense Health Program (See definition in "Level of Effort" attachment; currently about \$12 billion)), updated with an annual adjustment by the applicable composite inflation rates, changes by more than \$100 million, then DoD may adjust the level of effort by a proportionate amount (e.g., if the budget is \$400 million lower or higher, and defense health spending (Category 3) amounts to \$12 billion, the level of effort will fall or rise by approximately 3.3 percent).
- b) If there are any BRAC actions that result in reductions in DoD's ability to serve dual-eligibles, an adjustment will be made in the level of effort so as to hold DoD harmless.
- c) The initial estimated FY96 level of effort will be based on FY95 estimates; the final estimated FY96 will be re-based using actual FY96 numbers available as of October 1, 1997.
- d) For purposes of establishing level of effort in the base year, level of effort consists of DoD resources expended for dual-eligibles for space-available care and DoD's Uniformed Services Treatment Facilities costs. For purposes of establishing operational level of effort in demonstration years, level of effort consists of the same expenditure categories plus care provided to enrollees (i.e., enrollees below level of effort) in this demonstration.
- e) Level of effort for the baseline period is calculated using the methodology defined in Attachment E -- "Baseline Level of Effort". Level of effort for the demonstration years is calculated using the methodology defined in Attachment F -- "Operationalization of Level of Effort".
- f) To hone estimates of level of effort for the baseline period:
 - The level of effort will exclude outpatient pharmacy expenses but include DoD's USTF costs.

- The level of effort should treat DoD collections from Medicare supplemental policies the same in both the baseline and the operational level of effort. Both agencies agree to reexamine this issue if there is a substantial change in collections during the demonstration.
- DoD will estimate level of effort for..... *[Note: the final decision of basing level of effort on facility costs or the cost for a given site's population is somewhat of a technical issue and will be decided by the DHHS and DoD before final signature by the Secretaries.]*

g) To trigger monthly capitated payments:

- At beginning of year, set operational level of effort.
- Divide level of effort in a "space available" portion and an "enrolled" portion.
 - In the first demonstration year, set space available equal to a) the baseline level of effort less the dollar equivalent of the "below level of effort" enrollees plus b) 10 percent of that amount. "Below level of effort" enrollees equals total enrollees less those enrollees representing effort beyond the operational level of effort). For each subsequent year, the amount of space available care will be less than the previous year.
 - Set monthly targets for enrollees necessary to maintain level of effort.
- Given the per capita reimbursement rate, Medicare pays DoD for each enrollee who puts DoD over the monthly target.
- To hone estimates of level of effort for the baseline period:
 - DoD will estimate relevant "F" account costs directly and adjust the IDA "add-on" factor accordingly.
 - b) DoD will validate IDA's findings regarding MEPRS cost factors and the size of the add-on.

9. PROHIBITION AGAINST INCREASING AGENCY COST.

The demonstration project shall not increase the total cost of Medicare. In order to ensure the demonstration does not increase the total cost of Medicare, DHHS and DoD will take appropriate action, among which may be DoD reimbursing DHHS, suspending or terminating the demonstration, adjusting reimbursement rates or level of effort, or another appropriate course of action.

10. JOINT ANALYSIS OF COST, UTILIZATION AND OTHER DATA.

DHHS and DoD agree to carry out analyses of a merged data set of dual-eligibles based on questions (including utilization and cost prior to and during the demonstration) developed jointly by the two agencies.

11. EVALUATION.

- a) The demonstration is evaluated by an independent evaluator chosen jointly by DHHS and DoD, funded by DoD and in place at the start of the demonstration.

- b) The evaluation contractor will produce an annual report, an interim report within 18 months of the initiation of this demonstration, and a final report twelve months from the end of the demonstration.
- c) The evaluation will be based on the evaluation questions jointly developed by DHHS and DoD and detailed in Attachment H -- "Evaluation". Of those questions, the primary evaluation question will be "Can DoD and Medicare implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries?" The evaluation will also emphasize the four major areas identified by DHHS and DoD in delineating the evaluation questions. The evaluation will also examine the impact of the demonstration on medical services for active duty and active duty dependents.
- d) DHHS and DoD will provide the necessary data to support the evaluation.

12. GENERAL ACCOUNTING OFFICE STUDY.

If Congress directs the General Accounting Office (GAO) to conduct a review and report to Congress as to whether or not the demonstration has increased the total cost of the Military Health Services System or the total cost of Medicare, both agencies agree to jointly assist GAO with that review and report.

13. DURATION.

The demonstration lasts three years, but DHHS and DoD have the option of extending the demonstration for up to 18 months for currently enrolled beneficiaries. The demonstration begins on January 1, 1997.

14. WITHDRAWAL.

Either DHHS or DoD may terminate the demonstration with twelve months advance written notice to the other agency.

Bruce C. Vladeck
 Administrator
 Health Care Financing Administration
 Department of Health and Human Services

Stephen C. Joseph
 Assistant Secretary of Defense (Health Affairs)
 Department of Defense

Donna Shalala
 Secretary
 Department of Health and Human Services

William Perry
 Secretary
 Department of Defense

"MEDICARE SUBVENTION"

I am pleased to be here today to discuss Medicare subvention, a demonstration project that will be conducted by the Health Care Financing Administration (HCFA) and the Department of Defense (DOD) whereby Medicare will pay for dual-eligible Medicare/DOD beneficiaries in the DoD managed care program. In forging this agreement, we believe the stage has been set for a project that will provide quality service to these dual-eligible beneficiaries and, at the same time preserve and protect the Medicare Trust Fund for all Americans.

We are happy to be joining with our colleagues in the Department of Defense (DoD) in moving forward with this test. More than one million Americans are dually-eligible to receive health care through the Department of Defense's military health services system and through the Medicare program. Over the years, DoD and Medicare have separately provided access to quality care for these dual-eligible beneficiaries. This demonstration will give us the opportunity to assess the effects of coordination on improving efficiency, access, and quality of care for this population in a selected number of sites in Texas, Washington State, Oklahoma, Louisiana and Arkansas.

As HCFA and DoD collaborated to design this demonstration, we at HCFA kept our eyes on two imperatives: We must protect beneficiaries and we must protect the Medicare Trust Funds. As you know, this Administration has expressed its concern about the solvency of the Trust Funds, and has proposed measures to strengthen them each year since coming into office. We must ensure that Medicare benefits are available for all beneficiaries. As we worked on the design of this program, strategies to prevent further depletion of the Trust Funds were utmost in our thinking.

I'd like to detail for you some of the provisions of our agreement with DOD and the safeguards that we have created.

Our agreement protects the Medicare Trust Funds against the risks of cost-shifting. First and foremost, DoD will receive Medicare payments only after it surpasses its current "level of effort", i.e., the dollar amount DoD now spends rendering health care services to dual-eligible beneficiaries in military treatment facilities in the demonstration sites. This level of effort will be updated for each year of the demonstration.

Some services that are covered under Medicare are not covered by DoD, such as skilled nursing facility and home health care. Enrollees in the demonstration will be provided with the full Medicare benefit package.

After DoD meets its level of effort in the area covered by the demonstration, Medicare will reimburse DoD on a capitated basis equal to a percentage of the Adjusted Average Per Capita Cost (AAPCC) applicable to the beneficiaries enrolled in the demonstration. We have agreed to adjust the applicable AAPCC to exclude some of the costs associated with capital, indirect and graduate medical education and disproportionate share hospitals.

These exclusions are believed to be outside the purview of the Medicare payments under the demonstration. The reimbursement rate will be set at 93 percent of the applicable AAPCC in the first year. This is two percentage points less than the 95 percent that Medicare currently pays to risk HMOs. It reflects the increased efficiency of the DoD in providing care to Medicare beneficiaries. In years two and three, this rate will be set at 90.25 percent. At the end of each year, DHHS and DoD will reconcile any payment discrepancies and correct for any mistaken overpayments.

The maximum total Medicare reimbursement to DoD for any demonstration year will not exceed \$65 million. Further, DoD has agreed to open its facilities to audits by HCFA, and the Department of Health and Human Services Inspector General. We have designed this demonstration so that there will not be an increase in the total costs of Medicare. If it is found that Medicare costs are more than they would have been without the demonstration, the two departments have agreed to take any necessary corrective action. For example, DoD may reimburse HCFA; we may suspend or terminate the demonstration; or, we may adjust reimbursement rates or levels of effort. These are some of the most significant steps that we have taken to limit the total risk to the Medicare Trust Fund.

Our agreement protects, indeed expands, beneficiaries' freedom of choice--they can use their Medicare benefits to enroll in and easily disenroll from TRICARE, or they can obtain care from civilian providers and continue to seek care from DoD on a space-available basis. Our agreement protects beneficiaries' quality of care because DoD will provide the complete range of Medicare benefits (including skilled nursing facility and home health care services not normally provided by DoD), and in so doing will adhere to Medicare's conditions of participation and quality standards.

Thus, we strongly believe that we have taken all possible steps to protect both beneficiaries and the Trust Funds from harm. Will we succeed? The answer will lie in a rigorous evaluation of this demonstration by an independent evaluator. Over the demonstration's three years, the independent evaluator will monitor performance and collect data to answer these crucial questions:

- Is there an impact on the costs to either the Medicare Trust Funds or DoD?
- Do beneficiaries experience improved access to health care?
- Is there any change in quality of care provided to the enrolled population?
- Is there any effect on local health care providers and other Medicare beneficiaries in the surrounding community?

At the end of three years, we will see how coordination between our two programs improves efficiency, access, and quality of care for dual-eligible beneficiaries. If Congress should decide on a GAO study of the demonstration, both DoD and DHHS have agreed to jointly assist GAO with that review and report. In the meantime, we have put the necessary safeguards in place to protect beneficiaries and protect the Medicare Trust Funds.

The President strongly supports this demonstration. Secretary Shalala enthusiastically approved the agreement between the Health Care Financing Administration (HCFA) and DoD to coordinate our two programs in this three-year demonstration of Medicare "subvention."

We are hopeful that this demonstration will succeed, and that through it the beneficiaries we share in common with DoD will receive enhanced choices and improved services -- the real "bottom line" in this effort.



THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

JUN 27 1995

HEALTH AFFAIRS

Mr. Bruce C. Vladeck
Administrator
Health Care Financing Administration
Room 314G, Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Vladeck: 

As you may know, the Department of Defense (DoD) is quite interested in beginning a joint DoD/HCFA Medicare HMO Demonstration Project. With the enactment of the National Defense Authorization Act for Fiscal Year 1995, DoD was granted the authority to implement such a demonstration project. This demonstration would authorize military treatment facilities as a provider to a Medicare Risk HMO.

As you recall, the President has supported the concept of Medicare subvention in the Health Care Reform bill. Though scoring difficulties created a barrier legislatively, the Congress has displayed significant interest this year in such a project. I am sure we can design a joint project that would be beneficial for both agencies and for our beneficiaries.

We have had several meetings with staff from your agency in order to explore the operational details of such a program. However, HCFA in its comments on the proposed DoD TRICARE Rule stated, "While we agree that coordination agreements can have merit, they pose legal problems for the Medicare program, principally because the HMO cannot reimburse the MTF." I would like to suggest that we meet to discuss this proposed program and hopefully we can find a positive resolution to those concerns. So many of our mutual beneficiaries have asked for this program that I would prefer not to delay the demonstration any further.

I would also like to discuss with you a second demonstration, in two or more regions, which was originally suggested by the Office of Management and Budget (OMB). This demonstration project would be for Medicare-eligible DoD beneficiaries and DoD beneficiaries who become Medicare eligible during the demonstration who are currently using an MTF for their health care needs. To participate in the demonstration, the beneficiary must be signed up for Medicare Part B and they must be enrolled in TRICARE Prime. All covered health care services will be provided or arranged by the MTF. DoD will maintain its current level of effort in terms of dollars and number of beneficiaries. To the extent we go beyond that, we ask that Medicare cover the costs based on 93% of the Average Adjusted Per Capita Cost (AAPCC).

I would like to see HCFA and DoD together develop these mutually beneficial programs for our dual-eligible beneficiaries, including the most appropriate locations for the demonstrations. Please let me know when it would be convenient to meet on these programs. I look forward to hearing from you soon.

Sincerely,

A handwritten signature in black ink, appearing to read "Steve", written in a cursive style.

Stephen C. Joseph, M.D., M.P.H.



THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

AUG 02 1995

HEALTH AFFAIRS

Honorable Bruce C. Vladeck, Ph.D.
Administrator, Health Care Financing Administration
Room 314G, Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Dr. Vladeck:

Bruce

Let me say that I found our July 26th meeting on the Medicare demonstrations to be very positive and productive. Now that we have both stated our willingness to proceed with a Health Care Financing Administration (HCFA) and Department of Defense (DoD) demonstration project, we will work through the agreement necessary for the Medicare/DoD military managed care demonstration outlined during that meeting. (See attachment.)

As per our discussion, the staff of our two agencies will begin to meet immediately and work through the remaining issues, of which the following seem the most critical.

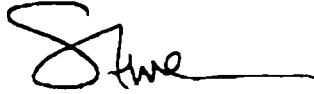
- Establish the DoD maintenance-of-effort measures and level.
- Develop a mutually agreeable reimbursement methodology and level.
- Determine how to fit the demonstration within HCFA demonstration/waiver authority.
- Decide how DoD meets essential and appropriate requirements for Medicare HMOs.
- Assure that DoD care meets or exceeds Medicare quality requirements.
- Analyze the dual-eligible population as to cost, utilization and demographics.
- Set the timetable for implementing and evaluating the demonstration.

I also recognize, as a result of our dialogue, that there are other peripheral issues which will be worked through by our two agencies. For purposes of developing this agreement, Gary Christopherson, my Senior Advisor, will be coordinating the DoD staff effort.

At the same time we are working on the military managed care demonstration, I want to also continue our dialogue and work on the other demonstration -- authorizing military treatment facilities as providers to Medicare Risk HMOs. Our resolution of the above issues should also address your stated concerns (quality, demonstration/waiver authority) about this latter demonstration.

On behalf of our dual-eligible Medicare/DoD beneficiaries, I look forward to our jointly carrying out this very critical demonstration. For this to succeed, in my opinion, the Medicare/DoD demonstration must be one that is of mutual benefit. Most importantly, the policy growing out of the demonstration must mutually benefit our agencies and the people we serve.

Sincerely,

A handwritten signature in black ink, appearing to read "Steve", with a long horizontal line extending to the right.

Stephen C. Joseph, M.D., M.P.H.

Attachment:
As Stated

MEDICARE DEMONSTRATION: MILITARY MANAGED CARE DEMONSTRATION

Under its demonstration authority, it is proposed that the Health Care Financing Administration and its Medicare program contract with the Department of Defense (DoD) and its Military Health Services System (MHSS) as a risk-type health maintenance organization (HMO) for dual-eligible Medicare/DoD beneficiaries.

DOD OBJECTIVES:

- MHSS maintains current financial commitment (estimated at \$1.4 billion with an annual adjustment by the applicable inflation rates in the Defense Health Program) for dual-eligible Medicare/DoD beneficiaries.
- MHSS maintains current commitment to at least 320,000 full-time, dual-eligible Medicare/DoD beneficiaries.
- MHSS is authorized to enroll dual-eligible Medicare/DoD beneficiaries as an HMO. Enrollees are treated as if enrolled in a Medicare private HMO.
- MHSS and Medicare appropriately share the financial burden for these dual-eligible Medicare/DoD beneficiaries. All DoD covered services not covered by Medicare are covered by DoD. All Medicare covered services not covered by DoD are covered by Medicare.
- MHSS is reimbursed, subject to DoD maintaining its current level of effort, as a Medicare HMO for new dual-eligible Medicare/DoD beneficiaries. Medicare and MHSS share savings from managed care for dual-eligible Medicare/DoD beneficiaries.

MEDICARE/MHSS DEMONSTRATION:

General Provisions:

- 1) Three-year demonstration begins October 1, 1996.
- 2) Demonstration applies to at least two DoD health service TRICARE regions.
- 3) The Military Health Services System's TRICARE Prime meets requirements of a Medicare HMO (applicable to private providers), except for State licensure and financial requirements.
- 4) Beneficiaries are eligible if they are Medicare and DoD eligible, are covered by Medicare Part B, and enroll in TRICARE Prime. TRICARE Prime enrollment is conducted.
- 5) Services are only covered if they are 1) Medicare or DoD covered services and 2) provided or approved by DoD.
- 6) Like any Medicare HMO, DoD provides and/or arranges for all Medicare covered services.

- 7) DoD maintains its current level of effort to at least 320,000 full-time, dual-eligible Medicare/DoD beneficiaries and to at least \$1.4 billion with an annual adjustment by the applicable inflation rates in the Defense Health Program. If the overall Defense Health Program decreases, DoD maintains a proportional level of effort in terms of dual-eligible beneficiaries and budget.
- 8) The demonstration is evaluated by an external contractor acceptable to both agencies. The evaluation contractor produces an annual report, an interim report within 18 months of the initiation of this demonstration, and a final report six months from the end of the demonstration.
- 9) Either agency may withdraw from the demonstration with twelve months written notice.

Demonstration Part 1 and 2:

Part 1 (DoD users (i.e. beneficiaries who have used a Military Treatment Facility in the past 24 months) who are Medicare beneficiaries and enroll in DoD's TRICARE):

- 1) For services not covered by the DoD benefit (e.g. skilled nursing facility and home health services), Medicare reimburses a) non-DoD providers or b) DoD for the cost at a rate of 95 percent of the portion of the AAPCC (Medicare's average annual per capita cost) attributable to these services.
- 2) DoD covers the cost of all Medicare covered services, except as above, and the cost of DoD covered services not covered by Medicare (i.e. pharmacy).
- 3) For those Medicare beneficiaries participating in Part 1 of the demonstration and subject to the Medicare Part B late enrollment penalty, Medicare waives the penalty.

Part 2 (DoD beneficiaries who become Medicare beneficiaries after October 1, 1996, enroll in DoD's TRICARE, and represent an increased level of effort.)

- 1) Medicare covers the cost of services at the rate of 93 percent of the AAPCC. This provision only applies after DoD exceeds its current level of effort (adjusted by the applicable inflation rates in the Defense Health Program) on Medicare eligible beneficiaries, including amounts spent under Part 1.
- 2) DoD covers the cost of DoD covered services not covered by Medicare.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

JUL 15 1996

The Administrator
Washington, D.C. 20201

NOTE TO: NANCY ANN MIN

SUBJECT: Excluding Non-Veterans from the VA-Medicare Demonstration

Over the past several months, HCFA, VA, and OMB have made remarkable progress developing the principles for a VA/Medicare demonstration. Now that we are poised to prepare authorizing legislation, I want to make clear that HCFA will keep its word to abide by these principles. However, I do wish to raise concerns about one particular aspect of the planned demonstrations: the exclusion of Medicare beneficiaries who are not veterans.

By excluding non-veterans from the demonstration, we will make VA hospitals or health plans the only category of Medicare participating providers permitted to discriminate against whole classes of Medicare beneficiaries, an unwelcome precedent. Excluding non-veterans will undermine section 1802 of the Social Security Act, which permits any Medicare beneficiary to use any provider who participates in Medicare, and section 1876(d), which permits every individual entitled to Medicare benefits under Parts A and B to enroll in a Medicare HMO. Such discrimination will be a particular problem in medically underserved areas, where non-veterans may have to travel long distances, past nearby VA facilities, to receive health care.

Excluding non-veterans from the demonstration also raises special difficulties for the spouses of eligible Category C veterans. Many couples choose to get their health care from the same providers or health plans. Because the demonstration will require the ineligible spouse to enroll in a different health plan, he or she will lose the social, psychological, and possibly medical benefits of receiving care in the same setting. Indeed, the President's Health Security Act recognized these concerns, and therefore authorized VA health plans to enroll family members of veterans.

Thus, the exclusion of non-veterans is a principle that should be revisited if we expand beyond the current demonstration. We should not preclude the possibility of Medicare beneficiaries who are not veterans obtaining health care in VA hospitals or health plans that participate in Medicare (via reimbursement for Category C veterans). So long as VA providers are also Medicare providers, we should take advantage of the VA's capabilities to improve access to care for all Medicare beneficiaries.

Bruce C. Vladeck

*Cat. A - low-income & service-disabled
(getting monthly check) connected*

Cat. C - all other vets

EXECUTIVE OFFICE OF THE PRESIDENT

08-Jul-1996 06:58pm

TO: Molly Brostrom
FROM: Nancy-Ann E. Min *NAM*
Office of Mgmt and Budget, HP
CC: Jeremy D. Benami
CC: Gordon Adams
SUBJECT: Attached Article on DOD Medicare Subvention

Saw your e-mail and thought you would be interested in the attached.

You're right that Pennington has continued to push for more action. Assuming that Gramm's amendment emerges out of the DOD authorization conference--is that a safe assumption, Gordon?--we will plan on having a report to Congress on the design of a demo and its potential costs by September 6 or thereabouts. I suppose we could also send forward our legislation to implement the demo, if they have it done--but the truth is, the report Gramm has asked for is so detailed, that I am not sure they will have time to both get his report done, and complete drafting of legislation, by the first of September. So in a sense, Gramm may have slowed things down. And as I've mentioned to you, asking the actuaries to estimate the potential costs of the demo--as Gramm did--may have been a mistake. I learned a long time ago that I don't have any control over that process!

Gordon and I have talked about scheduling a meeting with Joseph and Vladeck to make sure this process is moving along. We can let you know when that has been scheduled and you are welcome to come.

theon

Gary Christopher
Who's helping to make sure DOD one occurs? (i.e. no Hush)
Question of whether need legis - or Pres can do by Exec direction
- HCFA says yes → never communicated formally
When is full? Oct. 1
not reaching closure on any issues → up date, no incentive
3 yr demo - w/ 12 month kick out clause

6/11 Panetta Ltr
-we will move
on this issue

1 - timelike commitment
2 - Presl direction instead of leg. → most credit for
Res.
(Vol. 7) 753



REGULATORY

Coverage Policy

HCFA, DOD PLAN TO LAUNCH PILOT PROJECT BY FALL, OFFICIAL SAYS

The Health Care Financing Administration and the Defense Department are developing a demonstration project in which Medicare would pay for the care delivered to beneficiaries in DOD's medical system at an annual possible cost of several hundred million dollars, federal officials say.

Medicare spending could increase about \$2 billion a year if the demonstration project was made permanent and expanded across the nation, according to Congressional Budget Office estimates.

Under the demonstration, which will require congressional legislation, Medicare will pay for a designated number of its beneficiaries enrolled in DOD's managed care program known as Tri-Care, Joel Slackman, acting director of HCFA's special analysis staff, told BNA June 19.

Medicare Waiver Sought

HCFA plans to seek legislation for a waiver of current Medicare regulations preventing the program from reimbursing other federal departments for health care and launch the demonstration project in the fall, Slackman said.

Military retirees are eligible to receive care under two DOD programs—a direct care program in which beneficiaries are treated in the department's own facilities, and through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Retirees eligible for health coverage under Medicare may seek care in a military treatment facility (MTF) but are ineligible to participate in CHAMPUS, CBO Director June E. O'Neill told Congress earlier this year. Medicare does not reimburse DOD for care provided at an MTF for retirees eligible for Medicare, she testified.

Many of the about 1.5 million military retirees also eligible for Medicare prefer to be treated at MTFs because they face lower out-of-pocket costs than they would under Medicare, O'Neill said, although that may change as DOD downsizes its medical system of 100 hospitals and adds a managed care component.

DOD approached HCFA about the demonstration project and the two arms of the federal government, along with the Office of Management and Budget, are developing the pilot, Slackman told BNA. DOD estimates that its spends about \$1.5 billion of its \$16 billion annual health care budget on retirees also eligible for Medicare reimbursement, he added.

Three-Year Pilot

In a background memo on the feasibility of a demonstration project prepared in February by CBO, it

said the pilot would last no longer than three years and be limited to three DOD regions. Regions under consideration include those serving Texas, Washington/Oregon, and Hawaii. These regions contain approximately 220,000 military retirees, about 68,000 of whom most likely would take part in the demonstration, CBO said.

Under the pilot, Medicare beneficiaries would be required to enroll in DOD's Tri-Care plan and Medicare reimbursement would be limited to amounts above the current \$1.5 billion annual baseline now spent by DOD, CBO said.

That stipulation is necessary because Medicare costs are subject to the pay-as-you-go procedures of the Balanced Budget Act whereas DOD's costs are provided through the appropriations process.

However, despite the pay-as-you-go provisions, CBO reported that the project could cost Medicare "hundreds of millions of dollars" because of the difficulty estimating how many beneficiaries would take part in the pilot and how much DOD actually spends on Medicare beneficiaries.

Current discussions among HCFA, DOD, and OMB are focusing on methods to prevent cost-shifting to Medicare, Slackman told BNA. The pilot also could save Medicare money because DOD often pays less for medical care than Medicare, he added. □

Nursing Homes

HCFA LAUNCHES NATIONAL EFFORT TO CURB USE OF PATIENT RESTRAINTS

The Health Care Financing Administration has launched a national initiative aimed at reducing the use of physical restraints in nursing homes, the incidence of which the agency believes is too high despite the enactment nearly a decade ago of a nursing home reform law.

The National Restraint Reduction Initiative, which has the support of the nursing home industry, is being coordinated by HCFA Region III, headquartered in Philadelphia, and is based on that region's successful program to reduce the use of physical restraints on nursing home patients in Virginia.

The Virginia program, which began two years ago and included several days of training for nursing home staff in alternatives to physical restraints, reduced the use of restraints from about 33 percent of patients to about 18 percent, Peter Goodman, chief of survey and certification for Region III, told BNA June 20.

In the wake of allegations of misuse of psychoactive drugs and physical restraints in nursing homes, Congress in the Omnibus Budget Reconciliation Act of 1987 included provisions stating that nursing home residents have



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

June 13, 1996

DRAFT

MEMORANDUM TO THE CHIEF OF STAFF

FROM: Alice M. Rivlin

RE: "Medicare Subvention"--Proposals from DOD and VA to
Obtain Medicare Reimbursement for Services Provided
at Their Facilities

I understand that the subject of "Medicare subvention" came up at a recent veterans' roundtable in which the President participated. Medicare subvention means allowing DOD and VA to obtain Medicare reimbursement for services provided at their hospitals for DOD and VA beneficiaries who are also Medicare eligible. As with so many issues involving Medicare, this one is far more complicated than it may at first appear. The attached paper discusses what we have done with VA and DOD to develop demonstrations of Medicare subvention, the potential costs to the Medicare trust fund and scoring issues, and some options for moving forward.

The Problem: Although it might at first appear that a VA or DOD demonstration of Medicare subvention would be budget neutral because Medicare is already paying for these beneficiaries, both we and CBO believe that subvention could be costly. CBO has estimated the costs of a DOD demonstration at \$1.5 billion over six years and full-scale DOD implementation at \$18 billion over 7 years. CBO has not formally scored a VA demonstration, but based on their reasoning in estimating the DOD policy, we expect they would score substantial costs from a VA demonstration as well.

A demonstration would be budget neutral if VA/DOD reimbursed the Medicare trust fund for the additional costs incurred by the fund and did not spend more on these patients than they would have spent before the subvention. CBO scores this policy as a cost to Medicare because (1) no one knows how much DOD and VA currently spend on their Medicare beneficiaries (so there is no baseline), and (2) CBO believes both agencies have a strong incentive to shift costs from their discretionary budgets to the Medicare trust fund.

CBO's cost estimate creates two problems. First, it indicates that CBO (and probably the HCFA actuaries, the official arbiters of Medicare trust fund solvency issues) believes that

this policy will cost Medicare money, and thus potentially move forward the date of HI trust fund insolvency from 2001. Second, it means that the Administration and/or Congress will have to figure out a way to meet PAYGO requirements.

We have been working for the past few months with VA and DOD to try to solve both problems by designing budget-neutral demonstrations. Unfortunately, however, completing the design (and presenting the arguments about why it is budget neutral to CBO) would take another month for VA and six months for DOD. Moreover, making decisions about the design of the demonstrations that are driven by the desire to get CBO to score them as budget neutral may force other design choices that would be unpopular or unwise. For example, if we wanted to make sure that CBO would score the VA demonstration as budget neutral, we might have to limit the benefit package for veterans in the demonstration to the Medicare benefits package, instead of the richer VA benefits package. This would have the effect of discontinuing prescription drug coverage for some veterans who participate in the demonstration, a policy choice we may not want to make.

Recommendation: We recommend that the Administration propose legislation to authorize a VA demonstration. However, we cannot guarantee that CBO will score it as budget neutral. Therefore, we recommend that in transmitting the legislation to the Congress, the Administration should indicate that we intend to offset the cost of the demonstration with a reduction in VA's discretionary budget that would be dedicated to holding the Medicare trust fund harmless. (This would require directed scorekeeping to make it work under PAYGO rules, and VA will not want to pay for this with a reduction in its budget, but we did something similar to this -- with the VA's concurrence in the Health Security Act.)

With respect to DOD, we recommend that the President could direct DOD and HCFA expedite their work toward designing the demonstration and drafting legislation that could be submitted to Congress in the fall. Then we will have to deal with the financing of the DOD demonstration, but offsetting the cost by a reduction in the DOD "topline" seems to us to be appropriate.

MEDICARE SUBVENTION FOR VA AND DOD

Background. Section 1814(c) of the Social Security Act prohibits VA from receiving Medicare reimbursement for services provided to Medicare beneficiaries who are also eligible for VA medical care at VA hospitals and clinics. The same law prohibits DOD from receiving Medicare dollars for services it provides to dual eligibles at military treatment facilities. The rationale for this statute is that VA and DOD facilities are fully funded each year through the appropriations process, and the Federal government/Medicare trust fund should not have to "pay twice" for these beneficiaries.

For several years, the VA and its veterans' service organizations, and--more recently--DOD and its retiree organizations, have sought to change this policy. They view Medicare subvention as a way of attracting more VA and DOD eligibles to their systems and thus increasing the funding and support for their health programs.

This issue arose during the development of the President's health care reform plan, and as a result, the President's bill proposed to change the law and allow both DOD and VA to receive Medicare reimbursements. We dealt with the issue of the additional costs scored by both HCFA and CBO from the Medicare subvention policy by reducing DOD's "topline" and VA's discretionary medical care budget by the amount that it was estimated would be needed to reimburse Medicare for the additional costs. The logic was that DOD and VA were receiving additional mandatory funds from Medicare reimbursements, so their discretionary budgets could be reduced without harm. VA and DOD did not like this, but they accepted it in order to get the policy in the bill.

Agency Activities to Develop Subvention Demonstrations. The Vice President's "REGO II" initiative endorsed the concept of a budget-neutral demonstration of Medicare subvention for VA last summer. Since that time, OMB staff has been working intensively with VA and HCFA staff on designing such a demonstration and they are within a month or so of completing their work.

Work on a demonstration of Medicare subvention for DOD has just begun, but that process has intensified, and staff from OMB, DOD, and HCFA have been meeting for almost twenty hours a week for the last month or so. We are working towards completing the data collection and other work necessary to design a demonstration for DOD by this fall.

VA and DOD have been enthusiastic participants in the demonstration design process, but both agencies would probably prefer to have the Administration seek authorizing legislation for the demonstrations now, rather than waiting until we have obtained CBO's agreement that what we have designed is budget neutral. DOD has argued that we need to either submit our own bill or support Senator Dole's DOD subvention demonstration bill (scored as costing \$1.5 billion over six years) now, and similarly, VA has said that, given the discussion at the veterans' roundtable, the Administration should submit legislation now and worry about the costs later.

Potential Costs/Scoring of Medicare Subvention. Proponents of Medicare subvention for VA and DOD argue that Medicare subvention should not cost Medicare anything. They believe that, because Medicare is already responsible for these dually-eligible beneficiaries, Medicare dollars that are currently being spent in the private sector will simply be redirected to VA and DOD.

Unfortunately, however, CBO disagrees with this logic. They believe that Medicare subvention would be far from budget neutral and that it would increase costs to the Medicare program, for several reasons:

- "Cost Shifting". First, there are about 445,000 Medicare beneficiaries (50,000 in VA and 395,000 in DOD) receiving some sort of care in the VA and DOD health care systems. Both HCFA and CBO maintain that the ability to collect Medicare reimbursements will give DOD and VA incentives to shift health care costs for these people (and conceivably many others) from their discretionary budgets to Medicare (without reducing their discretionary budgets). Therefore, CBO says that in order for Medicare subvention to be budget neutral, we have to be able to show that this would not occur. To do that, we must have the ability to estimate accurately how much DOD and VA are currently spending on dual eligibles. (DOD and VA do not keep track of individual expenditures now.) This data is a big part of what OMB staff have been working with DOD and VA to develop.
- Adverse Selection. Second, CBO argues that the availability of Medicare reimbursements will create incentives for relatively healthy Medicare beneficiaries to switch from fee-for-service Medicare to DOD or VA systems that may be more expensive. Assuming that the DOD or VA system were reimbursed on a capitated basis for Medicare beneficiaries (this is what the Dole DOD subvention bill does and what DOD wants), CBO assumes that a fair number of healthy beneficiaries would be "recruited" by DOD and VA to

come to their systems. Whereas Medicare might have been spending very little on these healthy beneficiaries on a fee-for-service basis, if Medicare were reimbursing DOD or VA on a capitated basis, we could be spending several thousand dollars a year on each of them. (This is similar to the analysis CBO used in scoring big costs to Medicare MSAs in the vetoed reconciliation bill.)

A possible solution that the agencies are exploring is to design the demonstration so that Medicare would reimburse VA and DOD at a payment rate that is below the payment rate Medicare currently pays other risk contractors (95% of the fee-for-service rate in the area). Setting the reimbursement rates in this way may help to offset the adverse selection that would otherwise occur.

- Increased Utilization. In addition to a capitated model, VA also wants to test Medicare reimbursement on a fee-for-service basis. CBO may argue that VA would have incentives to increase utilization in a fee-for-service environment, where it will be reimbursed according to how many times it performs each procedure. CBO has also suggested that while HCFA has applied utilization controls to other providers, it may be difficult for HCFA/Medicare to discipline another agency. In addition, benefits offered over and above the Medicare package will change behavior.

Recent CBO Scoring.

- DOD. The "Coalition" group of House members proposed Medicare subvention for DOD only in their balanced budget plan last December. CBO scored this policy as costing \$17.5 billion over 1996-2002. More recently, CBO has scored Senator Dole's proposal for a Medicare subvention demonstration, again for DOD only, as costing \$1.5 billion over 1997-2002. DOD lobbied CBO heavily after its scoring of the DOD subvention, but our conversations with officials there lead us to believe that they will not change their view that this policy increases costs unless we are able to present them with some new information, such as reliable cost data that would enable them to construct a baseline of current spending on dual eligibles against

which the new policy could be scored.

- VA. We do not believe that CBO has ever formally scored Medicare subvention with respect to VA, but based on CBO's reasoning in scoring the DOD proposal, we expect that CBO will score substantial costs to a VA subvention demonstration.

Implications of CBO Scoring. Neither VA nor DOD can go forward with Medicare subvention demonstrations without a change in law. Unless we are able to design a budget-neutral policy and convince CBO that it works, any legislation authorizing Medicare subvention--even as a demonstration--would have PAYGO effects and would be scored as a cost to Medicare, technically requiring offsetting mandatory savings.

Moreover, HCFA's actuaries determine the solvency dates of the Medicare trust funds, and given their analysis of this policy in the past, we would have to assume that they would view it as accelerating trust fund insolvency. Thus, in the current environment, if we choose to go forward with this policy, and we want to maintain our position on strengthening the solvency of the Medicare trust fund, we would have to come up with either (1) additional Medicare savings, or (2) some other mandatory or discretionary savings that would be transferred to the Medicare trust fund to restore the outlays CBO scores from the Medicare trust fund. The latter options would require other legislative changes to satisfy PAYGO rules. Just last week, in a hearing on DOD health care issues, the DOD representative made a plea for Medicare reimbursements and was challenged by Senator Stevens, who asked how DOD could get money from Medicare "when Medicare is going broke."

Medicare & Military Managed Care



7/25/96

President Supports



7/25/96

Joint HCFA/DoD Objectives

- Provide accessible, cost-effective, quality-managed care
- Cost neutrality
- Maintain level of effort
- Appropriately share financial responsibility for dual-eligibles
- Derive shared savings



Process To Date

- DoD Proposal to HCFA (July '95)
- Initial Discussions (Fall '95)
- Legislative Proposal (Oct '95)
- Negotiations ('96)
- Agreement (?? July '96)



7/25/96

DoD Progress To Date

● Preparations for Demo

- » Setting up management in Health Affairs, Services & Regions
- » Preparing MTFs for enrollment & managed care
- » Setting baseline & operationalizing level of effort
- » Installing data systems
- » Preparing marketing materials

● DoD ready to begin October '96 (back-up date of January '97)



7/25/96

Issues in General Agreement

- Concept of level of effort
- Prohibition against increased agencies' cost
- Conditions of participation
- Eligible beneficiaries
- Services covered & patient copayments
- Reimbursement method as capitation
- Duration & withdrawal process
- Evaluation questions & GAO study



7/25/96

Issues Remaining Open

- **Demonstration size and locations**
 - » Regions 6 & 11 & State of Alaska vs. selected sites in Region 6)
 - » Cap based on enrollees (8,000) above level of effort or the \$ equivalent (\$75 million) (DoD agrees to if needed)
- **Reimbursement level for capitation payment (93% of AAPCC; 93% of reduced AAPCC)**
- **Final details of level of effort (in part tied to demo size)**



7/25/96

Demonstration Authority

- Preferred Option -- President Directs DoD & HCFA to do demonstration under existing authorities. (Action could be completed & announced early this fall)
- Back-up Option -- Joint legislative package submitted to Congress. (Action unlikely until 1997)



7/25/96

Military Health Care Downsizing Leaves Retirees in a Bind

By Spencer Rich
Washington Post Staff Writer

Since he retired from the Army in 1962, Chief Warrant Officer Donald Y. Morgan and his wife, Lucile, have received nearly all their health care for free at military hospitals and clinics. But that ended abruptly for Morgan last September when the only base hospital near his home closed, and he is bitter.

His feelings reflect those of many retirees as the Pentagon, reorganizing its health care system in a period of military downsizing and fiscal constraint, does not have the resources to take care of all retirees at military facilities.

Since the base hospital closed, the Morgans say they have been in a bind. The closest military hospital where they can get care is 120 miles away. They could turn to the Department of Veterans Affairs, but the nearest VA hospital is 60 miles away and won't take care of Morgan's spouse. Because they are over 65, the Morgans are ineligible for other health insurance the Pentagon provides. So they have had to turn to local civilian health care, paying for it with Medicare. Their annual out-of-pocket costs have jumped from zero to nearly \$4,000.

Morgan says he feels cheated. "They promised me quality care for the rest of my life when I went into the service. They've broken every promise they gave me," he said.

The complaints of Morgan and of many of the 1 million others in the same position have become a sensitive political issue this election year. Proposals to mollify these retired military through a controversial plan called "Medicare subvention" are receiving close attention from the military committees in Congress and the Clinton administration, which is considering a demonstration project to test the idea.

Under the proposal, Medicare would reimburse the armed forces whenever they treat elderly retirees free at military facilities, thereby boosting the Pentagon's funds to provide free care to a greater number of retirees. It would also allow those older than 65 to join the Pentagon's insurance programs to help reduce their out-of-pocket expenses.

For the Morgans, the military health care system worked well for years. Under that system, all active duty military personnel are guaranteed free care, usually at one of the military's 124 hospitals or 504 clinics. And regardless of age, career-military retirees (normally those who have served at least 20 years) and dependents are able to get free care at military facilities—but only if "space is available" and active duty personnel have been served.

The Morgans used a military hospital six miles from their Merced, Calif., home. It "always had space. They didn't charge me anything—I got eyeglasses, prescription drugs, everything else," including cancer surgery and a hip replacement for Lucile, 73, said Morgan, who is 80.

But when the hospital closed last September, the Morgans' options dwindled. If he were under 65, Morgan could enroll in TRICARE Prime, a new, low-cost, health maintenance organization the Pentagon sponsors for career military retirees and dependents. TRICARE Prime isn't free, but the Morgans would pay far less than the \$4,000 they are paying now.

Although Morgan is theoretically eligible for veterans' benefits, he said certain requirements make the veterans' system of little use to him. Under the system, Morgan would have to pay various charges, travel

"60 miles away to Fresno" for care, and still have to find care for Lucile.

And so they are relying on Medicare.

The armed forces' health system covers 1.7 million active-duty personnel and 6.6 million dependents and retirees and costs \$15.5 billion a year. Congress mandated that the system be reorganized in 1993 to contain costs and shift more dependents and retirees into civilian-type health plans where they pay part of the costs.

The new system, organized like a health maintenance organization, is in effect in some parts of the country. It will set up three insurance options so that retirees and dependents under 65 can be sure of coverage when space is not available at a military facility. They are:

- TRICARE Prime, a low-cost health maintenance organization (\$11-a-day cost to the patient for hospital care) with a limited choice of doctors and other health care providers under contract to the government.

- TRICARE Extra, a more costly preferred provider organization that offers a wider choice of doctors provided by civilian networks and insurance groups under contract to the government.

- TRICARE Standard is basically a fee-for-service plan with a wide range of civilian doctors and care providers.

But these plans do little to help people over 65 like the Morgans. The proposal to require Medicare to reimburse the military whenever military facilities treat Medicare-eligible patients free is under serious consideration by President Clinton, although it

might escalate the drain on the already hard-pressed Medicare trust funds.

The proposal has the support of members of congressional military committees including Rep. Owen B. Pickett (D-Va.) of the House military personnel subcommittee, who favors the plan because "military members and their families are used to getting treatment in a military facility."

A second proposal would allow people like Morgan to sign up for TRICARE, with Medicare paying the Pentagon a premium for the coverage. Still another proposal is that over-65 retirees and their families be allowed to buy health insurance through the federal employee health benefits program.

A broader question is how well the Pentagon will do in getting the new TRICARE system up and running by the late 1997 target date. To implement reorganization, the Pentagon divided the nation into 12 regions, and so far has signed contracts with consortia of health care providers and insurers in nine of the regions to help organize and manage the TRICARE system. TRICARE has started operating in seven, the Pentagon said.

Pickett said implementation "is going along very well. Progress has been impressive." A Senate Armed Services Committee spokesman said, "We think it's generally going in the right direction, but these are just the early returns."

The General Accounting Office has reported that "progress has been made," but how well the system can control costs through personnel interchanges between the military and private health groups and through controlling unnecessary services is still unclear.

These are big questions, but not as big immediately to the Morgans as the amount they're now paying for health care. "The enemy didn't get me in World War II. They missed me also in Korea. Now my own government has shot me down," Morgan said.

Critics, SANDY, More

CBO TESTIMONY

Statement of
June E. O'Neill
Director
Congressional Budget Office

ON
Medicare Subvention for the Department of Defense

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

March 7, 1996



**CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515**

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

BACKGROUND

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

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

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

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

OUTLINE OF DEMONSTRATION PROJECT

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

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

- o Beneficiaries would be required to enroll in DoD's managed care health plan (Tricare Prime);
- o DoD and the Health Care Financing Administration (HCFA) would establish a base level of effort equal to what DoD would provide under current law to retirees eligible for Medicare;
- o DoD would pay for all care up to the base level and would be reimbursed by Medicare for increments above the base level; and
- o Medicare's payment to DoD would be based on the per capita amount that it currently pays to risk-type health maintenance organizations (HMOs).

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

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

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

BUDGETARY IMPACT

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

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

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

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

TABLE 1. MONETARY FLOWS UNDER MEDICARE SUBVENTION

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

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

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

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

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

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

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

CONCLUSION

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

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



THE MILITARY COALITION

201 North Washington Street
Alexandria, Virginia 22314

*Per e-mail
- Molly*

August 9, 1996

The Honorable William J. Clinton
The White House
1600 Pennsylvania Ave. NW
Washington, DC 20500

Dear Mr. President:-

The Military Coalition, representing more than five million current and former members of the seven uniformed services, recently sent you a letter, dated August 1, 1996, asking for your support for a Medicare subvention test. The letter requested that you dedicate the resources necessary to have DoD and HCFA deliver a Medicare subvention plan to Congress by September 6, 1996, as requested by Congress in the conference agreement on the FY 1997 DoD Authorization Act.

Unaccountably, at a recent Senior Citizens Forum held by Representative Jim Moran in Virginia, your Medicare administrator, Mr. Bruce Vladek, informed attendees that your Administration has no intention of trying to meet the September 6 deadline, and would submit the Medicare subvention test plan to Congress by mid October at the earliest. This would make it extremely difficult to have legislation enacted in time to implement the test in FY 1997.

The Coalition notes that you have directed the Secretary of Veterans Affairs to submit legislation for a VA Medicare subvention demonstration program. The Coalition believes that the health care needs of the nation's uniformed service retirees deserve equal priority and hopes your Administration shows the same resolve for a DoD Medicare subvention demonstration program.

The Military Coalition respectfully requests your personal intervention to ensure that your public commitment to the concept of Medicare subvention does not become a hollow promise. The critical first step is to have DoD and HCFA deliver the Medicare subvention plan by September 6, 1996. We appreciate your strong support. Without subvention, uniformed services retirees will be locked out of military treatment facilities in contravention to the lifetime health care commitment.

Sincerely,

(Signatures enclosed)

John A. Shaud
Air Force Association

Carl H. Cole
National Military Family Assn.

Richard E. McGowan
Army Aviation Assn. of America

Carroll J. Gentry
National Order of
Battlefield Commissioners

Walter Bralbo
Assn. of Military Surgeons
of the United States

R. H. Lyman
Naval Enlisted Reserve Assn.

John H. M.
Assn. of the US Army

S. Peter Huber
Navy League of the US

Michael J. Dool
Commissioned Officers Assn. of
the US Public Health Service, Inc.

Rogers Fuller
Reserve Officers Assn.

Robert L. Lemi
CWO & WO Assn. US Coast Guard

J. William Dade
The Military Chaplains Assn. of the USA

Michael P. Cline
Enlisted Association of the
National Guard of the US

James
The Retired Enlisted Assn.

John R. Call
Fleet Reserve Assn.

Michael A. Nelson
The Retired Officers Assn.

David W. Greenman
Jewish War Veterans of the USA

Robert J. Walker
United Armed Forces Assn.

William B. Faly
Marine Corps League

J. R. Saramastro
USCG Chief Petty Officers Assn.

R. A. Ford
Marine Corps Reserve Officers Assn.

W. H. H.
US Army Warrant Officers Assn.

Ch. Schreiber
National Guard Assn. of the US

Bob Morrison
Veterans of Foreign Wars of the US



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"The Servicemember's Voice in Government"

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SOCIETY OF MILITARY WIDOWS
(Affiliated 1984)

November 8, 1995

Molly
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1600 Pennsylvania Ave, N.W.
Washington, DC 20500

Dear Mr. President:

I know that you have been concerned about quality of life issues for military personnel and budgeted billions of dollars over the next five years to improve quality of life for our brave men and women in uniform.

The most important concern of both active and retired military personnel is adequate medical care for themselves and their families. This concern does not end when our warriors hang up their uniforms. In fact, as they and their families age it becomes increasingly important. Access to military managed health care is being denied because of closure of hospitals as bases close and because of severe cut backs in medical personnel as a result of downsizing.

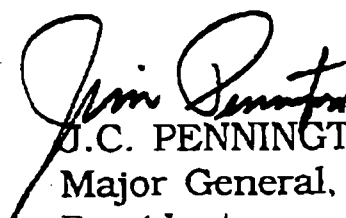
This problem can be helped by authorizing Medicare to reimburse military hospitals for the care of Medicare-eligible retirees and their families. As you will recall, your health care reform plan had this provision in it. Further, in a meeting with you in the Roosevelt Room on May 26, 1995, you reiterated your support for Medicare reimbursement (subvention). On your trip to Hawaii to celebrate the end of World War II (WWII), during the San Francisco stop-over, Mr. Leon Panetta assured Generals Jim Moore and Bill Gourley that Medicare reimbursement would be done.

On October 12, we met with the White House Interagency Veterans Task Force and once again a major topic was Medicare reimbursement (subvention).

We understand that you intend to veto the Budget Reconciliation Act unless several major changes are made. One of the reasons should be failure to include Medicare reimbursement in Medicare reform. Medicare reimbursement would save scarce Medicare Trust funds and we urge you to include it in your budget proposal when you send it to Congress with your veto of the Budget Reconciliation Act. Draft legislation is enclosed.

As a fall back position, a Medicare subvention (reimbursement) demonstration project is being discussed by the Department of Defense (DoD) and the Health and Human Services (HHS) would be preferable to no legislation at all this year. The enclosed draft legislative proposal would direct that a Medicare reimbursement demonstration project be conducted and that it be done without increasing costs to the government. We believe that now is the time to pass this much needed legislation.

Sincerely,


J.C. PENNINGTON
Major General, USA (Retired)
President

Enclosures

SUGGESTED LANGUAGE FOR INCLUSION IN MEDICARE REFORM

18 TITLE IV -- FINANCIAL MANAGEMENT

19 SEC. 401. REIMBURSEMENT TO THE UNIFORMED SERVICES FOR MEDICAL

20 CARE PROVIDED PERSONS ENROLLED IN MEDICARE

21 (a) Subsection (d) of section 1095 of title 10, United
22 States Code, is amended by deleting "title XVIII or XIX of the
23 Social Security Act (42 U.S.C. 1395 et seq.)" and by substituting
24 in lieu thereof "title XIX of the Social Security Act (42 U.S.C.

1396 et seq.)".

(b) Subsection (h) of section 1095 of such title is amended
to read as follows:

"(h) In this section, "third party payer":

"(1) means an entity that provides an
insurance, medical service, or health plan by
contract or agreement; and

"(2) includes, in the case of persons
entitled to insurance benefits under part A or
part B of title XVIII of the Social Security Act
(42 U.S.C. 1395c et seq.), the Secretary of Health
and Human Services, notwithstanding section
1814(c) and 1835(d) of such Act (42 U.S.C.
1395f(c) and 1895n(d)) or any other law.".

SEC. AUTHORITY FOR MEDICARE AND DOD TO CONDUCT DEMONSTRATION PROJECT ON SHARED RESPONSIBILITY FOR DUALY ELIGIBLE BENEFICIARIES.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT--The Secretary of Health and Human Services and the Secretary of Defense are authorized to conduct a demonstration project to determine whether payments under title XVIII of the Social Security Act for certain beneficiaries who are dually eligible under both such title XVIII and chapter 55 of title 10, United States Code, who receive care within the Military Health Services System will increase economy and efficiency under both programs.

(b) TERMS OF DEMONSTRATION PROJECT--The demonstration project authorized by this section shall be designed to avoid any increase, attributable to the demonstration project, in the total cost to the Secretary of Health and Human Services of such title XVIII or to the Secretary of Defense of such chapter 55. Other terms and conditions of the demonstration project shall be as agreed upon by the two Secretaries.

Further, the demonstration must include the use of the DoD managed care civilian networks for those who enroll in such programs. Additionally, for those retirees who choose not to enroll in such programs but elect to use a military treatment facility (MTF) on a fee for service basis, Medicare funds will be paid to the MTF under DoD's third party collection program at a amount as determined by the participating secretaries.

(c) WAIVER AUTHORITY--To the extent the respective Secretaries determine it necessary for the conduct of the demonstration project, the Secretary of Health and Human Services may waive provisions of titles XI and

5... #7

XVIII of the Social Security Act, and the Secretary of Defense may waive provisions of such chapter 55. that would otherwise be applicable.



Air Force Sergeants Association

International Headquarters, P.O. Box 50, Temple Hills, MD 20757-0050 • Phone: (301) 899-3500

JUN 23 1995

June 21, 1995

Carol H. Rasco
Assistant to the President for Domestic Policy
Office of Domestic Policy Council
Old Executive Office Building, Room 213
1700 Pennsylvania Avenue N.W.
Washington, D.C. 20500

Steve Joseph, DOD
-mtg w/HCFR
OMB input

Dear Ms. Rasco,

Military retirees who are Medicare-eligible are currently discriminated against because of their age. These retirees were promised health care for life in the Military Health Services System (MHSS) but lose that eligibility once they turn 65 and become Medicare-eligible. Frankly, the only thing stopping their continued participation in the MHSS is the separate responsibility and budgets of two administration departments, the Department of Defense (DOD) and the Health Care Finance Administration (HCFA). On behalf of the 160,000 members of the Air Force Sergeants Association, *I ask your leadership in working to get these two agencies together.* AFSA represents the millions of active and retired enlisted Air Force, Air Force Reserve and Air National Guard members, and their families.

In recent meetings, the Office of the Assistant Secretary of Defense for Health Affairs (OASD/HA) officials have told us they fully support Medicare subvention. This is where a Medicare-eligible military beneficiary would get care at a military treatment facility or through the TRICARE system and HCFA would transfer Medicare-targeted dollars to DOD to pay for that care. DOD officials have told us they are confident they can deliver care to this group at less-than-average cost, saving taxpayer dollars.

According to OASD/HA, one of the principle blocks to allowing Medicare subvention to be enacted is a difference of opinion between DOD and HCFA regarding its cost and effectiveness in providing treatment to this group of beneficiaries. Ostensibly, however, it comes down to a budget "ownership" discussion. HCFA argues that care for Medicare-eligibles should not come out of its budget, because it believes care is already being provided for free at Military Treatment Facilities (MTF). The reality, however, is that fewer and fewer Medicare-eligible military retirees obtain "space-available" care because the downsizing of the military has meant a dramatic reduction in the number of MTFs and fewer and fewer doctors to handle space-available patient traffic. AFSA expects this trend to continue well into the future.

(more)

Care, whether paid for by DOD or HCFA, comes out of citizens' taxes. The greatest concern for both taxpayers and beneficiaries is getting the most value for their dollar. Retirees do not care which agency receives their premiums and enrollment fees, and taxpayers want to support their government fairly and wisely. TRICARE promises to offer lower-cost care to its beneficiaries than they are currently paying.

AFSA believes, as does DOD, that Medicare subvention would lead to lower health care costs for Medicare-eligible retirees. We urge you to bring DOD and HCFA together on the Medicare subvention issue. In this way, the expectations of taxpayers and beneficiaries will be satisfied in the most cost-effective way possible. As always, AFSA is ready to assist you on matters of mutual concern.

Sincerely,



JAMES D. STATON
Executive Director

NATIONAL ASSOCIATION FOR UNIFORMED SERVICES

5535 HEMPSTEAD WAY
SPRINGFIELD, VA 22151-4094
(703) 750-1342

Fax (703) 354-4380

"The Servicemember's Voice in Government"
Established 1968

SOCIETY OF MILITARY WIDOWS
(ESTABLISHED 1869)

September 30, 1995

President William J. Clinton
The White House
1600 Pennsylvania Avenue NW
Washington, DC 20500

Dear Mr. *Bill* Clinton:

For your information, I have enclosed a copy of our Association's September/October 1995 edition of the Uniformed Services Journal (USJ) entitled *Military Medical Care in Crisis* and a transmittal cover letter to Congress requesting support in resolving the crisis.

Thank you for your continued support of a strong national defense and the earned benefits such as medical care that were promised retirees and other personnel in exchange for their services to the nation. Keeping the promises of these earned benefits is absolutely essential to the maintenance of a future high quality volunteer military force to support this strong national defense.

Sincerely,

J. C. Pennington
J. C. PENNINGTON
Major General, USA, Retired
President

Enclosures

P.S. Thank for your effort to save Medicare. Based on your recent statement by you at the White House meeting that you supported Medicare. I understand a report of Medicare being closed. I am asking you to please make a decision in the current ongoing question on the Medicare bill. As you know if you keep the promise of keeping Medicare for all serving and former.

NATIONAL ASSOCIATION FOR UNIFORMED SERVICES



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(703) 750-1342

Fax (703) 354-4380

"The Servicemember's Voice in Government"

Established 1968



SOCIETY OF MILITARY WIDOWS
(AMERICAN 1884)

September 29, 1995

The Honorable
U. S. House of Representatives
Washington, D.C. 20515
20510

The Honorable
U. S. Senate
Washington, DC

Dear :

Enclosed you will find our Association's September/October 1995 Uniformed Services Journal (USJ) (enclosure 1). Please read this issue which, as indicated by the cover, explains how the entire military health care system is in crisis.

The purpose of this issue is to help educate our members and their elected officials about the most important issues facing members of the military family with special emphasis on medical care. The Department of Defense is being required, by lack of funds and declining personnel resources, to systematically dismantle a great medical system which has been a national treasure. If this trend is not reversed by congressional action, the result will be that the soldiers, sailors, airmen, marines, coast guardmen and their families who literally saved the world in WW II, fought the hot wars since, and won the cold war, will be disenfranchised from their earned and promised medical care. This and other broken promises, if not reversed, will eventually destroy the All Volunteer Force, the most important key element of a strong national defense.

Please read the article by Dr. Stephen Joseph, Assistant Secretary of Defense, Health Affairs, (page 6 of the USJ) acknowledging the medical care commitment to all service personnel including retirees, and his plan to save the military medical care system if he receives adequate support within DoD and most importantly, the Congress. The promises and the commitment to armed services personnel must be kept by the country they fought to protect. Both points -- a medical system in crisis and the health care promise -- are eloquently explained by Senator Inouye in his article on page 12 of the USJ.

To fix a critical piece of this medical care plan, we urgently need Medicare reimbursement for the over 65 retirees and family members so they can be enrolled in the TRICARE program. Without it these old soldiers who thought they had won lifetime medical care by 20-35 years of service, often in two or three wars, are literally thrown out of the system to fend for themselves just when they need care the most. To make matters worse, even though they paid for their health care again under Medicare, they find that they cannot use their Medicare benefit to obtain care in a military or VA hospital. This is brought about by the current interpretation of budget laws and because of the fact that bureaucrats in the Department of Health

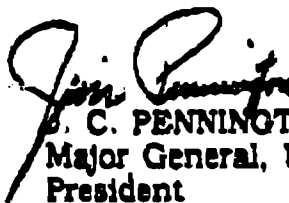
and Human Services, especially the Director of the Health Care Financing Administration (HCFA), do not support HCFA reimbursement (subvention) despite the fact that President Clinton has personally told us he supports it (see page 4 of the USJ)! Therefore, it is urgent that you take immediate action to save the military medical care system before it is too late.

We urgently ask you to review the legislative issues we have highlighted and the articles on what is happening throughout the health care system. Be sure to read the NAUS medical care plan on page 18 of the USJ. Our plan supports Dr. Joseph's plan and his recent testimony before the House Subcommittee on Civil Service (enclosure 2). He explains TRICARE as a cost effective option for continuing the military health care system that keeps the promises made to those who have served this nation, insures that the military medical system is ready for any future war, and saves Medicare Trust Fund expenditures.

We urgently need more cosponsors of HR 580 for Medicare reimbursement (subvention) and the introduction of a Senate companion bill. We also ask you to apply pressure to the Health Care Financing Administration to stop its obstruction and delaying tactics and require it to move forward on an interim subvention demonstration project to start no later than January 1, 1996. This demonstration will also save scarce Medicare Trust funds. To provide an additional health care alternative, we ask you to provide military medical beneficiaries the option of signing up for the Federal Employee Health Benefits Program (FEHBP). This will relieve pressure on military treatment facilities and improve access for beneficiaries.

Please call us if you have questions or need additional information.

Sincerely,


J. C. PENNINGTON
Major General, USA, Retired
President

Enclosures

MEDICARE DEMONSTRATION: MILITARY MANAGED CARE DEMONSTRATION

The Department of Defense (DoD) has proposed to the Health Care Financing Administration (HCFA), Department of Health and Human Services (DHHS), a demonstration where the Medicare program would treat the DoD and its Military Health Services System (MHSS) as a risk-type health maintenance organization (HMO) for dual-eligible Medicare/DoD beneficiaries. Under this arrangement, the DoD could continue to maintain its current level of effort in terms of financial commitment to caring for the dual eligible population. Medicare could pay for dual-eligibles receiving care from the DoD managed care program above DoD's current level of effort..

The Health Care Financing Administration (HCFA) and Department of Defense (DoD) are currently working through the agreement necessary for the Military Managed Care Demonstration. As one step in this process, the two agencies, working with the Office of Management and Budget, are drafting legislative language that would authorize such a demonstration. HCFA and DoD are jointly examining issues to establish the demonstration's feasibility. This involves analysis of DoD and HCFA data to assure that this demonstration does not increase the total federal cost of both programs. Both Departments are working with OMB to assure that the demonstration is of mutual benefit to both agencies, as well as the beneficiary populations served.

The Military Managed Care Demonstration is intended to respond to Medicare/DoD dual-eligible beneficiaries who have asked that they be more able to use the Military Health Services System as their Medicare provider. In order to overcome concerns with previous legislative and demonstration proposals, the current demonstration proposal differs in that DoD agrees to maintain its level of effort. Further, to address a concern over budget rules, the demonstration is considering expending DoD's dollars for dual-eligible beneficiaries' first and then turning to HCFA to cover additional DoD/Medicare beneficiaries wanting to enroll in DoD's TRICARE Prime.

The goal of this effort is to improve access to needed health services for this dual-eligible population while assuring that the demonstration does not increase the total federal cost of both programs. DoD has proposed the following framework.

- MHSS enrolls Medicare dual-eligible beneficiaries and maintains level of effort (subject to appropriate reductions due to reduced budget for the Defense Health Program) for dual-eligible beneficiaries.
- Medicare authorizes the MHSS to enroll, provide health services, and be reimbursed (after level of effort is achieved) for dual-eligible beneficiaries (who enroll in TRICARE Prime) similar to a Medicare private HMO.
- MHSS and Medicare appropriately share the financial burden for these dual-eligible beneficiaries. All DoD covered services not covered by Medicare are covered by DoD. Similarly, all Medicare covered services not covered by DoD are covered by Medicare.
- DHHS and DoD will develop an appropriate payment system and approaches to quality assurance that are mutually agreeable.
- The demonstration would be for a limited period of time (e.g. three years) covering selected geographic areas.
- The demonstration would be evaluated by a mutually acceptable evaluator.

InterOffice Memo

To: Jeremy Ben-Ami
From: Bob Jones
Date: July 27, 1995
Subject: NAUS letter

The attached letter was sent to my office from Jim Pennington of the National Association for Uniformed Services. It concerns HR 580; military treatment facilities, Medicare, and HMO's. Also included with his letter was a letter from DoD doctor Stephen Joseph and a fact sheet on military managed care. Please take whatever action is deemed appropriate and correspond directly with Gen. Pennington. Thanks for your assistance.

*I believe that this proposal should
be closely reviewed by the Dept of Defense
and HCFA.*

NATIONAL ASSOCIATION FOR UNIFORMED SERVICES



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Fax (703) 354-4380

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SOCIETY OF MILITARY WIDOWS
(Affiliated 1984)

July 17, 1995

The White House
Attention: Mr. Robert Jones, Public Liaison
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. Jones:

One hundred and eighty-five of the House of Representatives have co-sponsored H.R. 580. As you know, it has long been a goal of NAUS and the Military Coalition to have Medicare provide reimbursement (subvention) to military treatment facilities for the care of Medicare-eligible military retirees. This was needed in the past and is necessary today since DoD will not allow Medicare-eligible retirees to enroll in its new Tricare program without such reimbursement. We are glad that both the Senate and House DoD Authorization Bills for 1996 contain Sense of the Congress provisions supporting reimbursement of DoD medical treatment facilities (MTF) by HHS for treatment of Medicare-eligible military beneficiaries in MTFs. Study after study has shown that this is a cost effective way to provide medical services to Medicare-eligible military retirees who were promised life time military medical care by recruiters and commanders since WW-II. However, since CBO has scored subvention as a PAYGO violation, we have been at an impasse with the Health Care Financing Administration (HCFA) and the Congress in implementing this plan.

Dr. Stephen C. Joseph, the Assistant Secretary of Defense for Health Affairs, now has clearance from OMB to work directly with HCFA to work out the details for conducting a demonstration project to accomplish the task administratively. Please see the attached letter from Dr. Joseph to Mr. Bruce C. Vladeck, the Administrator of HCFA.

We believe that the demonstration of a military treatment facility as a provider to a Medicare Risk HMO is consistent with the current objectives of lowering and stabilizing Medicare expenses. We understand that the House Ways and Means Health Subcommittee expects to unveil a plan in September to stabilize Medicare costs drawing heavily on the managed care model, the best-known type of which is a health maintenance organization (HMO). Central to the plan is the concept of encouraging Medicare beneficiaries to enroll in a managed care plan to save Medicare money. We believe that the DoD proposed demonstration will accomplish this goal for Medicare-eligible military personnel

and cut cost by increasing the opportunity for getting them into a managed care HMO. Now is a perfect time to test the concept.

Furthermore, in our opinion, now is a perfect time for the Executive Branch to support an opportunity that frankly has no losers.

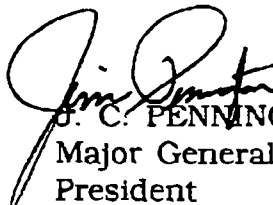
The Director of the NAUS Legislative/Political Action Team, Colonel Chuck Partridge, and I met with Dr. Joseph last week. We asked Dr. Joseph what we needed to do to move forward with the issue of Medicare reimbursement (subvention) and he said the proposed demonstration project in his letter to Mr. Vladeck is our best chance of getting HCFA subvention moving and overcome the present budgetary impasse. The letter proposes a funding mechanism that removes the PAYGO problem and in fact will result in savings to the Medicare Trust Fund.

However, our information is that HCFA is still opposed to the project since essentially now they think they, in effect, have a "free ride" with DoD still taking care of some Medicare-eligible personnel on a "space available" basis. However, as you know, with the drastic reduction of medical funds and personnel in the military medical care system, little or no space will be available in the future and if this problem is not fixed now, all Medicare-eligible military retirees will eventually be thrown onto the Medicare system on a costly fee for service basis. *Ultimately this would be more costly for the government, especially for HCFA.*

To help break the impasse, we at NAUS and the Military Coalition request that you contact Mr. Vladeck, at telephone number (202) 690-6726, asking that he promptly begin a joint DoD/HCFA Medicare HMO Demonstration Project as authorized by the FY 95 National Defense Authorization Act, and as proposed in the letter from Dr. Joseph dated June 27, 1995.

If you have any questions, please call me or Colonel Partridge at (703) 750-1342. My extension is 3003 and Colonel Partridge's extension is 3008.

Sincerely,


J. C. PENNINGTON
Major General, USA, Retired
President

Enclosure

P.S. If you can get these
Demonstration approved and
moving for military
retirees and other Veterans -
For DOD and the VA we
believe, it will be a
Big Plus for President
Clinton and Jane Bryan
And of course we are very
grateful for your help
Past and Present
Jim



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, D. C. 20301-1200

JUN 27 1995

*Ben Am. - Brian 24.105
Remington - Brian 25.105*

Mr. Bruce C. Vladeck
Administrator
Health Care Financing Administration
Room 314G, Humphrey Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Mr. Vladeck. *Bruce*

As you may know, the Department of Defense (DoD) is quite interested in beginning a joint DoD/HCFA Medicare HMO Demonstration Project. With the enactment of the National Defense Authorization Act for Fiscal Year 1995, DoD was granted the authority to implement such a demonstration project. This demonstration would authorize military treatment facilities as a provider to a Medicare Risk HMO.

As you recall, the President has supported the concept of Medicare subvention in the Health Care Reform bill. Though scoring difficulties created a barrier legislatively, the Congress has displayed significant interest this year in such a project. I am sure we can design a joint project that would be beneficial for both agencies and for our beneficiaries.

We have had several meetings with staff from your agency in order to explore the operational details of such a program. However, HCFA in its comments on the proposed DoD TRICARE Rule stated, "While we agree that coordination agreements can have merit, they pose legal problems for the Medicare program, principally because the HMO cannot reimburse the MTF." I would like to suggest that we meet to discuss this proposed program and hopefully we can find a positive resolution to those concerns. So many of our mutual beneficiaries have asked for this program that I would prefer not to delay the demonstration any further.

I would also like to discuss with you a second demonstration, in two or more regions, which was originally suggested by the Office of Management and Budget (OMB). This demonstration project would be for Medicare-eligible DoD beneficiaries and DoD beneficiaries who become Medicare eligible during the demonstration who are currently using an MTF for their health care needs. To participate in the demonstration, the beneficiary must be signed up for Medicare Part B and they must be enrolled in TRICARE Prime. All covered health care services will be provided or arranged by the MTF. DoD will maintain its current level of effort in terms of dollars and number of beneficiaries. To the extent we go beyond that, we ask that Medicare cover the costs based on 93% of the Average Adjusted Per Capita Cost (AAPCC).

I would like to see HCFA and DoD together develop these mutually beneficial programs for our dual-eligible beneficiaries, including the most appropriate locations for the demonstrations. Please let me know when it would be convenient to meet on these programs. I look forward to hearing from you soon.

Sincerely,

A handwritten signature in cursive script, appearing to read "Steve".

Stephen C. Joseph, M.D., M.P.H.

MEDICARE DEMONSTRATION: MILITARY MANAGED CARE DEMONSTRATION

Under its demonstration authority, it is proposed that the Health Care Financing Administration and its Medicare program contract with the Department of Defense (DoD) and its Military Health Service System (MHSS) as a risk-type health maintenance organization (HMO) for dual-eligible Medicare/DoD beneficiaries.

DOD OBJECTIVES:

- MHSS maintains current financial commitment (estimated at \$1.4 billion with an annual adjustment by the applicable inflation rates in the Defense Health Program) for dual-eligible Medicare/DoD beneficiaries.
- MHSS maintains current commitment to at least 320,000 full-time, dual-eligible Medicare/DoD beneficiaries.
- MHSS is authorized to enroll dual-eligible Medicare/DoD beneficiaries as an HMO. Enrollees are treated as if enrolled in a Medicare private HMO.
- MHSS and Medicare appropriately share the financial burden for these dual-eligible Medicare/DoD beneficiaries. All DoD covered services not covered by Medicare are covered by DoD. All Medicare covered services not covered by DoD are covered by Medicare.
- MHSS is reimbursed, subject to DoD maintaining its current level of effort, as a Medicare HMO for new dual-eligible Medicare/DoD beneficiaries. Medicare and MHSS share savings from managed care for dual-eligible Medicare/DoD beneficiaries.

MEDICARE/MHSS DEMONSTRATION:

General Provisions:

- 1) Three-year demonstration begins October 1, 1996.
- 2) Demonstration applies to at least two DoD health service TRICARE regions.
- 3) The Military Health Service System's TRICARE Prime meets requirements of a Medicare HMO (applicable to private providers), except for State licensure and financial requirements.
- 4) Beneficiaries are eligible if they are Medicare and DoD eligible, are covered by Medicare Part B, and enroll in TRICARE Prime. TRICARE Prime enrollment is conducted.
- 5) Services are only covered if they are 1) Medicare or DoD covered services and 2) provided or approved by DoD.
- 6) Like any Medicare HMO, DoD provides and/or arranges for all Medicare covered services.

- 7) DoD maintains its current level of effort to at least 320,000 full-time, dual-eligible Medicare/DoD beneficiaries and to at least \$1.4 billion with an annual adjustment by the applicable inflation rates in the Defense Health Program. If the overall Defense Health Program decreases, DoD maintains a proportional level of effort in terms of dual-eligible beneficiaries and budget.
- 8) The demonstration is evaluated by an external contractor acceptable to both agencies. The evaluation contractor produces an annual report, an interim report within 18 months of the initiation of this demonstration, and a final report six months from the end of the demonstration.
- 9) Either agency may withdraw from the demonstration with twelve months written notice.

Demonstration Part 1 and 2:

Part 1 (DoD users (i.e. beneficiaries who have used a Military Treatment Facility in the past 24 months) who are Medicare beneficiaries and enroll in DoD's TRICARE):

- 1) For services not covered by the DoD benefit (e.g. skilled nursing facility and home health services), Medicare reimburses a) non-DoD providers or b) DoD for the cost at a rate of 95 percent of the portion of the AAPCC (Medicare's average annual per capita cost) attributable to these services.
- 2) DoD covers the cost of all Medicare covered services, except as above, and the cost of DoD covered services not covered by Medicare (i.e. pharmacy).
- 3) For those Medicare beneficiaries participating in Part 1 of the demonstration and subject to the Medicare Part B late enrollment penalty, Medicare waives the penalty.

Part 2 (DoD beneficiaries who become Medicare beneficiaries after October 1, 1996, enroll in DoD's TRICARE, and represent an increased level of effort.)

- 1) Medicare covers the cost of services at the rate of 93 percent of the AAPCC. This provision only applies after DoD exceeds its current level of effort (adjusted by the applicable inflation rates in the Defense Health Program) on Medicare eligible beneficiaries, including amounts spent under Part 1.
- 2) DoD covers the cost of DoD covered services not covered by Medicare.

CLINTON BUDGET CUTS MILITARY RETIREE COLAS - AGAIN -

President Clinton has submitted to Congress his fiscal 1997 budget. Although widely criticized by the Chairman of House National Security Committee and the Senate Armed Services Committee for not providing enough funding for military readiness, modernization and military construction, military retirees are alarmed by another of the proposals contained in the President's budget. If he gets his way, federal civilian retirees will once again be singled out for COLA delays — which will result in a lifetime cut in retired pay. Many observers believe the COLAs of military retirees are also likely to be delayed. That's because of a provision in the 1996 Defense Authorization Act which states that military retirees will receive the same COLAs as federal civilian retirees in 1998 and beyond. However, if for some reason that provision would not come into effect, it is then likely that Congress would decide to delay military retiree COLAs for the same period as civilian retirees.

Military retirees are alarmed by another of the proposals contained in the President's budget.

Specifically, Clinton would delay payment of the COLAs from January 1 to April 1 for 1997 through 2003 — a total of seven years, and a total delay in COLA payments of 21 months. The inequity of the proposal results from the fact that Clinton has not proposed delaying the COLAs of any other group or groups of individuals who receive federal COLAs. TREA is opposed to singling out federal

civilian retirees and military retirees for COLA cuts, and believes all recipients of federal COLAs should be treated equally.

In addition, Clinton wants to arbitrarily reduce the Consumer Price Index (CPI) by .3 percent. The CPI is used by the government to determine the rate of inflation, and thereby, determine the amount of the COLA that will be given each year.

It is widely acknowledged that the CPI overstates the rate of inflation, but there is a great deal of controversy over just how much. TREA believes there should be no change in the CPI until a careful study has been done by economists and other non-political professionals to determine the real rate of inflation. We are strongly opposed to politicians in either party reducing the CPI just so they can balance the budget.

We will closely monitor what happens to the President's proposals, and we'll fight to stop them if they, or any similar proposals, appear to be getting serious consideration in Congress.

MEDICARE SUBVENTION BILLS INTRODUCED IN CONGRESS

Senate Majority Leader Bob Dole has introduced a bill to allow the Department of Health and Human Services to evaluate the cost-effectiveness of Medicare reimbursement to the DoD for treatment of military retirees aged 65 and over. In government circles, this is known as "Medicare Subvention". A companion bill has been introduced by Congressman J. C. Watts of Oklahoma.

Based on the findings of the study, the bill would allow over-age-65 retirees to enroll in TRICARE Prime and be treated in military hospitals. As Dole stated in a press release concerning the bill, "although military retirees over the age of 65 may use military medical treatment facilities on a space-available basis, that option is rapidly becoming nonexistent as military facilities downsize and TRICARE expands across the country."

TREA has long supported Medicare Subvention, and we strongly back the Dole/Watts legislation.

Representatives Joel Hefley (R-CO) and J. C. Watts (R-OK) joined forces in an effort to offer an amendment to the 1997 Defense Authorization Act when it reaches the House floor. Both Congressmen were optimistic that the Rules Committee would support their efforts as there was not a fee-for-service provision contained in their pilot program proposal. They felt without a fee-for-service clause in their amendment, any objection over budget constraints would have been met. The Rules Committee did not agree and will not allow their amendment.

THE WHITE HOUSE

John Adams, TREA Director for Government Affairs, recently met with White House staff and military organization representatives. The major portion of this 90 minute meeting was taken up with our concerns over access to the Military Health Services System (MHSS). Representatives from the Office of Manpower and Budget (OMB) and the Health Care Finance Administration (HCFA) spent nearly 50 minutes explaining why Medicare Subvention has been and will continue to be a difficult goal to achieve. Despite having 45 people from various federal agencies and departments working this issue, they believe budget rules and the financial difficulties faced by Medicare funding will prevent Medicare Subvention from reaching the Federal Employees Health Benefit Plan (FEHBP) as an option to the over-65 military retiree community very attractive. Medicare may go broke in 2002 without reduced spending in Medicare programs and increased contributions.

LINE-ITEM VETO: GOOD FOR MILITARY RETIREES?

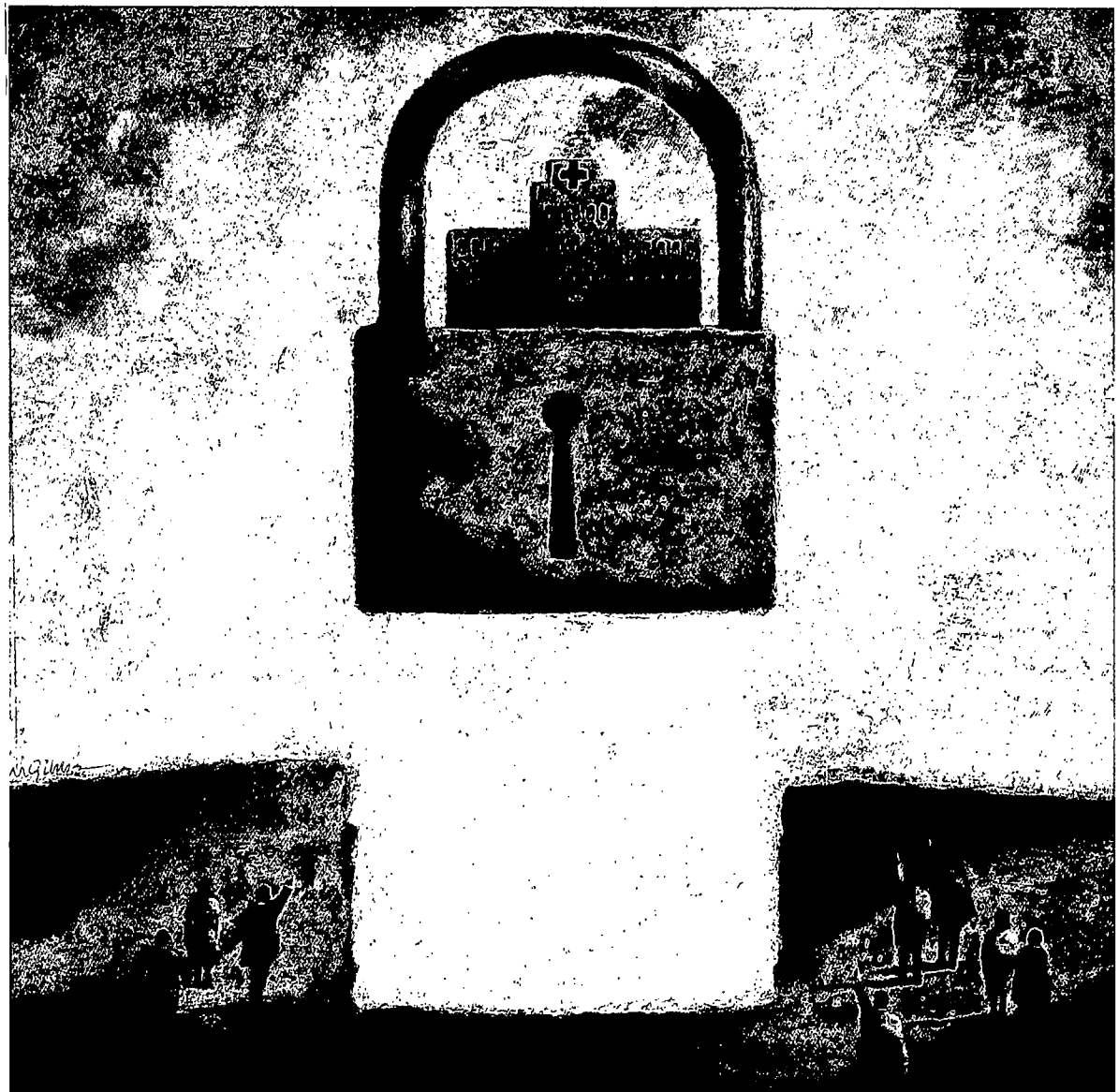
Congress has passed, and President Clinton has signed, legislation giving the President a line-item veto starting January 1, 1997. When the law takes effect, the President will have the power to veto specific line items in any spending bill, within five days of signing the bill into law. Congress can override a veto by a 2/3 vote in each chamber. Defense Authorization and Appropriation bills, as well as tax and entitlement bills,

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LOCK OUT

Military retirees are facing the biggest threat ever to their military health care benefit.

Unless Congress changes the current law, the DoD's new Tricare program will shut out more than 1.2 million retired beneficiaries from the military health care system.



REPORT PREPARED BY THE RETIRED OFFICERS ASSOCIATION
COVER ILLUSTRATION BY MICHAEL GIBBS

Tricare is the Department of Defense's (DoD's) new managed health care program. While Tricare has certain merits, it also has a huge flaw: Tricare bars all Medicare-eligible retirees and family members from enrolling in Tricare Prime, an option similar to a health maintenance organization (HMO). In fact, all career military members and their families eventually will be affected by this "lock-out," because even those who enroll now will be dumped from Tricare at age 65 when they become eligible for Medicare. This lock-out not only breaks long-standing health care commitments to retirees but also increases costs for taxpayers and hurts military medical readiness.

Identifying the Problem—and the Solution

The current law inadvertently encourages DoD and Medicare to work against each other rather than cooperate for the good of the country. As the defense budget tightens, DoD has a strong incentive to push older retirees and families out of the military medical system and back into Medicare, although Medicare costs both the government and retirees more money than care in the military system. Theoretically, Medicare-eligibles can still use military treatment facilities (MTFs) on a space-available basis. In truth, however, space-available care is rapidly becoming nonexistent as military facilities downsize and Tricare expands across the country.

The solution to the Tricare problem is simple. Change the law to allow "Medicare subvention," which means Medicare would reimburse DoD for care provided to older beneficiaries enrolling in Tricare Prime or otherwise using MTFs. Through subvention, DoD and Medicare can work together to save money for the government and the retirees—and improve readiness at the same time.

Detailing the Faces of Tricare

Last year, Congress approved DoD's plan to phase in a managed health care plan called Tricare. This plan develops pools of military and civilian health care professionals and facilities to service eligible beneficiaries. The program's goal is to keep patients healthy while

keeping costs down. Tricare will be up and running in many U.S. locations within a year and throughout the country by 1997. As the name suggests, Tricare offers three health care options.

Tricare Prime. This HMO-type plan is the only option that requires an annual enrollment fee. The Prime option also calls for copayments (see chart, p. 4). Enrollees receive care through MTFs or a supporting network of civilian providers who supply services at negotiated, discounted rates. DoD views Tricare Prime as the most efficient way to deliver health care services. From the beneficiaries' perspective, it is the least costly option for those who need frequent care.

Tricare Standard. This option is identical to the standard Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Although Tricare Standard beneficiaries will have a wide choice of providers, they will pay higher costs than under Prime. This fee-for-service program requires annual deductibles and copayments (25 percent for retirees). Tricare Standard has no enrollment fee, but it is the most costly option in terms of out-of-pocket expenses for beneficiaries who require regular care.

Tricare Extra. This last option is a lower-cost version of Tricare Standard. Tricare Extra applies only when beneficiaries use civilian providers who are part of DoD's preferred-provider pool. No enrollment fee is required. Deductibles are the same as with Tricare Standard, but copayments are 5 percent lower (20 percent for retirees). Tricare Standard users also benefit from the lower Tricare Extra copayment whenever they use preferred providers.

Highlighting the Changes: Good and Bad News

In December 1994, Deputy Secretary of Defense John M. Deutch announced the fee structure for Tricare Prime (see chart, p. 4). This was a response to the 1994 Defense Authorization Act requiring DoD to define a "standard, uniform health benefit" for all beneficiaries under Tricare.

The news was good for active duty families. Thanks to a strong stand by the Joint Chiefs of Staff, active duty families will pay no enroll-

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ment fee. For retirees eligible for Tricare Prime, there was bad news mixed with the good.

On the up side, retiree advocates representing military associations, including The Retired Officers Association (TROA) and The Military Coalition, won major concessions on copayments for inpatient care and outpatient fees for doctor visits. Both of these costs will be substantially lower than those now in effect for Base Realignment and Closure (BRAC) programs. Hospital rates are \$11 per day (vs. \$125) with no professional fees for inpatient hospital care, and the new outpatient fee for civilian providers is \$12 instead of \$15. The fees will not be increased for five years.

On the down side, the Tricare Prime enrollment fees are more than four times the current enrollment fees at BRAC sites in Texas; Louisiana; Florida; and Tidewater, Virginia.

Still, many retirees eligible for Tricare Prime will see a net gain. First, Tricare Prime offers low outpatient fees compared with standard CHAMPUS. Second, because the personal cost liability is small under Tricare Prime, many retirees could discontinue their CHAMPUS supplemental insurance.

Yet the biggest problem remains: Medicare-eligible retirees are not even allowed to enroll in Tricare Prime.

Examining the Conflict Between DoD and Medicare

The roots of the problem go back to how the government budgets for health care. DoD gets no money for treating Medicare-eligibles. DoD only receives appropriated funds to care for active duty military members plus those retirees and dependents eligible for CHAMPUS.

Tricare's civilian provider network is paid with CHAMPUS-appropriated funds. But CHAMPUS eligibility stops when Medicare eligibility starts at age 65, and current law won't let Medicare reimburse DoD for care in MTFs. Although DoD can treat Medicare-eligibles in MTFs on a space-available basis, DoD must absorb the cost, resulting in less money to care for active duty troops and CHAMPUS-eligibles. Unfortunately, as budgets get tighter, DoD has a big financial incentive to turn Medicare-eligibles away from

the military system, regardless of past promises.

The Medicare bureaucracy sees the issue differently. Medicare avoids paying for health care every time a Medicare-eligible beneficiary is treated in an MTF. For instance, in 1994, DoD provided more than \$1 billion in space-available care in MTFs to about 230,000 Medicare-eligible military retirees. But that free ride for Medicare is about to become history.

DoD is already shifting the cost back to Medicare as military bases and MTFs are closed or downsized and thousands more Medicare-eligibles are turned away from military health care each year. By the end of 1997, Medicare will be picking up that \$1 billion cost that DoD has been absorbing. To date, however, Medicare officials have not acknowledged that the DoD lock-out and associat-

ed jump in Medicare outlays will occur, so they have resisted the idea of reimbursing DoD. This lack of cooperation shifts more costs onto older retirees (because they pay more under Medicare) and onto taxpayers, too.

Enacting Subvention Will Cut Government Costs

It would cost Medicare less to pay DoD for health care than it would to buy the same care in the

private sector. A 1988-90 Medicare/MTF pilot project involving 75 coronary artery bypass grafts at U.S. Naval Hospital San Diego showed that Medicare could save \$17,000 per procedure by paying military facilities to perform the grafts rather than civilian hospitals.

In addition, a 1990 Government Accounting Office (GAO) study (GAO/HRD 90-131), directed by the House Armed Services Committee, also indicated that military care is less costly for the government than civilian care. After comparing six military hospitals with civilian counterparts, GAO estimated savings of \$18-21 million in CHAMPUS funds. Savings would have been even greater if Medicare-eligible beneficiaries treated in MTFs had been included in this comparison.

Finally, DoD's "Section 733 Study of the Military Medical Care System," released in May 1994, found that military care is actually up to 24 percent less expensive than civilian care.

All this evidence shows that the current law prohibiting Medicare from reimbursing DoD

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indirectly results in higher taxes for Americans. This situation will worsen as DoD pushes older beneficiaries into Medicare in the private sector.

The law must be changed to give an incentive for cooperation between DoD and Medicare. Enacting Medicare subvention will provide that incentive and reduce costs for Medicare, retirees, and taxpayers. If necessary, savings for Medicare can be guaranteed. The law can specify that reimbursements to DoD be capped at 95 percent of the rates Medicare pays to civilian HMOs.

Tricare Prime Fees for CHAMPUS-Eligible Military Retirees

The chart below shows the annual Tricare Prime (HMO option) fees that will become standard as Tricare Prime is phased in across the country. Active duty members and families are exempt from the Tricare Prime enrollment fee.

Type of Care	HMO Areas*
Enrollment	
(Indiv./Family)	\$230/\$460
Office Visit	
MTF	0
Civilian Facility	\$12
Hosp. Care (per day)	
MTF	\$11
Civilian Facility	\$11
Prof. Fees	0
(Limits)	(None)
Civilian Outpatient Rx	\$9

*For retired Tricare Prime enrollees, the cap on out-of-pocket expenses is reduced from \$7,500 to \$3,000. The cap remains \$7,500 for non-enrollees.

SOURCE: DOD

Enhancing Military Readiness Through Subvention

Aside from the cost issue, locking out older retirees from the military health care system also undermines the long-term readiness requirement to ensure the nation's military forces are fully prepared to defend national interests.

Military personnel readiness requires strong incentives for top people to serve military careers of 20 to 30 years. As partial offsets, the government must offer—and long has offered—strong institutional supports that include promises of lifetime health care. Now, after decades of arduous service and sacrifice and at an age when medical benefits are crucial, older retirees are being locked out of military health care.

General Motors and most large corporate employers provide their retirees some medical

supplemental assistance besides Medicare. The federal government provides similar assistance for its retired federal employees, including retired members of Congress and congressional staffers. Military retirees deserve no less for their decades of sacrifice. They have earned continued access to the military health care system.

Shabby treatment of retirees is not lost on active duty members. Unless we meet our obligations to today's military retirees, government promises to the current force will ring hollow, and retention and readiness will suffer.

Medical readiness is also a significant issue. The military medical system must attract, train, and retain physicians and other health professionals to meet any potential defense medical contingency. Specialties like family practice have certification standards requiring treatment of the full patient spectrum, including the elderly. Many professionals worry that Tricare's exclusion of older retirees will force them to leave the military for private practice to maintain certification. By ensuring a broader patient base, Medicare subvention will eliminate this risk and reinforce medical readiness training to meet any contingency.

Outlining TROA's Subvention Campaign

Much is at stake in TROA's fight for Medicare subvention: cost-effective health care, taxpayer savings, military readiness, and fulfillment of longtime commitments to retirees.

TROA and the Military Coalition, a consortium of 27 military and veterans organizations, have joined several influential members of Congress in a vigorous campaign for Medicare subvention. Rep. Joel Hefley (R-Colo.) has introduced legislation (H.R. 580) along with four original cosponsors: Reps. Pete Geren (D-Texas), Joe Barton (R-Texas), Gary Condit (D-Calif.), and Sam Johnson (R-Texas). TROA is now working to find a sponsor in the Senate who will be similarly committed to Medicare subvention.

Tricare is a step in the right direction. However, Medicare-eligible beneficiaries have earned the right to participate, and the law must be changed to require Medicare to reimburse DoD for those who enroll. Support the campaign for Medicare subvention. Urge your elected officials to prevent Medicare-eligible beneficiaries from being locked out of military facilities. 