MEDICARE SUBVENTION

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTH CONGRESS

SECOND SESSION

SEPTEMBER 17, 1996

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MEDICARE SUBVENTION

TUESDAY, SEPTEMBER 17, 1996

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:13 p.m., in room 1100, Longworth House Office Building, Hon. Bill Thomas (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
September 13, 1996
No. HL-24

CONTACT: (202) 225-3943

Thomas Announces Hearing On Medicare Subvention

Congressman Bill Thomas (R-CA), Chairman of the Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Medicare subvention. **The hearing will take place on Tuesday, September 17, 1996, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 2:00 p.m.**

Oral testimony at this hearing will be heard from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

The Health Care Financing Administration and the Department of Defense (DoD) have developed an agreement to coordinate the Medicare program and the military health care services system in a three-year demonstration of Medicare subvention. The demonstration would involve dual-eligible beneficiaries (military retired personnel and their family members and survivors who are also eligible for the Medicare program). Under this arrangement, the Medicare program would treat the DoD and its Military Health Services System as a risk-type health maintenance organization for the dual-eligible Medicare\DoD beneficiaries. The DoD would continue to maintain its current level of effort in terms of financial commitment to caring for the dual eligible population. Medicare would pay for dual-eligibles receiving care from the DoD managed care program above the DoD's current level of effort. The demonstration would take place over three years in selected geographic sites in Washington State and Texas (including the Tacoma-Seattle and San Antonio areas). Approximately 60,000 dual-eligible beneficiaries live in these sites.

In addition, H.R. 3142, the "Uniformed Services Medicare Subvention Demonstration Project Act" would establish a demonstration project to allow the DoD to receive Medicare capitated payments for health care coverage provided to Medicare-eligible military beneficiaries under the TRICARE program. The bill, as introduced, was referred to the Committee on Ways and Means, and in addition, to the Committees on Commerce and National Security. The National Security Committee recently considered the legislation.

FOCUS OF THE HEARING:

The hearing will focus on issues surrounding the establishment of a Medicare demonstration program on subvention, and the implications of such a demonstration.

(MORE)

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should submit at least six (6) copies of their statement, with their address and date of hearing noted, by the close of business, Tuesday, October 1, 1996 to Phillip D. Moseley, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, at least one hour before the hearing begins.

FORMATTING REQUIREMENTS:

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be typed in single space on legal-size paper and may not exceed a total of 10 pages including attachments.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, full address, a telephone number where the witness or the designated representative may be reached and a topical outline or summary of the comments and recommendations in the full statement. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are now available on the World Wide Web at 'HTTP://WWW.HOUSE.GOV/WAYS_MEANS/' or over the Internet at 'GOPHER.HOUSE.GOV' under 'HOUSE COMMITTEE INFORMATION'.

*****

Chairman THOMAS. Good afternoon. Today's hearing will focus on the proposed demonstration for Medicare for military retirees. We are also going to examine the question of expansion to veterans.

The Medicare subvention proposal would authorize the Department of Defense and the Department of Health and Human Services to conduct a 3-year demonstration project that will provide certain military retirees the option to use their Medicare benefits to join a Defense Department-sponsored health maintenance organization, I believe, called TRICARE.

In other words, Medicare would begin to pay premiums to the Department of Defense for the medical coverage of military retirees.

The legislative goal of both departments is to provide better care for military retirees and their eligible dependents without increasing Medicare's costs.

Some believe the proposal will actually reduce Medicare expenditures. However, the CBO has estimated the program will cost $200 million a year.

The Medicare Board of Trustees tells us that the Part A Trust Fund will be exhausted in 2001. Based upon all of the data that we have seen on snapshots on year to date and the July funding, that date may in fact move to the year 2000 or earlier.

It concerns me that we may be placing additional costs and burdens on the part of the Medicare Part A Trust Fund. If it can be shown that CBO is wrong, I am all for giving beneficiaries more choices. After all, that was one of the main thrusts of our proposal in restructuring Medicare to provide options to beneficiaries. My concern is that we were dealing primarily with the private sector where cost factors are on the surface and broken down, especially in the private sector in the business arrangement. We may not be able to get complete cost center data for the Department of Defense that would create a comfort level.

The last thing we want to do—at least the last thing I want to do—is to simply use Medicare to prop up military treatment facilities that are already funded through appropriations, or to provide funds as the CBO indicated where the Department of Defense through this demonstration project would be supplied money that may or may not be used for health care.

I look forward to hearing from Dr. Vladeck, Administrator of HFCA, and Dr. Stephen Joseph, the Assistant Secretary of Defense for Health Affairs on these important issues.

In front of me is the Chairman of the Veterans' Affairs Committee, Bob Stump of Arizona, and Ranking Member, Sonny Montgomery. They have a proposal to establish the same type of demonstration project that would require Medicare reimbursement for health care services to certain Medicare eligible veterans.

This proposal opens up a whole host of issues because of the very nature of how health care is delivered to veterans. I look forward to their testimony, and frankly, I am very pleased, although it is at a time late in this session, that we are finally beginning to look at these government health programs and at the concern that every World War II veteran is now Medicare eligible. All of us agree that bricks and mortar is not something that the Veterans Administration is going to be heavily into, and as the Department

of Defense carries out a significant medical program for not just military retirees but their dependents as well, the integration in some way of all of these programs needs to be in our thinking as we examine Medicare for the larger population as well.

So I would turn to my Ranking Member, the gentleman from California, for any opening statement he might make.

Mr. STARK. Thank you, Mr. Chairman. Thank you, for holding this hearing. My questions, or my concerns, deal with how this demonstration can ensure quality for our retired servicepersons, and I want to make sure that the military and veterans hospitals stay current with the latest quality standards, and that they allow access to a full range of centers of excellence. I also worry that in this expansion, for example, what would happen to the beneficiaries that I know my distinguished colleagues Mr. Stump and Mr. Montgomery will suggest, who could use their Medicare go to veterans hospitals, what if they gave up Medigap policies, and then wanted to return, or moved? How would they get back into a Medigap policy at a reasonable price without waiving preexisting conditions? It is one thing to move people into a program, but people do change their mind, or move, or veterans hospitals have been known to close. What do you do then if the person has relied on the veterans hospital treatment and cannot get back into the AARP Medigap policy, and really then is at risk for the 20-percent copays. This could really shove them over into a Medicaid problem.

I am somewhat reluctant to get started into something like that until we make sure that we have covered all the bases for the people who are coming into it.

Just for example, it is my understanding that we now pay about $150 million a year for 60,000 retirees. That is $2,500 a head. You can buy the best Medigap policy in the country for $1,500 a year, which gives you pharmaceuticals, and care in Europe if you happen to be traveling, and everything you could want. We would save $60 million a year if we just went out and bought them a Medigap policy.

Now, you have to tell me that they are getting $1,000 a year worth of something that we should not give to private insurers for the same thing.

I think there are a lot of unanswered questions that could work to the disadvantage of the broad population of military retirees, if we do not make sure that this all fits together smoothly. Each group does what they do best. And I look forward to hearing the testimony of our distinguished colleagues in HCFA and in the Department of Defense as we wind through all this.

Thank you.

Chairman THOMAS. Thank you.

Mr. Chairman, Ranking Member, we have your written testimony. It will be made a part of the record, and you may inform us in any way you see fit about your idea and where you think the veterans and Medicare ought to go.

STATEMENT OF HON. BOB STUMP, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ARIZONA

Mr. STUMP. Thank you, Mr. Chairman.

With your permission, I will summarize my statement.

Mr. Chairman, let me first thank you for holding this hearing on Medicare subvention. It is something that a lot of us have been working toward for a long time.

Last week as you stated, the National Security Committee did mark up H.R. 3142. Mr. Montgomery and I had an amendment that we were prepared to try to attach to that bill which eventually passed the Committee by unanimous vote. But after some persuasive arguments from Mr. Hefley, we decided perhaps it was best for us to go our own route. We in turn, introduced a freestanding bill which is H.R. 4068, which we will mark up tomorrow in the VA Committee.

Since your Committee has primary jurisdiction over these matters, we wanted to call our bill to your attention. We appear today, on behalf of H.R. 4068, and on the DOD subvention bill, H.R. 3142.

Ours is quite similar, Mr. Chairman. It would establish a 3-year demonstration project for Medicare subvention for the Department of Veterans Affairs. It is very similar in policy and scope to H.R. 3142 and contains the same cost containment provisions that are part of H.R. 3142.

It calls for the Department of Veterans Affairs and the Department of Health and Human Services to establish a demonstration project under which the VA would collect and retain Medicare payments for Medicare eligible veterans. This project would operate over a 3-year period for approximately 30 VA medical centers selected by the Secretary of Veterans Affairs. To ensure cost neutrality, the Health Care Finance Administration would reimburse the VA at only 93 percent of the adjusted per capita cost.

VA would receive reimbursement only for new users, those Medicare eligible veterans not currently being treated by the VA. These are veterans who most likely fall below the disability level of 50 percent, and above the poverty level which is roughly $21,000. We are talking about new users.

We have been moving aggressively in this direction on the VA Committee. We have already passed H.R. 3118, which mandates that the VA offer more outpatient care, trying to get away from costly inpatient care.

CBO stated that this bill would cost a fantastic sum of money, and to answer that, we agreed to cap our cost on H.R. 3118. We have also agreed to do this, as I believe I am correct in saying that the DOD bill has already been capped at $65 million. Mr. Stark mentioned the cost of CBO was in the neighborhood of $200 million. And I believe the bill that covers DOD has already agreed to a cap at a cost of $65 million.

We are sure that eligibility reform will work. We have argued for a long time that we can treat many people for less money if we can get away from this archaic business of having to hospitalize everyone to treat them. It is my opinion that we should never build another VA hospital bed in this country. We have ample, though there may be exceptions in the Sun Belt.

With regard to outpatient care, we are in a sense an HMO; we operate on a capitated budget. I know that it may not answer your question, Mr. Stark. It may be a little too technical for me to answer without information from the VA. I can tell you that we are working in that direction, because we want to offer these services

to veterans. Veterans have trouble understanding why they cannot go to a VA facility now, and have VA pick up the cost.

Mr. Chairman, this concludes my remarks. I will now let my colleague, Sonny Montgomery testify. Between the two of us, we hope we can answer your questions, and thank you very much for holding this meeting today.

Thank you, Mr. Chairman.

[The prepared statement follows:]

Statement of Honorable Bob Stump
on
H.R. 4068, Veterans Medicare Subvention
Demonstration Project Act
before the
Ways and Means Subcommittee on Health
September 17, 1996

Mr. Chairman, I appreciate the opportunity to appear before the Subcommittee today with my good friend, Sonny Montgomery, -- and I want to compliment you, Mr. Chairman, for holding this hearing on the topic of Medicare-subvention.

Last week the Committee on National Security, which Sonny and I also serve on, marked up H.R. 3142, to establish a demonstration project for DoD Medicare-subvention.

I had prepared an amendment to that bill, which we were prepared to offer at the National Security mark-up. However, instead of offering the proposal as an amendment to H.R. 3142, we introduced it as a free standing bill, H.R. 4068.

The Ways and Means Committee has primary jurisdiction over H.R. 4068, with the bill also being referred to the VA Committee and the Commerce Committee.

Mr. Chairman, H.R. 4068 would establish a 3-year demonstration project for Medicare-subvention for the Department of Veterans Affairs.

This bill is very similar in policy and scope to H.R. 3142, and contains the same cost containment type provisions.

It calls for the Department of Veterans Affairs and the Department of Health and Human Services to establish a demonstration project under which the VA would collect and retain Medicare payments for Medicare-eligible veterans.

The project would operate for a three-year period in approximately 30 VA medical centers selected by the Secretary of Veterans Affairs.

The bill requires the VA to establish managed care plans and enroll veterans who desire to participate under this demonstration.

To ensure cost neutrality, the Health Care Financing Administration would reimburse the VA at only 93 percent of the adjusted per capita cost.

VA would only receive reimbursement for "new users", those Medicare-eligible veterans not currently being treated by the VA.

To avoid double billing, the cost of Medicare- eligible veterans currently receiving care at the VA would still be covered by VA's annual appropriation.

Finally, the bill subjects the VA to a thorough reporting and evaluation system on which to judge the merits of the demonstration project and whether it should be modified or continued in the future.

Mr. Chairman, the VA is moving aggressively to transform its health care delivery system from one that has traditionally been hospital and inpatient-based, to a modern system based upon the principles of primary and outpatient care.

Additionally, the House has passed H.R. 3118, which reforms VA's eligibility criteria, further accelerating this shift to more cost effective care.
However, like Medicare-eligible military retirees, many Medicare-eligible veterans cannot gain access to the treatment facilities established to serve them.

Veterans have trouble understanding why they can't get their care from the VA and have Medicare reimburse VA, just like it would any other provider of health care.

I strongly believe Congress should establish Medicare-subvention demonstration projects for both DoD and the Department of Veterans Affairs.

H.R. 4068 does exactly that for the VA.

I urge you to act on both proposals before this Congress adjourns.

Thank you Mr. Chairman.

STATEMENT OF HON. G.V. (SONNY) MONTGOMERY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MISSISSIPPI

Mr. MONTGOMERY. Thank you, Mr. Chairman. This is kind of a first for Mr. Stump and I. We have never testified in the big room before, so thank you for giving us this opportunity. We have been in Pete Stark's little room in years past talking about this same subject.

Chairman THOMAS. I am sure you sit on your wallets in this room.

Mr. MONTGOMERY. I will follow my chairman. I will be brief and cover some points.

This veterans bill, as he said, closely parallels H.R. 3142, and the Veterans' Committee, as Mr. Stump said, will take up H.R. 4068 tomorrow, and I assume we will pass a bill.

The VA health care system, Mr. Chairman, has transformed itself into a modern primary care delivery system. The demonstration project authorized by the bill we have introduced should make VA health care available to some of the veterans who are turned away for such care today. And I think that is really the bottom line for us, to get more veterans to be treated at our VA hospitals.

At the same time, there should not be any increase in Medicare costs.

Now, I think this is what the—we need the demonstration for. The bill would ensure that there would be no increase in two ways. First it guarantees that Medicare will only pay 93 percent of what it normally pays for health care for veterans carried under the demonstration project.

Second, it requires the VA to continue to pay for the care of the veterans it currently serves. In other words, Medicare will not pay a cent for a veteran now under VA care. Medicare will only pay for new patients that the VA serves above the VA current level.

Now, this is only a demonstration project. We would like to be included with the military if this Subcommittee sees fit to move ahead with that other bill.

And let me emphasize this, I kind of believe that we can do this work for less than Medicare is costing now in private hospitals. And I have said this over and over again, we have our own brick and mortar; we have our hospitals; they are paid for. Yes, the taxpayers paid for them. We have the largest volunteer system in world. People, these Legionnaires behind us, they work every day in these VA hospitals. And one of the best things we have is the university medical school support.

You get a knee operation, which I have had, it is about $6,000 in a private hospital. In a VA hospital, it will cost from $2,000 to $3,000. So I just cannot believe that we cannot service Medicare veterans at a lower cost in our VA hospitals than in the private hospitals. We have the system, we are ready to go, and we think we can save money. That is why we want to have this demonstration project.

Thank you.

[The prepared statement follows:]

REMARKS OF HON. G.V. (SONNY) MONTGOMERY

BEFORE THE COMMITTEE ON WAYS & MEANS

SUBCOMMITTEE ON HEALTH

SEPTEMBER 17, 1996

MR. CHAIRMAN, THANK YOU FOR THE OPPORTUNITY TO APPEAR BEFORE YOU TODAY. I WILL BE BRIEF. FOR THE LAST SEVERAL YEARS, VETERANS GROUPS AND MILITARY RETIREES HAVE SEEN THEIR HEALTH CARE OPTIONS SHRINK. ALTHOUGH THEY MAY BE ELIGIBLE FOR MEDICARE, DOD-SPONSORED HEALTH CARE, AND VA CARE, RESOURCES TO SUPPORT THEIR CARE THROUGH VA OR DOD TREATMENT FACILITIES HAVE NOT KEPT PACE WITH THE DEMAND FOR SERVICES.

I SUPPORT FAVORABLE CONSIDERATION OF H.R. 3142. THIS LEGISLATION, WHICH WAS FAVORABLY REPORTED BY THE NATIONAL SECURITY COMMITTEE LAST WEEK ESTABLISHES A WORTHWHILE DEMONSTRATION PROJECT FOR MEDICARE ELIGIBLE MILITARY RETIREES. I ALSO ASK THAT YOU CONSIDER H.R. 4068, A VETERANS' BILL THAT CLOSELY PARALLELS H.R. 3142. THE VETERANS' COMMITTEE IS EXPECTED TO FAVORABLY CONSIDER H.R. 4068 ON WEDNESDAY, SEPTEMBER 18.

AS MR. STUMP HAS SAID, THE VA HEALTH CARE SYSTEM IS TRANSFORMING ITSELF INTO A MODERN PRIMARY CARE DELIVERY SYSTEM. THE DEMONSTRATION PROJECT AUTHORIZED BY THE BILL WE HAVE INTRODUCED SHOULD MAKE VA CARE AVAILABLE TO SOME OF THE VETERANS WHO ARE TURNED AWAY FROM SUCH CARE TODAY. AT THE SAME TIME, THERE SHOULD NOT BE ANY INCREASE IN MEDICARE COSTS. THE BILL WOULD ASSURE THIS IN TWO WAYS. FIRST, IT GUARANTEES THAT MEDICARE WILL ONLY PAY 93% OF WHAT IT NORMALLY PAYS FOR HEALTH CARE FOR VETERANS CARED FOR UNDER THE DEMONSTRATION PROJECT.

SECOND, IT REQUIRES VA TO CONTINUE TO PAY FOR THE CARE OF THE VETERANS IT CURRENTLY SERVES. IN OTHER WORDS, MEDICARE WON'T PAY A CENT FOR THE VETERANS NOW UNDER VA CARE. MEDICARE WILL ONLY PAY FOR NEW PATIENTS VA SERVES ABOVE THE LEVEL CURRENTLY RECEIVING VA CARE.

THIS IS ONLY A DEMONSTRATION PROJECT, MR. CHAIRMAN. I THINK IT IS WORTH TRYING. IF IT DOESN'T LIVE UP TO OUR EXPECTATIONS, IT WILL EXPIRE. BUT THE ADMINISTRATION AND ALL OF THE VETERANS' GROUPS THINK IT'S WORTH TRYING, AND SO DO I. PLEASE GIVE IT YOUR FAVORABLE CONSIDERATION.

Chairman THOMAS. Thank you both very much.

Sonny, you say you have got the system, you are ready to go. One of the things that has occurred is that the Department of Defense has set up its so-called TRICARE, and they are ready to go. Whether they make sense or not is the question that we are dealing with, but they are in fact ready to go.

Where are we with the managed care concept with the VA, I believe it is called VISN, V-I-S-N. Could they take on a demonstration project such as this within the next 6 months or early next year? Are they comparable in terms of up and running?

Mr. MONTGOMERY. I have this comment I would like to make that, in fact the VA has done a great deal of planning to prepare to establish managed care plans. It is in the workings. We have a new system working downtown at the VA health care center, and I think they can do it. And they are prepared to do it. I was told that. You probably could ask the VA Administrator if he thinks they could do it. But our studies show, and we anticipated your question, we can do it.

Chairman THOMAS. And anyone, Mr. Chairman, or any of your resources, how many veterans currently use the VA health care system?

Mr. STUMP. I believe the figure is 2.2 million veterans.

Mr. MONTGOMERY. Is 2.2 million; that is a year.

Chairman THOMAS. So 2.2 million use it. And what is the universe of eligible veterans to use the system?

Mr. STUMP. About 9 to 10 million veterans are eligible for VA care. There are 26 million veterans. I believe approximately 11 million veterans are qualified to use the VA. These are veterans with disability and indigent status.

Chairman THOMAS. So if we have 26 million veterans, approximately 11 million of the 26 million currently meet the disability and/or income threshold, which makes them eligible. My understanding is your legislation would remove the disability and income requirement?

Mr. STUMP. Do you mean this bill, Mr. Chairman?

Chairman THOMAS. Yes.

Mr. STUMP. No, it would not.

Chairman THOMAS. It would still be limited to that group that is eligible to use the VA——

Mr. STUMP. It would be limited to that group between the indigent status and the 50-percent disabled group, the new users that are not using it now.

Chairman THOMAS. How many would that be?

Mr. STUMP. Mr. Chairman, I cannot answer that. I do not know whether Mr. Montgomery has an answer or not. I do not know.

Mr. MONTGOMERY. I know the problem you are aiming at. We have the service-connected——

Chairman THOMAS. I do not know what problem I am aiming at, Sonny, I am just trying to get numbers.

Mr. MONTGOMERY. OK. Say the service-connected veteran, and the low-income non-service-connected veteran, we should continue to take care of them and not put them under Medicare. But I do not think the bill spells that out, but that should be done.

Mr. STARK. If the Chair would yield?

Chairman THOMAS. Sure.

Mr. STARK. I only have 2 years of active duty and 8 years or something of reserve, so I am a veteran, but I am not retired. Now, when I get Medicare in a couple of weeks, could I then go to a veterans hospital? Would I be one of the new eligibles?

Mr. MONTGOMERY. You can go to the veterans hospital as long as you have an honorable discharge, and you have one. The problem is how the Veterans Department would classify you. If the beds are available, you can get in there. But it is the classification——

Mr. STARK. Under your bill, would I then be able to use my Medicare at a veterans hospital?

Mr. MONTGOMERY. Yes, you would be. You would be eligible. And you would have a better chance if we could have Medicare eligible. That is one of the purposes, to open it up some more.

Mr. STARK. Thank you, Mr. Chairman.

Chairman THOMAS. Certainly. And obviously, what we would need to do is to get a handle on the number of folks we are dealing with here, at least in terms of the DOD HCFA one. We have some figures that we have been able to look at in the three project areas in the potential universe.

Now, as CBO will indicate, there is a potential problem with that universe by virtue of how many would have used fee-for-service who now move into managed care, and it begins to create the same problem that our friends on the other side of the aisle discussed in terms of medical savings accounts; that is, if you are sending fixed amounts of money that otherwise would not have been spent under managed care because healthy people are going to be able to be counted in these groups as well, we need to figure out the magnetism of a Medicare Program tied to veterans; and the same problem with the DOD Medicare Program tied to military retirees that may attract people who actually require us to spend more money than we otherwise would have spent if they stayed in the traditional Medicare fee-for-service.

So the numbers become fairly significant if you are going to look at multipliers as you carry out the program. So we are going to have to sit down and work out numbers.

Mr. STUMP. Mr. Chairman, I think that the VA could supply those figures to us almost immediately.

Chairman THOMAS. And obviously—my assumption is, not obviously, my assumption is that because the bill is so recent, we do not have a cost estimate from CBO. I know we just got the——

Mr. STUMP. We requested a CBO cost estimate, but we do not have it.

Chairman THOMAS. Right, it is going to take some time.

Mr. MONTGOMERY. Mr. Chairman, we are really making major changes in our VA health care system, and they are all for the better. And 95 percent of all the VA applicants or persons who go into a VA hospital, mainly go into outpatient clinic care. And Mr. Stump and I have introduced a bill where more could use it.

So we are really trying to open it up, and this is just another step forward that we presented to you today.

Chairman THOMAS. The reason I said it was very appropriate that you folks did introduce your bill is that we have a situation where we have had separate medical structures of the military for

a long time, and we are beginning to move in a direction of merging, or at least contracting from the general to the specific. And in the back of my mind, I am wondering why we do not just go completely general for everybody. Somebody has got to tell me why it makes more sense funneling money from the larger societal structure into the specific structures.

The primary reason to do it would obviously be cost savings, and we are going to have to begin working on just how much it does cost. The assumption is it is cheaper. But I think as we begin to analyze it, we will find that perhaps the ability to determine cost centers is not as easy as we might think based upon the way in which traditionally these programs have determined their cost. And these are just concerns. We need to get at it. The timing is good. It is appropriate, because as we begin to look at plans for all of the society, you folks need to make sure that you are at the table, because some of the restructurings that you are suggesting may in fact make a lot of sense. And then again, based upon the numbers, they may not.

Does the gentleman from California wish to inquire?

Mr. STARK. Thank you, Mr. Chairman. I think you let me interrupt to get my inquiry in, and I appreciate the witnesses bringing this to us. I am not quite sure where we are procedurally with this, or when the other bill, which—you want this amended to the bill that is going to bring up the Defense Department demonstration, or do you want a separate bill?

Mr. STUMP. Mr. Stark, we have introduced a separate VA subvention bill. Mr. Montgomery and I will mark up H.R. 4068 in Committee tomorrow. We had originally wanted to include it with the DOD bill, but we did not do this. We have a clean bill.

Let me say one more thing. We would be perfectly willing to work to put additional caps on this legislation. We are that sure this bill will not cost additional money. We want to get a demonstration product project off the ground and prove that we can do it at less cost than Medicare is now doing.

Mr. STARK. Thank you.

Chairman THOMAS. Does the gentleman from New York wish to inquire?

Mr. Houghton.

Mr. HOUGHTON. Thank you, Mr. Chairman.

Just let me understand this. I am a veteran, and I have diabetes. How am I treated differently now than I would be under the demonstration project, and also who pays for it?

Mr. MONTGOMERY. Well, you are certainly not eligible for free care right now, I can answer that because of your other means. I will put it like that. But if the beds were available, you would be eligible, if you paid the required copayments and you have an honorable discharge.

On a diabetic condition, if you are not service connected, and you do not qualify as low income, the criteria that has been set up by the Veterans Department, they could not take you in unless they had extra treatment capacity and you paid a copayment. So your diabetic condition would not be treated. Does that answer it?

Mr. HOUGHTON. Under either condition?

Mr. MONTGOMERY. The only way you can get in is if everybody moves out of Minnesota, there are only a few veterans left up there, and we have a big hospital with a lot of beds open, then you could go into that hospital.

Mr. HOUGHTON. I guess that answers it. Fine, thank you.

Chairman THOMAS. Perhaps we need to, just before we go to the gentleman from Connecticut, understand prior to the other testimony what we are dealing with.

What we currently have in the bill that was moving earlier is a demonstration program between the Department of Defense and HCFA dealing with military retirees and their dependents.

Mr. STUMP. That is correct.

Chairman THOMAS. Now, all military retirees are veterans. But not all veterans are military retirees, because they have got to spend what, a minimum of 20 years, to reach the military retiree status.

So by definition, the military retiree universe is a smaller one than the veterans.

By the structure that the Veterans Administration has established, not all veterans as per the discussion with the gentleman from New York, being a veteran is not sufficient to be eligible for care at a VA hospital, you have to meet additional criteria.

What are you planning in this bill to expand the criteria for veterans to be eligible in the veterans structure? Anything at all?

Mr. STUMP. None, Mr. Chairman.

Chairman THOMAS. Let me wait until all the visitations have occurred.

Do you agree, Sonny?

No additional expansion of veterans for treatment at veterans facilities with your bill?

Mr. MONTGOMERY. I would think under the demonstration that that would bring—I am not sure of this—but I think that would bring in more dollars, and then we could treat other veterans. That is kind of the idea of——

Chairman THOMAS. I understand that. I am not concerned about how you manage the money, I am concerned right now about the universe of eligibility for people who may use it.

Now, what would occur is you might—I believe the current universe is 11 million of the 26 million—you maybe go beyond the current 2.9 million who use the service closer to 11 million if you added this additional service which would attract people who were otherwise eligible into the system. But that does not increase the universe of eligibles. It merely offers another program which those who are in that universe might feel that it would be more attractive for them to go to the veterans facility. That is what we are talking about.

Mr. STUMP. Mr. Chairman, if I may, we are only talking about veterans.

Chairman THOMAS. Veterans.

Mr. STUMP. Category C veterans who are Medicare eligible. These are veterans who are 65 and not currently covered under the indigent status or under the disability status.

To answer your question, the expansion is only to those that are 65 who have not previously used the VA.

Chairman THOMAS. OK. Then it is not the 11 million that are currently, it is the 11 million who are 65 or older, is that correct?

Well, we will sit down and work out the numbers. I am trying to understand the potential universe if this benefit were added to the VA structure of those who would otherwise be eligible but now do not currently use the VA system. Am I making sense?

Mr. STUMP. Yes, Mr. Chairman, you are to me. I would say that there is no reason to ever expect we would attract that number of people.

Chairman THOMAS. I understand. You and I make sense a lot of times with each other, it is just that the rest of the world listening to us sometimes——

Mr. STUMP. We do not know that number.

Chairman THOMAS. Well, and that, of course, is a concern, and we will just have to sit down and work these numbers through, because what happens is the whole question—and I do not want to get into the details of what we do here, but we have been wrapped up for the better part of several years now dealing with adverse risk selection, and the question of if you set up a program which attracts someone who would be cheaper if they stayed in the old program, and because of the managed care comprehensive costing structure, they come into this program, it actually costs us more than it would if we left them alone. And this is a magnet to military and veterans that may attract some people who would otherwise stay out of the system and to the society be cheaper in their treatment.

And so that is why we have got to be concerned about the way in which we open up programs, especially under managed care structures.

Mr. STUMP. Mr. Chairman, it is hard for me to imagine that we would attract those people. Certainly there are many, many, instances where we cannot compete with the modern up-to-date private-sector hospitals. We are only looking for those veterans that for convenience or other reasons may prefer to go to the VA hospital. These are veterans who are Medicare eligible, and do not qualify because of their disability, or do not qualify because of their income.

Chairman THOMAS. I understand that, and Mr. Chairman, I am only concerned that if we OK the program, then 1½, 2, 5 years down the road, there is not a vote on the floor of the House to upgrade the facilities because after all, we do treat Medicare eligible, and they deserve the same treatment facilities that the private sector gets. And so I just want to know what I am buying when I——

Mr. MONTGOMERY. Mr. Chairman, there is a provision in the bill——

Chairman THOMAS. I understand the demonstration project, but I am talking about the—I am talking about the other side of the demonstration project.

Mr. MONTGOMERY. Well, there are two secretaries, the Secretary of Health and Human Services, and the Secretary of the Veterans Department have to establish a maximum number of Medicare eligible veterans for which payment may be made. That is in the bill——

Chairman THOMAS. That is for the demonstration project.

Mr. MONTGOMERY. That does put some control on the demonstration project.

Chairman THOMAS. Right. That is for the demonstration project. I understand that.

Mr. MONTGOMERY. That is correct.

Chairman THOMAS. All right.

Mr. Lewis, do you wish to inquire?

Mr. LEWIS. Thank you, Mr. Chairman. I do not think I want to inquire, but I want to take this opportunity to commend Mr. Stump and Mr. Montgomery for their long commitment and dedication to the need and welfare of veterans. And with Mr. Montgomery's decision to retire, I want to take that opportunity to also say that I first met Chairman Montgomery in May 1961 when he was the General of the Mississippi National Guard.

And over the years, since I have been here, I have seen him as a friend, as a person who has kept his eyes focused with a vision, with a dream, to do what he considered was best for veterans, and for the people of this country, and I just want to say to you, Chairman Montgomery, we are going to miss you, and thank you for being here, and Mr. Stump, thank you also for being here to testify today.

Mr. MONTGOMERY. I thank the gentleman for the comments on Mr. Stump and myself. We were on the same bus, the Freedom Riders bus, we are very close friends, and it shows you what a great country we have got that you are here to help us, and we were there, back in those days. So thank you for our long friendship.

Chairman THOMAS. Thank you very much. The gentlewoman from Connecticut.

Mrs. JOHNSON. Thank you. As I followed this discussion about numbers, the conclusion that I am coming to is that there are 9.2 million veterans over 65, veterans including military retirees, is that correct?

Mr. MONTGOMERY. We will have to get that number.

Mrs. JOHNSON. You have to get back to that, because I am drawing the conclusion there are 9.2 million veterans. I do not know if that includes retirees.

Mr. MONTGOMERY. All retirees are veterans.

Chairman THOMAS. Yes, 1.3 military retirees using military hospitals, and 2.9 military—I mean, just veterans, using VA hospitals. So that would give me 3.1 million veterans who are using either military hospitals or VA hospitals already out of the 9.2 eligible.

So, I mean, those are the kind—you can get back to us on this. I mean, this is I think not a good thing to try to clear up here, but we need a clear understanding of who the universe is, and whether there would be any new choices for current veterans who are part of that 2.9 million who use our VA hospitals, would they now have access to the military hospitals? Would the 1.3 million retirees now have the choice of military hospitals or VA hospitals? Are we creating a larger universe of choice for all veterans, whether they are retirees, or just veterans? No? So, I think that if we are doing that, then we are actually eliminating the old definition of "low income," or "service connected," something that we all anguished at the time that we did it, and would really like to find a way to be more flexi-

ble in including both VA and military hospitals into the larger system. We hope to do this through Medicare.

I mean, we worked—I have been an advocate of that approach for a long time, so I am very sympathetic to what you are trying to do here.

Does your bill look at guaranteeing military retirees in areas where a military hospital has closed? This is a big problem I am running into, military retirees in an area where military hospitals have closed, having penalty-free access to part B of Medicare. I mean, now they can get back into Medicare, but they have to pay a penalty. Well, they should not have to pay a penalty to get back into part B Medicare because they did not choose it because they were military retirees.

So we might want to get a cost of that, too, because that should be a fairly inexpensive matter to fix. And just as retirees in America, anyone over 65 in America, they ought to have access, and it is not their fault that we told them they were going to get military coverage, and then we withdrew it.

So that, I gather, is not part of your demonstration, but I would ask your staff to look at that as we move forward.

Then, I just need to understand a little more clearly, in the bill, apparently Medicare will give DOD capitated payments for beneficiaries who enroll in these TRICARE options but only after DOD has surpassed its level of effort. In other words, Medicare would not put new money in until DOD spends all the money it is given by us for retiree health care. And I find that a little confusing.

How are we going to know when they hit that? Aren't they already there? I mean, we only appropriate as much as it requires to keep them open and care for a certain number of patients. Would we do that on census, that if their census exceeds a certain amount, and they're Medicare eligible, then we would compensate them for those Medicare patients?

You see, we need to sit down in a little different forum than this and understand these, sort of, you know, technical aspects of how this would work.

Mr. STUMP. Mr. Chairman, if I may attempt to answer that; in a sense, Mrs. Johnson, we do not—I do not—I cannot concur in the figures you are using. I want to get those figures. But most military retirees are above the income level. They would not qualify. They would use the DOD. Now, we are mixing DOD and VA here.

Mrs. JOHNSON. Does this bill only apply to VA?

Mr. STUMP. There are two bills, the one that armed services put out last week and our bill. We have introduced a new bill that we are going to mark up tomorrow, H.R. 4068, that applies only to VA.

What we are asking for, and have been working for for a long time, is Medicare subvention. DOD has a bill. We have a bill. We are trying to get part of that, nothing more, hopefully nothing less. We just want to be included in this whole movement if we are going to go to Medicare subvention.

Chairman THOMAS. If the gentlewoman would yield, we partly have the cart before the horse here, because the horse is the TRICARE, the DOD Medicare agreement which is in legislative form, and has been moving.

The veterans are saying if in fact this is moving, we would like to have the same treatment. That bill will be marked up in Veterans' Committee as the Chairman said——

Mr. STUMP. That is correct.

Chairman THOMAS [continuing]. Tomorrow. It is just that this hearing occurred today, and out of courtesy, the Members get to go first, so in essence, they are talking about the cart; the horse will come up when we are finished with the Members. I do not mean that——

Mr. MONTGOMERY. Mr. Chairman, I am sure these witnesses behind us who come up next learned a lot here.

Chairman THOMAS. They are chomping at the bit.

Mr. MONTGOMERY. Yes, I am sure they are with the tough questions you have given us——

Mrs. JOHNSON. Another bullet here is that enrollment will be limited to dual eligibles who previously used military treatment facilities and who agree to participate in part B of Medicare. I guess this refers to the other bill.

I am looking forward to working with you. I think these are very important issues, and I think we have to be much more aggressive in dealing with the relationship between our system of health care for veterans, and our system of health care for retired Americans. And as we get at the end of the hearing, I am sure my questions will be refined and we will be able to move forward.

Thank you.

Mr. STUMP. Those military retirees that we see are those with service-connected disabilities, using the VA system over the DOD system.

Mr. MONTGOMERY. And we tried, when we were closing these military hospitals, and I am sure one of the Assistant Secretaries can talk about that with Defense, probably when they close a military base, if the VA could, and we might have done it in one or two places, but have come in and set up some type of outpatient clinic, I think that would solve a lot of problems of the military not having a place to go.

Mrs. JOHNSON. But at the very least, they ought to——

Mr. MONTGOMERY. It was another money matter.

Mrs. JOHNSON. Right, and the very least, they ought to be able to provide a list to Medicare of the retirees that are affected, so that they do not have to pay the penalty for part B to get back into part B, which would then give them access to the health care resources of the region.

Anyway, thank you very much for your leadership on this, a really difficult issue, and I look forward to working with you.

Chairman THOMAS. Any additional questions?

I want to thank both of you. This is an example of the timeliness and the concern that both of you have shown in making sure that veterans are adequately taken care of, and I commend you for your continued vigilance.

Mr. STUMP. Thank you, Mr. Chairman.

Chairman THOMAS. Thank you very much.

Now, I would ask Bruce Vladeck, Administrator of the Health Care Financing Administration, and Dr. Stephen Joseph, Assistant Secretary of Defense, Health Affairs, to come forward and perhaps

provide us with an understanding of the current legislation that has been marked up between the Department of Defense and HCFA in this 3-year Medicare subvention demonstration project.

Mr. Vladeck, you are on my left, your right, so you might as well begin. The written testimony will be made a part of the record, and you may inform us in any way you see fit.

STATEMENT OF HON. BRUCE C. VLADECK, PH.D, ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Mr. VLADECK. Thank you very much, Mr. Chairman.

Chairman THOMAS. Welcome back to the big room.

Mr. VLADECK. Thank you, sir. I am pleased to be here today, as always. I am especially pleased to appear with my colleague of many years, Stephen Joseph. He and I worked together in New York a decade ago, and I have been pleased that we have had the opportunity to work together again in Washington. We did have some discussion on our way up to this table as to which of us was representing which end of the horse, and we will defer that until a later time. We have worked very closely with the Department of Defense, Dr. Joseph's office, for the past year to come to an agreement for a demonstration project on Medicare subvention under which Medicare would pay for dually eligible Medicare military retirees in the Department of Defense managed care program.

In forging this program, we believe that we have set the stage for a project that will provide quality service for dual eligible beneficiaries, while at the same time addressing the concerns about the well-being of the Medicare Trust Funds, and the trust funds' availability for all current and future Medicare beneficiaries.

More than 1 million of our current 38 million Medicare beneficiaries are also eligible to receive health care through the Department of Defense. Over the years, we have had these two parallel systems. The demonstration which we have proposed in the legislation will provide us the opportunity to very carefully and systematically assess the effects of working more closely together on improving the efficiency of care. The demonstration will also ensure access to services and the quality of care for that portion of the 1 million beneficiaries, who live around a number of military facilities in Texas, the State of Washington, Oklahoma, Louisiana, and Arkansas.

In working together on this demonstration, we had two major concerns. The first is that we wanted to make sure that Medicare beneficiaries who were also military retirees could be assured of receiving high quality care, no matter which system they received it in.

Second, we are of course concerned about the fiscal impacts of the demonstration and the potential longer term policy decisions on the Medicare Program. We are aware of the CBO scoring of an earlier version of subvention legislation to which the Chairman referred earlier.

A large part of our discussion with the Department of Defense over the last number of months has revolved around mechanisms to protect the Medicare Trust Funds, to limit Medicare's liability under this program, and to be sure that we could get the informa-

tion that would permit us to fairly evaluate the fiscal impacts of this project without any substantial risk to the trust funds.

Our agreement provides that the Department of Defense will maintain its existing level of effort on behalf of beneficiaries who participate in the demonstration project. We have very elaborate procedures for measuring, updating, and applying the existing level of effort. Through contract of services, the Department of Defense will make available to demonstration participants the same services which Medicare beneficiaries are entitled. Currently, the Department of Defense does not provide these services, such as skilled nursing facilities and home health care.

We have also capped Medicare's total payments under this demonstration at a total of $65 million a year. Perhaps most importantly, in terms of the financial impacts of this demonstration program, we have provided for an annual reconciliation process. This process would involve the two departments jointly and possibly include the participation of the General Accounting Office to review in detail the outlays, both on our part, and on DOD's part, for beneficiaries served in the demonstration's DOD facilities. In addition, this reconciliation process would ensure that the effects on the Medicare Trust Funds are limited

At the same time, and this is the bottom line for us in a most fundamental way, the agreement as it is incorporated into the proposed legislation not only protects, but expands the freedom of choice of Medicare beneficiaries. As is now the case, they can continue to receive Medicare services in the fee-for-service system, or enroll in any of a number of different managed care plans that are available to them in the communities in which they live. However, beneficiaries who are already using the military system, and choose to do so, could under this demonstration have the additional choice of receiving all of their services through the DOD system without having to worry about issues of availability of services, or of space available kinds of care.

We believe that we have taken all the necessary and prudent steps to protect the trust funds. We believe that we have taken all the necessary steps to improve the choices and the quality for our beneficiaries, without putting them at risk.

The question is whether this will succeed at demonstrating that indeed we can adopt these new policies without additional cost to the Medicare Program, or to the Federal Treasury in general. The answer is that we do not know.

That is why we have called for a demonstration project under very carefully defined terms. That is why the legislation calls for an independent evaluation and for an evaluator who will monitor performance as we go. The demonstration will give us hard answers to such questions, not only about cost impact, but on the changes in access to care and the quality of care for our beneficiaries. In addition, the demonstration will determine quite importantly the impacts on other local providers of health services and any shift in utilization toward military treatment facilities.

After 3 years, we should see the effects of coordination between our two programs, including overall spending on beneficiary satisfaction, access to care, and quality of care.

We are confident that after a very lengthy and complicated process, with thanks to the persistence and good efforts and cooperation of the Department of Defense and our own staff, we have put together a project that holds considerable promise for improving the availability of health care to 1 million of our beneficiaries who certainly deserve all the help and support which we can give them. This project also limits all the risks which have been considered in previous projects.

We are hopeful that the demonstration will succeed. We are certain the project has been established in a way that will let us know whether it has succeeded or not. This idea has been considered for a long time. It is something that the President feels very strongly about, and we are pleased to be in a position to go forward with a test that will give us information about the project's real implications.

In conclusion, I am pleased to appear before you again today. I know Dr. Joseph has some comments, and then obviously, we are happy to respond to any questions.

[The prepared statement follows:]

STATEMENT OF BRUCE C. VLADECK, PH.D.,
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

"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. Of the 38 million Medicare beneficiaries, more than one million 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.

Chairman THOMAS. Thank you very much, Mr. Assistant Secretary, any written testimony will be made a part of the record. You may inform us in any way you see fit.

STATEMENT OF HON. STEPHEN C. JOSEPH, M.D., M.P.H., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, U.S. DEPARTMENT OF DEFENSE

Dr. JOSEPH. Thank you, very much, Mr. Chairman. With your permission, I would submit my entire testimony, and summarize verbally, focusing my remarks on some of the issues and questions that have been raised in the prior panel, and now here.

Bruce Vladeck, just as he used to try to do in New York, has stolen my best line about who is which end of the horse, but since I get to go last, I guess I know.

But it is a pleasure to be here before this Subcommittee today and talk about this agreement which has been worked out, hammered out is probably a better word, between the Departments of Defense and Health and Human Services for a Medicare subvention demonstration.

This is an idea that has been in discussion and debate for over a decade. It is not easy to implement, because of many of the factors that you have already mentioned, and many others, and will require the enactment of legislation.

One thing that I think is important to keep in mind, Mr. Chairman, is that military medicine has a mission to provide health care wherever and whenever our men and women in uniform need it. And that mission thus has two interlinked responsibilities.

The first which we must never forget, and which is really different from any of the other Federal health systems, is to operationally deploy medical capability, people, equipment, and supplies, with the troops when they deploy, in order to provide that care on the battlefield.

The second part of that mission is to operate a vibrant health care delivery system to provide health care, what we call peacetime health care, as opposed to the wartime health care, the first part of the mission; to provide health care to our 8.3 million beneficiaries; and to ensure that our medical personnel who must be prepared for wartime deployment, physicians, nurses, technicians, corpsmen, medics, are trained, and sharp, and ready to deploy.

In meeting the requirements of that second so-called peacetime health care responsibility, the military health services system must have a large and varied patient population.

For that reason, the Congress years ago authorized the MHSS to provide care to the families of our active duty personnel, and then to our retirees and their families. This care, however, and this is the central fact, was put on a space available basis so that nothing interferes with care for the active duty force.

Military medicine today is rapidly moving toward a managed health care delivery framework, known as TRICARE which you have mentioned. By next year, we will have fully implemented TRICARE in our 12 regions across the Nation, and in our overseas commands, and we believe that we already have strong evidence of success.

But unfortunately with our move to managed care in TRICARE, the one group of beneficiaries who are not fully participating in this success is the growing number of our Medicare eligible beneficiaries, some 1 million in all.

Medicare subvention, or the reimbursement from Medicare for care that the military health services system provides to dual eligible personnel, would allow our Medicare eligible beneficiaries to enroll in our managed care system, TRICARE Prime.

After significant negotiation and examination of how the Medicare system works, and how our system would satisfy the Medicare risk HMO requirements, we have worked out an arrangement that will allow a demonstration of the Medicare subvention concept.

Permit me to say here in response to Mr. Stark's earlier comments, CBO has not scored this demonstration. The CBO figures which you mentioned earlier, Mr. Stark, were a scoring of an earlier proposal on actually a theoretical rather than a real proposal.

Furthermore, as Bruce Vladeck has already mentioned, the demonstration that is on the table now has a $65 million cap on transfer expenditures after current level of effort is met, and also there is a rather elaborate process for reconciliation at the end of each year's period, which would keep this from being a cost increase to Medicare, or to Federal outlays total for that matter.

Chairman THOMAS. Dr. Joseph, just to make sure the record is straight now rather than wait in until the conclusion of your testimony, we have in our possession dated today, and I know it only came this afternoon, you may not be in possession of a CBO analysis, which I believe is on the actual bill, not a theoretical.

Dr. JOSEPH. Sir, you may be correct, but the best of any information was that the Hefley bill has not been scored, the President's legislative submission has not been scored, and the $200 million figure, which is a figure very familiar to Mr. Vladeck and I——

Chairman THOMAS. I apologize for interrupting. Go ahead with your testimony, and then we will have CBO come up, so we can begin to clear some of this up.

Dr. JOSEPH. Fine.

Chairman THOMAS. I apologize, and would you please continue.

Dr. JOSEPH. The demonstration as proposed would cover the area of San Antonio, plus three other sites in our region 6, which is that region of the country; and the Madigan-Bremerton area in TRICARE region 11, which are the States of Washington and Oregon.

We will also identify three sites in region 6 to serve as comparison sites.

The demonstration will last for 3 years, and both agencies have the option of extending it for 18 months for enrolled beneficiaries. The agreement stipulates that we would begin the demonstration 60 days following enactment of legislation, or on January 1, 1997, whichever is later. And there is a provision for each agency, or either agency, to withdraw from the demonstration with 12 months written notice.

People who would be eligible for participation in the demonstration will include those who are eligible both for care from DOD and through Medicare's agent program; enroll in TRICARE Prime, our HMO option, or covered by Medicare part B; agree to receive cov-

ered services only through TRICARE; are residents of the geographic areas covered by the demonstration, and where enrollment in the demonstration is offered; and who as dual eligibles, used the military treatment facility before July 1, 1996, or became dual eligible starting after June 30, 1996.

The services to be covered under this demonstration include the standard Medicare benefit in addition to specific TRICARE Prime benefits. One of the major considerations in developing this arrangement is the agreement that DOD will continue to maintain its level of effort in providing care for the dual eligible population, in order to avoid imposing these costs on the Medicare Trust Fund.

This commitment to continuing our current level of effort has generated a series of very detailed conditions, reimbursement criteria, and evaluations by both agencies.

DOD will meet or be deemed to meet the applicable and agreed upon requirements similar to a Medicare risk HMO. With respect to reimbursement, it is based on capitation, the same as for Medicare health maintenance organizations. The reimbursement rate is at a level at least 2 percentage points less than for Medicare HMOs, and with rate adjustments that would avoid double payment for MHSS costs already funded by appropriations.

Enabling legislation for this demonstration has been submitted to the Congress, and we look forward to working with a bipartisan coalition of Members to quickly enact it this year.

The cornerstone of this historic agreement is that there be mutual benefit for our dual eligible beneficiaries, for the Medicare Trust Fund, for DOD, and for the American taxpayer. The agreement is specifically designed such that it will not increase the total cost of Medicare. In partnership with the Department of HHS, our goal is to implement a cost effective alternative for delivering accessible and quality care to dual eligible beneficiaries.

In closing, Mr. Chairman, I want to recognize the powerful support from those here in Congress who have championed this effort. Without the very essential bipartisan drive, and the support of many Members in both Houses, and on both sides of the aisle, we would not be at this threshold of opportunity. We need your support, that of your Subcommittee, as we move to see the enactment of enabling legislation.

I will be happy to respond to your questions, or your comments on the specifics, or on the concepts. Thank you.

[The prepared statement and attachment follow:]

STATEMENT OF STEPHEN C. JOSEPH, M.D., M.P.H.
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS
U.S. DEPARTMENT OF DEFENSE

Mr. Chairman, Distinguished Members of the Committee, it is with great pleasure that I am here today to speak with you about the just-concluded agreement between the Departments of Health and Human Services and Defense for a demonstration of Medicare Subvention.

This demonstration embodies a concept offered by the President in his health care reform package, it is a concept that President Clinton strongly supports today. In his round-table discussions with veterans and military retiree representatives, the President has sought to learn of the key issues these groups face. Each session has included a strong plea by beneficiaries that the health care benefits of older veterans and military retirees not be forgotten, that they be allowed to continue using the system, the hospitals, the physicians they have come to trust...and that their entitlements to Medicare be available for use in the Military Health Services System. Very recently, at one such round-table discussion, Major General Jim Pennington, President of the National Association of Uniformed Services, sought the President's commitment to move more expeditiously on plans to test Medicare subvention. The President gave his commitment, directed his staff to move expeditiously, and I am here today to present to you the significant progress we have made in meeting the President's commitment.

Medicare subvention is an idea that has been discussed for over a decade. It is not an easy-to-implement idea and will require the enactment of legislation. It involves tremendous cooperation and synchronization of very different federal health care programs. For the past two years, members of the military medical departments and my Health Affairs staff have incrementally and painstakingly built the conceptual design that has led to the agreement just signed. In building that demonstration design, we sought and gained strong support from the Secretary and Deputy Secretary of Defense, the Chairman and the Joint Chiefs of Staff as well as other senior leaders within the Department. This is a moment of realization for all who have worked with such dedication to achieve this agreement with the Department of Health and Human Services.

As you well know, Medicare subvention is not solely an Administration commitment. This issue has reached the offices of many Members of Congress. There have been bills sponsored in the Senate and here in the House, last year and this year, with over 200 Members co-sponsoring the bills introduced by Mr. Hefley.

This is a measure that transcends politics, it has the backing from Members on both sides of the aisle, on both sides of the Capitol. It is a measure that responds to the concerns of tens of thousands of our older military retirees who have served this nation well.

This widespread support recognizes the fact that military Medicare-eligible people are living across this nation, in every state, and they take an active role in voicing their concern that commitments made must be kept. It also recognizes the determined advocacy and tireless efforts of The Military Coalition and the National Military and

Veterans Alliance. These representatives of military beneficiaries have sought Medicare subvention for many years, so this demonstration should be a welcomed one, and a proposal that they should feel proud to have played a major part in achieving.

Mr. Chairman, military medicine has a mission to provide health care wherever and whenever our men and women in uniform need it. That mission has two interlinked responsibilities. First, to operationally deploy medical capability -- people, equipment and supplies -- with the troops in order to provide that care. Second, to operate a vibrant health care delivery system to ensure our medical personnel -- physicians, nurses, technicians, corpsmen and medics -- are trained and ready to deploy. In meeting the requirements of that second responsibility, the Military Health Services System must have a large and varied patient population. For that reason the Congress, years ago, authorized the MHSS to provide care to the families of our active duty personnel, and then to our retirees and their families. This care, however, is on a space available basis so that nothing interferes with care for the active duty force.

In the last thirty to forty years much has changed. The Armed Forces have grown smaller, the military infrastructure has shrunk, the budget grows tighter, and the national security strategy has dramatically changed. In each of these evolutions, the Military Health Services System has participated. We have fewer health care facilities, fewer medical personnel, more -- and more-intense -- missions to support, and we must find ways to be more accountable to the American public for the dollars we spend.

In keeping with these changes, and with definitive guidance from our Congressional oversight Committees, military medicine began its shift to managed health care delivery. By next year, we will have fully implemented TRICARE across the nation and in our overseas commands. This is a total transformation, a revitalization of the Defense medical system. It involves our beneficiaries making a choice for how they will receive their health care...and many are choosing our Health Maintenance Organization option: TRICARE Prime. The reasons are many, but among them are the improved access to high quality care and the assurance that they can receive care in military medical facilities. TRICARE is proving to be a great success.

Unfortunately, the one group of our beneficiaries **not** fully participating in this success is the growing number of our Medicare-eligible beneficiaries. These men and women have served their country and they have paid faithfully into the Medicare Trust Fund. They are covered by Medicare if they choose to seek care from physicians outside the Military Health Services System, and they are able to seek care in military medical facilities on a space-available basis. But, that space availability is at risk as more beneficiaries sign up for TRICARE Prime. The Prime enrollees are filling the appointment schedules of our military providers.

Medicare subvention, or the reimbursement from Medicare for care the Military Health Services System provides to military Medicare-eligible personnel, would allow our Medicare-eligible beneficiaries to enroll in TRICARE Prime. Rather than splitting their

health care needs between providers outside the Military Health Services System and the space-available military facilities, these beneficiaries would be able to access the military medical treatment facilities the same as our other enrolled retirees. It is the ability to receive care from the military system that these beneficiaries want.

As the individual responsible for the military health care delivery system, I want them to have access to this system, the Surgeons General of the military services want to care for them, and the military's senior leadership want them to be able to come to military treatment facilities. Many ask why?, why not just have these beneficiaries go downtown using their Medicare eligibility, it would be less expensive for the military services. Our response is threefold. First, because we want to honor the commitments made to them; second because they are our patients, and it is the military system where they are most comfortable especially when they are in need of health care; and third, because we need them for the variety of health problems they present, which contributes to our medical readiness training.

After significant negotiation and examination of how the Medicare system works and how our system would satisfy the Medicare risk HMO requirements, we have worked out an arrangement that will allow a demonstration of the Medicare subvention concept. (See Attachment)

The demonstration will cover San Antonio plus three other sites in our TRICARE Region 6, and the Madigan-Bremerton area in TRICARE Region 11. We will also identify three sites in Region 6 to serve as comparison sites. The demonstration will last three years, and both agencies have the option of extending it for 18 months for enrolled beneficiaries. We plan to begin the demonstration 60 days following enactment of legislation or on January 1, 1997, whichever is later. Either agency may withdraw from the demonstration with 12 months written notice.

People eligible for participation in the demonstration will include those who:

- Are eligible both for care from DoD and through Medicare's aged program,
- Enroll in TRICARE Prime,
- Are covered by Medicare Part B,
- Agree to receive covered services only through TRICARE,
- Are residents of the geographic areas covered by the demonstration and where enrollment in the demonstration is offered,
- As dual-eligibles, used a military treatment facility before July 1, 1996, or became dual-eligible starting after June 30, 1996.

The services covered under this demonstration include the standard Medicare benefit in addition to specific TRICARE Prime benefits. One of the major considerations in developing this arrangement is the agreement that DoD will continue to maintain its level of effort in providing care for the dual-eligible population in order to avoid imposing these costs on the Medicare Trust Funds. This commitment to continuing our current

level of effort has generated a series of very detailed conditions, reimbursement criteria, and evaluations by both agencies. DoD will meet, or be deemed to meet, the applicable and agreed upon requirements similar to a Medicare risk HMO. With respect to reimbursement, it is based on capitation, the same as for Medicare health maintenance organizations. The reimbursement rate is at a level at least two percentage points less than for Medicare HMOs and with rate adjustments to avoid double payment for MHSS costs funded by appropriations.

Enabling legislation for this demonstration has been submitted to the Congress and we look forward to working with a bipartisan coalition of Members to quickly enact legislation this year.

The cornerstone of this historic agreement is that there be mutual benefit...for our dual-eligible beneficiaries, for the Medicare Trust Fund, for DoD, and for the American taxpayer. This agreement is designed such that it will not increase the total cost of Medicare. In partnership with the Department of Health and Human Services, our goal is to implement a cost-effective alternative for delivering accessible and quality care to dual-eligible beneficiaries.

In closing, Mr. Chairman, I want to specially thank the many advocates in the military beneficiary associations who have worked relentlessly to pave the way for this agreement. I want also to thank Dr. Vladeck and the members of his staff who have joined us in negotiating the details of the agreement, and who will continue our new partnership through the course of the demonstration.

I want to recognize the powerful support from those here in Congress who have championed this effort. Without the very essential bipartisan drive and the support of many Members in both Houses and on both sides of the aisle, we would not be at this threshold of implementation. Mr. Chairman, we need your support, and that of your Committee, as we move to enact the enabling legislation.

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

THE DOD-MEDICARE SUBVENTION DEMONSTRATION

The Departments of Health and Human Service and Defense have forged an agreement to coordinate the Medicare program and the military health care services system in a three-year demonstration of Medicare "subvention."

The demonstration will involve dual-eligible beneficiaries (military retired personnel and their family members and survivors who are also eligible for the Medicare program).

It will take place over three years in five geographic areas in Washington state and DoD Region 6 (Texas, Oklahoma, Louisiana, and Arkansas), including (1) Tacoma-Seattle, and (2) San Antonio. Approximately 60,000 dual-eligible beneficiaries live in these sites (the exact number will depend on the location of the other three areas).

Medicare will give DoD capitated payments for beneficiaries who enroll in TRICARE--DoD's regional managed care program modeled on health maintenance organization (HMO) plans offered in the private sector--but only after DoD surpasses its "level of effort" (i.e., the dollar amount DoD now spends delivering health care services to dual-eligible beneficiaries in military treatment facilities in the demonstration sites).

Enrollment will be limited to dual-eligibles who previously used military treatment facilities and who agree to participate in Part B of Medicare.

DoD will provide the complete Medicare benefit, including skilled nursing facilities and home health care, and will meet Medicare's quality standards and conditions of participation as a Medicare HMO.

For every enrollee above the level of effort, DoD will receive 93 percent of the adjusted average per capita cost (AAPCC) in the first year. (Medicare risk HMOs receive 95 percent of the AAPCC.) In later years, DoD will receive 90.25 percent of the AAPCC, adjusted to exclude some or all of the costs associated with direct and indirect graduate medical education, disproportionate share hospital payments, and capital expenditures.

An independent evaluator will assess the costs to DoD and Medicare, the quality and accessibility of care for dual-eligible beneficiaries, and any effects on local health care providers and other beneficiaries.

Because of the Administration's concern about the solvency of the Trust Funds, the demonstration will include these key protections: (1) a $65 million annual cap on Medicare payments; (2) an end-of-year reconciliation process to correct for any mistaken overpayments; and (3) audits of DoD facilities by the DHHS Inspector General and HCFA.

Beneficiaries will have enhanced choice. They will be able to use their Medicare benefits to enroll in and easily disenroll from TRICARE, obtain care from civilian providers, or continue to seek care from DoD on a space-available basis.

Chairman THOMAS. Thank you very much.

Since we are going to be discussing some numbers that have been generated, I think it would facilitate the discussion if, Mr. Van de Water, you would come up and then we can either clear up, or establish some degree of certainty.

Mr. Vladeck, and Dr. Joseph, receive, both of you indicated—excuse me, I know Dr. Joseph indicated—Bruce you may not have—I think in your written testimony that there was need for legislation, that we have to pass legislation.

What is it that requires us to pass legislation—well, let me ask Bruce a different way.

You cannot do this under your demonstration authority, right?

Mr. VLADECK. Yes, sir.

Chairman THOMAS. Why?

Mr. VLADECK. I believe it is section 1814 of the Social Security Act—please do not hold me to that the exact citation—but there is a specific provision in the act that forbids Medicare payments to the Department of Defense's facilities, Veterans Affairs' hospitals, facilities operated by the Indian Health Service, and other Federal Government-operated facilities.

HCFA's demonstration authorities, as you know, are in several other places in the law, and involve relatively specific sorts of demonstrations that we may undertake. HCFA's demonstration authorities have to do largely with payment or covered services, and in some instances, types of providers.

HCFA's General Counsel's reading of the statute indicates that the demonstration authorities elsewhere in the law are not broad enough to waive the section of the bill that specifically forbids payment to a military facility.

Chairman THOMAS. So legislation is necessary to broaden the scope for entering into demonstrations?

Mr. VLADECK. We have written this legislation to specifically authorize this demonstration. The legislation is not designed to repeal or to undermine the broader restrictions that currently exist in the law, nor to broaden our general demonstration's authorities.

Chairman THOMAS. Was it or was it not necessary in this specific legislation to also specifically spell out, if that is not redundant, the payment structure, 93 percent of the adjusted average per capita cost, and what you do with graduate medical expenses attached to ordinary Medicare payments. Was that necessary to be done in this legislation?

Mr. VLADECK. No, sir.

Chairman THOMAS. Why didn't you just get a general agreement and then work out the pricing without locking in a specific structure that is different than current risk contracts?

Mr. VLADECK. Frankly, I think it is fair to say that the administration wished to avoid problematic relationships with the Congress. Therefore, we decided not to propose legislation of this sort until there was an agreement within the executive branch on exactly what the demonstration would constitute. In addition, we did not want to put ourselves in the position of having the Congress authorize or mandate a demonstration project. We might have had difficulty reaching an agreement. It was decided that we would introduce legislation once we had agreement among the various parts

of the executive branch. We would then be able to tell the Congress that based on our agreement, we were knowledgable of what the proposed project would accomplish. Congress would know what they were buying by the authorization. We could promise Congress that implementation of any legislation would not be slowed up, or impeded by issues of interagency relations.

Chairman THOMAS. And that could not have been fulfilled with a general statement of budget neutrality, or that current level of effort would be exhausted by the DOD prior to payment for Medicare.

I guess my concern is that what you are doing also on this legislation is to a degree setting a precedent, so you are very comfortable in indicating to this Subcommittee that the specific payment arrangement on this contract is in no way an indication that this is a structure that HCFA would like to expand beyond this demonstration project, whether or not it proves successful.

Mr. VLADECK. Clearly, Mr. Chairman, the establishment of a payment level below 95 percent of the AAPCC in the second and third years—in all 3 years of this demonstration, and the separate treatment in the second and third year of the AAPCC that can be attributed to graduate medical education, or disproportionate share, or capital expenses, parallels our thinking about changes in Medicare payment policy involving managed care plans. This position is reflected in the President's balanced budget proposal which we have previously discussed in hearings before this Subcommittee.

We wanted the demonstration to be consistent with our thinking on broader policy issues. At the same time, we didn't want to have any uncertainty or confusion about what we were requesting from the Congress in this legislation. The legislation specifically authorizes this project, and does not broaden the authorities of the Secretary, or of HCFA, relative to the Medicare Program. We wanted to provide you with a relatively well defined package so that we could say in good faith, "This legislation permits us to do exactly this."

Chairman THOMAS. I guess you might understand the sensitivity of this Subcommittee which believes it has jurisdiction over the subject matter when in fact changing the AAPCC risk contract structure is now being done in a bill that has another Committee as its primary jurisdiction. That concerns us very much.

Mr. VLADECK. Yes, sir.

Chairman THOMAS. On the memorandum of agreement, I understand you are going to be doing it in two regions, so perhaps for the record, we need to supply some rationale for the selection of regions 6 and 7 of largely Texas and the Southwest area, and the Washington-Oregon area. What was the thinking in terms of going with these particular areas?

Dr. JOSEPH. The rationale basically comes in two parts. The first, we wanted regions that were as mature as any in the TRICARE managed care process, which involves triservice orientation of the military facilities, and a relationship with a managed care support contractor.

Second, we wanted regions where we had both a good mix of different kinds of facilities, different levels of facilities, if you will, and also where we had sophisticated medical centers that could give us

a look at the widest range of services provided to our beneficiaries. In San Antonio, both the Army and the Air Force have flagship hospitals, if that is not mixing a metaphor, and we also have a large retiree population. And in Takoma, Madigan Army Hospital is a large medical center, and we also have several smaller facilities, Navy and otherwise, in that area.

So on the grounds of both maturity and in essence, a kind of scientific selection of demonstration sites, those two regions stood out.

In those two regions, we would estimate that in the areas within those regions that we choose as demonstration sites, there are probably up to 60,000 dual eligible Medicare and military retiree individuals, and the demo will probably involve 15,000 of them, in terms of its actual execution.

Chairman THOMAS. Notwithstanding the fact that as you describe it, it is a mature managed care area that we are operating in in both regions 6 and 11, we do not have the ability to determine whether we can be smart shoppers in the area among contractors, is that true?

Dr. JOSEPH. That is correct, sir. We have existing managed care support contracts in both, and I think I carefully said "more mature." I do not think any of our TRICARE regions at this time would qualify as what people sophisticated in the health care business would call a mature HMO region; but they are most mature of our system, and meet most of the criteria of development of utilization management, quality assurance, oversight of the contract, and so forth.

Chairman THOMAS. Was there any discussion about the fact that the demonstration might not be as completely useful as possible since you have preselected the contractor in the area and will not have an opportunity to do some sharp shopping for price?

Dr. JOSEPH. I do not think so. We believe, and I can furnish you those figures if you wish, that the bargaining and negotiation over the development of those contracts were within the last 2 years in both instances, has resulted in contracts that are quite favorable on a cost basis to the government.

Chairman THOMAS. Now, we have had some discussion about the costs, and I believe that the information that we have in front of us from CBO covers the bill as it is written, and it is not theoretical, is that correct, Mr. Van de Water?

Mr. VAN DE WATER. The estimate which we prepared, Mr. Chairman, is for the bill that was reported by the National Security Committee last week, H.R. 3142. The proposals that Dr. Vladeck and Dr. Joseph have made do not comport in some significant respects with the bill as reported by the Committee. In particular, the administration's proposal is more limited with respect to the number of locations at which the demonstration could be carried out. As Dr. Vladeck said in his statement, there would also be a $65 million limit on Medicare's gross reimbursements to the Department of Defense. That is an important—a significant—difference. Therefore, although we have not seen the legislative proposal which goes along with the administration's plan, our estimate of it would not be identical to our estimate of H.R. 3142.

[The following was subsequently received:]

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
WASHINGTON, D.C. 20515

June E. O'Neill
Director

September 17, 1996

Honorable Floyd Spence
Chairman
Committee on National Security
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

The Congressional Budget Office has prepared the enclosed cost estimate of H.R. 3142, the Uniformed Services Medicare Subvention Demonstration Project Act, as ordered reported by the House Committee on National Security on September 12, 1996.

The bill would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

June E. O'Neill

June E. O'Neill

Enclosure

cc: Honorable Ronald V. Dellums
Ranking Minority Member

Congressional Budget Office
Cost Estimate

September 17, 1996

1. BILL NUMBER: H.R. 3142

2. BILL TITLE: Uniformed Services Medicare Subvention Demonstration Project Act

3. BILL STATUS: As ordered reported by the House Committee on National Security on September 12, 1996.

4. BILL PURPOSE: The bill would create a demonstration project to allow Medicare to reimburse the Department of Defense (DoD) for health care that Medicare beneficiaries receive in military treatment facilities through the managed care option of the Tricare program.

5. ESTIMATED COST TO THE FEDERAL GOVERNMENT:

   The table below summarizes the budgetary effects of the bill. It shows the effects of the bill on direct spending and authorizations of appropriations.

(By fiscal year, in millions of dollars)

	1996	1997	1998	1999	2000	2001	2002
DIRECT SPENDING							
Spending Under Current Law							
Estimated Budget Authority	198,191	217,200	238,144	259,683	281,215	304,913	330,923
Estimated Outlays	196,051	215,516	236,419	257,411	279,466	303,179	328,522
Proposed Changes							
Estimated Budget Authority	0	150	200	200	50	0	0
Estimated Outlays	0	150	200	200	50	0	0
Spending Under the Bill							
Estimated Budget Authority	198,191	217,350	238,344	259,883	281,265	304,913	330,923
Estimated Outlays	196,051	215,666	236,619	257,611	279,516	303,179	328,522
SPENDING SUBJECT TO APPROPRIATIONS ACTION							
Spending Under Current Law							
Estimated Auth. Level[a,b]	15,117	15,117	15,117	15,117	15,117	15,117	15,117
Estimated Outlays	15,166	15,196	15,092	15,080	15,084	15,084	15,084
Proposed Changes							
Estimated Auth. Level[c]	0	-150	-200	-200	-50	0	0
Estimated Outlays	0	-100	-200	-200	-100	0	0
Spending Under the Bill							
Estimated Auth. Level[a,b]	15,117	14,967	14,917	14,917	15,067	15,117	15,117
Estimated Outlays	15,166	15,096	14,892	14,880	14,984	15,084	15,084

a. The 1996 figure is the amount already appropriated

b. Amounts for fiscal years 1997 through 2002 are authorizations subject to appropriations action and assume that appropriations under current law remain at the 1996 level. If they are adjusted for inflation the base amounts would increase by about $450 million a year, but the proposed changes would remain as shown in the table.

c. These estimates excludes the costs to administer and evaluate the demonstration program.

6. BASIS OF ESTIMATE:

The bill would require that the demonstration occur in two or more geographic regions over a three-year period beginning on January 1, 1997. The estimate assumes

that the project is limited to three of the Department of Defense's administrative regions--fewer than the bill would allow, but more than anticipated in a recent memorandum of agreement (MOA) between DoD and the Health Care Financing Administration (HCFA). The MOA defines a demonstration at several specific sites, but CBO assumes that under legislation that would give broader authority the MOA would be revised.

Under the bill, Medicare would reimburse DoD for expenditures above a base level of effort, which would be determined by DoD and HCFA in order that the demonstration project not raise overall Medicare costs. (The MOA contains a similar objective but would attempt to achieve it in a different way.)

Direct Spending

Even though the bill aims at no change in Medicare's or DoD's costs, CBO believes Medicare costs would rise by about $200 million a year. This increase would stem from informational and administrative problems in determining what each agency would have spent under current law.

The stipulation that the project be budget neutral for both DoD and Medicare would be extremely difficult to implement. Although one could argue that the measurement problems could go either way, there are at least three reasons to believe that Medicare's costs would rise under the subvention demonstration program.

First, knowing how many Medicare beneficiaries will seek care directly from DoD 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. 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 baseline level is subject to considerable uncertainty about the numbers of beneficiaries, the extent of their receipt of care from non-DoD sources, and their response to being included in the Tricare enrollment system. Despite the current lack of an enrollment system, data from DoD indicate 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. If healthy retirees are undercounted in the baseline level, they would become the financial responsibility of HCFA under the bill, even though they now get most of their care from DoD.

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 baseline level of care that would work against budget neutrality. The demonstration would tend to attract beneficiaries who had previously used a military treatment facility. DoD would therefore have information on potential participants' medical histories and would have a financial incentive to steer relatively healthy, lower-cost people to the demonstration. Moreover, 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 baseline 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. Even after the fact, it would not be easy for the General Accounting Office or any other auditing agency to determine the financial outcome of the demonstration because it, too, would have to rely on estimates and assumptions about events and behavior that would have otherwise occurred under current law.

Third, because Medicare's current method of paying risk plans does not adequately adjust for differences in health status among beneficiaries, Medicare's costs would rise if relatively healthy beneficiaries who would otherwise receive care in the private sector on a fee-for-service (FFS) basis choose to receive it in DoD's managed care (MC) program. (The demonstration program would pay slightly less for participants who would otherwise be enrolled in a managed care plan under Medicare.) The sector in which participants would otherwise be enrolled has important implications for the bill's potential costs. Maximum enrollment in the demonstration project would depend on an estimate of whether the participants would otherwise be enrolled in FFS or MC. If the estimate was that a large number of MC enrollees would participate, the maximum enrollment permitted under the bill would be high. If participants actually would have been FFS enrollees, however, the demonstration would incur costs for a large number of participants.

On balance, CBO estimates that DoD could shift 50 percent of its costs under the demonstration 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 access to information would lead to errors that compound rather than offset.

This estimate also assumes that the demonstration project would take place in three of DoD's administrative regions--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 estimate assumes that 30 percent of the eligible population in those regions would ultimately enroll in DoD's managed care program to continue to receive their care from DoD. Finally, Medicare is assumed to reimburse DoD at a rate of $5,425 per capita in 1997, a rate that would rise to about $6,775 in 2000.

Spending Subject to Appropriations Action

In terms of its relationship with DoD, HCFA would pay more to DoD than it now pays to the private sector, and DoD would be free to spend the extra reimbursement on things other than medical care for the beneficiaries eligible for Medicare.

The increase in mandatory spending would allow discretionary authorizations to decline by the same amount because DoD would be able to spend the receipts from Medicare. The same factors that would lead to higher Medicare costs would obscure 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.

On the other hand, discretionary costs would rise to cover HCFA's and DoD's administrative costs to manage and evaluate the demonstration project. These costs would probably amount to a few million dollars.

7. PAY-AS-YOU-GO CONSIDERATIONS:

The Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The bill would have the following pay-as-you-go impact:

(By fiscal year, in millions of dollars)

	1996	1997	1998
Change in Outlays	0	150	200
Change in Receipts		Not Applicable	

8. ESTIMATED COST TO STATE, LOCAL, AND TRIBAL GOVERNMENTS:

The bill contains no intergovernmental mandates as defined by the Unfunded Mandates Reform Act of 1995 (Public Law 104-4) and would have no significant impacts on the budgets of state, local, or tribal governments.

9. ESTIMATED IMPACT ON THE PRIVATE SECTOR:

This bill would impose no new federal private-sector mandates as defined in Public Law 104-4.

10. PREVIOUS CBO ESTIMATE: None.

11. ESTIMATE PREPARED BY:

Federal Cost Estimate: Michael A. Miller (226-2840)

Impact on State, Local, and Tribal Governments: Pepper Santalucia (225-3220)

Impact on Private Sector: Neil Singer (226-2900)

12. ESTIMATE APPROVED BY:

Paul Van de Water

Paul N. Van de Water
Assistant Director
for Budget Analysis

Chairman THOMAS. Well, notwithstanding the $200 million number, what we have is a stop loss of $65 million, is that correct?

Dr. JOSEPH. Well, sir, if I might add to that, I think there are two provisions——

Chairman THOMAS. I am just trying to understand the statement that Bruce made about the $65 million amount.

Mr. VAN DE WATER. May I comment on that, Mr. Chairman?

Dr. JOSEPH. That is only a partial—that is only a part of the stop loss that exists. As both Bruce and I said in our testimony, there is also a reconciliation process to assure no further loss, and there is also the adjustments to items within that 93 percent of AAPCC, that would further ensure against loss.

Chairman THOMAS. And how—would it in fact extend to a change in the 93 percent, plus the deducts during the reconciliation process? My concern is locking in legislatively a new number, and then reconciling it around that number, when in fact, the number may be the problem.

Mr. VLADECK. There are two issues. One is that the reconciliation process, as I understand it, actually focuses less on what Medicare has paid than on the level of effort. This level of effort refers to the maintenance of the Department of Defense's level of expenditure on behalf of its beneficiaries, before and after the demonstration.

Chairman THOMAS. You have to be comfortable that in fact they have carried out their level——

Mr. VLADECK. That is correct. Basically, the primary purpose of the reconciliation process, is to assure that there has not been a shifting of cost from preexisting patterns of expenditure by the Department of Defense to Medicare in the course of the demonstration.

Second, our agreement requires an annual review by the two Department Secretaries with the assistance of a neutral third party, if called for, of the way in which the payment methods and the percent of AAPCC are working. The agreement also ensures an opportunity to reconsider the level of payment for the subsequent year.

Although the agreement ensures a projected level of Medicare payments under the demonstration, it also provides for a mechanism which may be adjusted over the life of the demonstration in the event experience runs very different from expectations.

Chairman THOMAS. Well, and that is of concern as CBO has indicated in their analysis on page 4 where it says "Moreover, DOD has a greater incentive to shift its costs to Medicare than the Health Care Financing Administration has to prevent shifting."

I am concerned about cost shifting. I am very concerned about the adverse risk selection concerning people who are in fee-for-service versus the attraction of the military retiree on a managed care structure, especially, since you are moving into an area that has managed care, a more mature, as Dr. Joseph indicated, a more mature managed care structure. Many of these people who may be moving into the TRICARE HMO may be coming from another HMO, so that you have a significant march of people, not just from one HMO to another HMO, which might affect the risk mix, but also fee-for-service into this new military-based HMO which might in fact deal with risk selection as well.

Is this part of the demonstration project to determine the universe where they came from and the impact, not just on DOD but on the area itself in terms of health care delivery?

Mr. VLADECK. We are explicitly concerned in the evaluation, and this is an issue that has come up before in the history of the subvention discussions. We are concerned about the impact of the demonstration project on other providers of care to Medicare in the area. If every potentially eligible military retiree sought all of their care through the TRICARE system, that would clearly have an impact not only on the other Medicare HMOs in the community, but also on the community hospitals and on some of the physicians' networks.The project's impact on other providers is an explicit part of the demonstration.

Let me just add one other point if I may about the specifics of our agreement.

Eligibility for the demonstration is limited to military retirees who have either just become Medicare eligible, or who have already established user——

Chairman THOMAS. The July 1, 1996, date, right.

Mr. VLADECK [continuing]. Of military facilities. In terms of a significant shift in the patient population in San Antonio, or Takoma, we would not anticipate that, because this segment of the population is already in the system.

Chairman THOMAS. Except for those who become eligible after June——

Mr. VLADECK. Except for those who become eligible in the course of the demonstration.

Second, the TRICARE system's lock-in is analogous to other Medicare risk contractors. For instance, when beneficiaries elect the TRICARE option, beneficiaries would be eligible for Medicare reimbursement only within the TRICARE system, unless they had emergency out of area kinds of services. Both of these issues affect the nature of the risk to Medicare that would be presented by this demonstration.

I have not had a chance to discuss these issues with Mr. Van de Water before this hearing. This is not the time for us to get into details, but I believe concerns with earlier legislation and H.R. 3142 have been addressed. Some of these concerns were quite appropriately raised by CBO and have been addressed, or at least carefully considered quite a great deal as we refined this project. We will need to have further conversations with CBO to see if we can come to some closer meeting of the minds about the potential budgetary impacts.

Chairman THOMAS. And finally for this round, you indicated—both Dr. Joseph and you have indicated—that there has been a degree of spadework done over a long period of time moving to this legislation. The Chairman and the Ranking Member of the Veterans' Affairs Committee are offering a proposal which would extend it into the veterans.

Do you, Mr. Vladeck, believe that you can come to a conclusion with them in the next several months, or early next year to create what would be in essence a parallel project for the Veterans Administration as well?

Mr. VLADECK. We actually have a parallel project and a parallel understanding with the Veterans Affairs. In many ways, the Veterans Affairs' health care system is less sophisticated than the Department of Defense's system. For example, the VA subvention would involve a fee-for-service component as well as a capitated component.

We also are not as far along in being able to estimate the existing level of effort in the VA. However, the administration has proposed parallel VA legislation, and it is not identical to the DOD proposal, because the two systems are not identical.

Chairman THOMAS. And is that a yes, you would have no problem at all having a program up and running by the beginning of the year or shortly thereafter?

Mr. VLADECK. I believe that if we were to enact the corrected version of H.R. 3142, or whatever tomorrow, we could have a demonstration up and running with the Department of Defense by January 1. I am not confident that we would be able to start quite as quickly with the Veterans Affairs. We have a little bit more preparatory work to do with the VA.

Chairman THOMAS. What does that mean?

Mr. VLADECK. For example, they have not yet——

Chairman THOMAS. One year, two years, three years?

Mr. VLADECK. We could begin it during the next fiscal year, fiscal 1997.

Chairman THOMAS. Mr. Van de Water, any comments?

Mr. VAN DE WATER. Only that Dr. Vladeck is correct. Based on what we have seen in the testimony and our cursory review of the very extensive memorandum of understanding, the administration certainly has made attempts to deal with the problems that we have raised. I do not think that we would find that the cost of the administration's proposal is quite down to zero, but my initial reaction is that it would be somewhat less than H.R. 3142, as reported by the Committee.

Chairman THOMAS. Well, don't we have a requirement for budget neutrality here?

Dr. JOSEPH. In the agreement, sir, yes.

Chairman THOMAS. To what extent, notwithstanding the cap structure, do you believe any of these changes have moved us toward budget neutrality?

Mr. VAN DE WATER. Yes. We believe that the changes have moved in that direction. But as you——

Chairman THOMAS. Has it reached budget neutrality?

Mr. VAN DE WATER. Probably not.

Chairman THOMAS. OK. We will have to examine the "probably not" aspect, then.

Mr. Stark.

Mr. STARK. Thank you, Mr. Chairman.

If I understand this, Dr. Joseph, your staff, I guess, has said that you are prohibited by statute from using CHAMPUS appropriations to assist people over 65, but you could change that statute, couldn't you? You could ask us to change that law, could you not?

Dr. JOSEPH. The Congress could certainly change that law.

Mr. STARK. All right. And then you got $9 billion more than you asked for, than the President asked for, in your budget, and you

could just spend some of that $9 billion to take care of these people, right?

Dr. JOSEPH. Well, sir, I do not have the $9 billion——

Mr. STARK. Yes, but you are getting it. So, I mean, now you are back here—the trust fund is going broke and you want us to give you money, and you got $9 billion extra. I think that is pretty gutsy. But you say that it will help you prepare for wartime readiness.

Now, explain to me, I happen to be in this age category, how my health care is going to help you make us ready in wartime. Would you explain that to me?

Dr. JOSEPH. I certainly would, and I would like to respond to your first comment afterward, if you would allow me to.

I think it is clear that for good medical care in wartime, we need highly accomplished orthopedic surgeons——

Mr. STARK. That is right. The Governor of Pennsylvania when we had the Gettysburg invasion called out the militia, all the people 15 to 60, and I suppose you have got a bunch of old folks, too, that you are going to call up. I will not come anymore. But, you know, I guess that—my point—doctor, this—look, come on——

Dr. JOSEPH. I would be happy to respond to your question, Mr. Stark, if you will allow me to.

Mr. STARK. You guys——

Dr. JOSEPH. Otherwise, I will not.

Mr. STARK [continuing]. Do not waste my time. The military did not want the Hebert School when Hebert forced it on you, now it has become an institution, and you want the Medicare Trust Fund to bail out your budget when you could pass this law in the Defense Committee. There is no reason on God's green Earth why Medicare should get in there and bail you guys out. This does not make sense. It is the dumbest thing I ever heard. And I hope that you will go back to the Secretary and the President, and tell them so. I will if you don't. It does not make any sense. Six hundred million dollars, and you guys are wasting money away on weapons systems that will not work. We have senior citizens who are not getting good medical care, and you want to reach in here—you ought to be ashamed of yourself. This just does not make any sense at all. And believe me, the President ought to be ashamed of himself. We have made a case in our party for defending Medicare, and here you guys are wasting money hand over foot. I see these stupid generals flying these helicopters every morning, you would think you would have generals smart enough to learn how to drive their own cars.

So I am afraid you ought to go back and redo this. You want this bill changed, change your own laws, and then you got all the money you need, and you can leave the Medicare Trust Fund alone.

Thank you very much, Mr. Chairman.

Chairman THOMAS. The gentleman's time is not expired.

Mr. HOUGHTON. Well, we will go back and do some more.

Chairman THOMAS. The gentlewoman from Connecticut.

Mrs. JOHNSON. I just want to clarify a few facts, and raise some concerns.

I understand this demonstration is aimed at people who are eligible for care in the military hospitals, and are Medicare eligible, is that correct?

Dr. JOSEPH. Yes, ma'am.

Mrs. JOHNSON. And it has to be people who have already received some care before June 30 in the military hospitals?

Dr. JOSEPH. That is correct.

Mrs. JOHNSON. Now, first of all, DOD is already being reimbursed for these folks. I mean, you have been providing care for them.

Dr. JOSEPH. We have been providing care for them on a space available basis. We certainly have not been reimbursed, certainly not fully reimbursed for them. That is the issue. Back in the old days, 20 or 30 years ago when there was plenty of open space in military hospitals, and plenty of excess capacity, those beneficiaries who were entitled to care on that space available basis, found it quite easy to get that care. As resources have shrunk down, and——

Mr. STARK. You are spending more money now than you were 20 years ago.

Dr. JOSEPH. Well, we have closed—I am not sure Mr. Chairman, whether I should persist in trying to answer Mrs. Johnson's remark and come back to Mr. Stark. I would be happy to do either. We have closed 30——

Chairman THOMAS. In the response to Mrs. Johnson, if you will be specific in terms of numbers and dollars, that would be inclusive.

Dr. JOSEPH. We have come down since 1988, 30 hospitals out of approximately 150. We have come down almost 30 percent in personnel, and there has been—we have closed hospitals on bases such as you yourself were referring to in your initial comments. And on the other hand, the portion of our beneficiary population which comprises this retiree group, particularly the over 65 retiree group, is our fastest growing portion of the population. So what has happened in recent years is that it has become more and more difficult for beneficiaries who were entitled to care on a space available basis to actually go in and get that care.

Now, we are not budgeted, we are not funded, for that care on a space available basis. Over the years, we have taken it out of hide, so to speak, and it used to be easy to do that.

Mrs. JOHNSON. One moment. Let me try to get this clear, Mr. Secretary.

Nationally, that is absolutely true. Nationally we have reduced the number of military hospitals, and we have an increasing number of retirees.

But in the areas where you are going to pilot this, for instance, in Bremerton, you had a growing number of retirees, but we also have been allocating more and more money to the hospital there to take care of them.

In other words, right now, we are paying for everybody who has been cared for before July 1, and the only people who are going to be eligible is that same group of people.

Dr. JOSEPH. No, ma'am, we would say that we have not been paying for all the people whose care has been supplied on a space available basis.

Mrs. JOHNSON. OK. Explain that.

Dr. JOSEPH. The facilities, the uniformed personnel, contract personnel, and the moneys to buy supplies and equipment, are not based on the care that is provided on the space available basis to those eligible beneficiaries. They are based on——

Mrs. JOHNSON. In other words, are you saying that the reimbursement for retirees treated on a space available basis has been inadequate?

Dr. JOSEPH. It has been—it is inadequate to provide that care, that is correct.

Mrs. JOHNSON. Of course, we do have that same complaint from many Medicare hospitals, that our reimbursement is inadequate to their costs, and we have gone through terrible problems with that over the years, to try to identify adequacy.

What I hear you saying is that you want us to reimburse because Medicare reimburses better than DOD reimburses, and therefore you get a more adequate benefit, is that really it?

Dr. JOSEPH. No, ma'am, I think that is—excuse me—I do not believe that is what we are saying. What we are saying in its simplest terms are that a space available beneficiary who believes quite correctly that at some time in the past was promised free lifetime care from the Department of Defense——

Mr. STARK. When was that?

Dr. JOSEPH. I beg your pardon, sir?

Mr. STARK. When was that? When were they promised that?

Dr. JOSEPH. In the recruiting brochures that——

Mr. STARK. But not in the law?

Dr. JOSEPH. But not in the law.

Mr. STARK. Yes, we should put those recruiting sergeants in jail. They were not promised that. That is not in the law.

Mrs. JOHNSON. Mr. Secretary, have you looked at the numbers as to what it would cost to allow every military retiree who used to have access to a military hospital, and therefore was covered by military appropriations to let every one of them have access to Medicare part B without penalty, and then, if the DOD thinks that it should be picking up what would be the effect of Medigap premium, then we should do that, see? But the demo you are talking about is never going to help people who do not live near a military hospital, because they are never going to qualify. This is not going to eventually affect all retirees because the eligibility criteria are too narrow.

Dr. JOSEPH. I do not think the eligibility criteria are too narrow, and our position would be that——

Mrs. JOHNSON. Well, I know in Connecticut with the reduction, there are plenty of people who now live too far from military hospitals to use them for their regular care, and what they need is access to some plan in our area, and better access to the VA hospital.

Dr. JOSEPH. And under our managed care system, our TRICARE system, that is precisely what the managed care support network provides. It provides access to care provided by the contractor——

Mrs. JOHNSON. In other words, you would see retirees throughout——

Dr. JOSEPH. [continuing]. Outside the——

Mrs. JOHNSON [continuing]. The country rather than getting access to Medicare part B, getting access, and paying their own part B premium, and their own Medigap premium, getting access to TRICARE, which would be essentially a zero premium Medicare HMO, correct?

Dr. JOSEPH. Well, if that is what they chose, number one. Number two, it would be be zero premium, because it is not for the eligible retirees. Number three, to go back to your previous——

Mrs. JOHNSON. It's not for whom?

Dr. JOSEPH. I beg your pardon, ma'am?

Mrs. JOHNSON. It is not for which retirees?

Dr. JOSEPH. It is not a zero premium. There is an enrollment fee for the retirees.

Mrs. JOHNSON. But is it an annual enrollment fee?

Dr. JOSEPH. Yes, ma'am.

Mrs. JOHNSON. Is it equal to the part B premium?

Dr. JOSEPH. It is not equal to the part B premium. It is somewhat less than the part B premium. But if I may, just to pursue that——

Mrs. JOHNSON. But it covers both part B services and Medigap services?

Dr. JOSEPH. It does not cover the current complete range of Medicare provided services. That is why the demonstration is written the way it is.

Mrs. JOHNSON. Does it cover some Medigap services?

Dr. JOSEPH. It covers some Medigap services, yes. And that is——

Mrs. JOHNSON. So it would be less than the part B premium for a larger than Medicare plan?

Dr. JOSEPH. And that is the point I was trying to get to before, that the eligible—the dual eligible retiree today can choose to go downtown to an HMO or to a private physician, and that health care provider is reimbursed for the care. That the same eligible retiree can choose, and very often does, to come back into the military hospital where for a whole series of reasons, he or she may well rather be, get that care if they can get it on a space available basis, and there is no reimbursement to us for it.

Chairman THOMAS. On that point, in the Washington area, are there any HMOs that are zero premium? Or do you have to pay, given the AAPCC in the area?

Mr. VLADECK. I am sorry, Mr. Chairman, I did not fully hear that.

Chairman THOMAS. Do you have to pay for an HMO out-of-pocket in the Washington area? Is there any HMO or——

Mr. VLADECK. I believe that we have zero premium Medicare plans. I know that we do in Maryland.

Chairman THOMAS. I did not say Maryland or——

Mr. VLADECK. I do not know about the District.

Chairman THOMAS. We do not have—that region is not in the two regions. It is the Seattle area that we are dealing with.

Mr. VLADECK. That is correct. I believe that we have zero premium plans in San Antonio and not in Seattle, that is correct, sir.

Chairman THOMAS. All right. Now, back to my original question——

Mr. VLADECK. Let me amend——

Chairman THOMAS [continuing]. There are no zero premium plans in the greater Seattle area?

Mr. VLADECK. There are now zero premium plans in the Seattle area; but there have not been any historically. In the last couple of years, there have been new entrants into the Seattle market who are offering a zero premium Medicare plan.

Chairman THOMAS. And my assumption is that the military retirees will not have to pay out of pocket?

Dr. JOSEPH. In the current demonstration agreement, there is no enrollment fee for the demonstration. However, the enrollees would pay the part B premium in the demonstration.

Chairman THOMAS. No, they would in a zero premium as well. That is nonresponsive. My concern is that we are creating a demonstration program in an area, and I do want to see the data, that shows how many people are signed up for zero premium HMO notwithstanding the fact that it is offered versus the number of people who are paying out of pocket who are nonmilitary retirees for an HMO program in the greater Seattle area for which military retirees will receive a program with no out-of-pocket payment. And that is a concern.

Mr. VLADECK. Mr. Chairman, if I may, and partially in response, or in additional response to Mrs. Johnson's question, there are a significant number of military retirees who for reasons of geographic accessibility, continuity of care, availability of particular specialties' services, or for reasons of absolute preference, continue to receive care on a space available basis through the military treatment facilities. These retirees choose this option even when they have a Medicare card with which they could get care from other providers in other institutions.

Although we have yet to completely convince CBO, this demonstration proposal is to see if we can find a way to ensure that military retirees who are Medicare beneficiaries and prefer to receive their services through the military system can continue to do so. This project will be conducted in an environment in which the expectation is that the availability of military facilities for people who are not enrolled in the TRICARE Program will diminish over time.

We have already had some instances in some parts of the country in which military hospitals were closed. Beneficiaries who were accustomed to using military facilities were able to get care elsewhere, but in many cases at the cost of some considerable inconvenience, disruption of services, or disruption of the continuity of care.

I think what our duly eligible beneficiaries are concerned about is that over time, as the military and the military health care system evolve, the military may be without some sort of subvention arrangement. It may also be less and less possible for these beneficiaries to continue to receive care from the providers from whom they have been receiving care with a very high level of satisfaction.

This is why the subvention demonstration project is defined in relatively narrow terms. For instance, participation is limited to beneficiaries who are already in the system. The project will also consider the issue of whether, given the two different ways in which the Federal Government finances health services for these beneficiaries, we can change the mix of financing to some extent. However, we hope that any change will have no net increase in cost to the Federal Government and will continue to protect the availability of these services to our dual beneficiaries.

Mrs. JOHNSON. Just to return to my question, I understand what you are trying to do, and I think there is some good rationale for doing it across the country, both for the retirees, and for veterans. But for your own enlisted people, you have done this sort of cold turkey. Now, dependents only have space available. It is a terrible system. It was not working. I am delighted you have offered TRICARE.

But why do you not just say to retirees, "Look, you can join this in order to have access to the military hospitals," and then just that part of the budget that you have used for reimbursing military hospitals, you just segregate those dollars and they go to pay TRICARE premiums. I do not see why you do not just make it competitive. I mean, military retirees can choose TRICARE, and if the military hospital is good enough to get the TRICARE business, or let them choose another managed care plan, let them have their choice of managed care plans including TRICARE. Put the military hospital with its space available limitations up against other hospitals in the other areas.

But our only concern is that our veterans have access to care, in this case military retirees. But I do not see that the system you have set up about current level of efforts and all that stuff, I mean, I hear what you are saying, but I do not know if we are going to do this. I cannot imagine doing this. I cannot imagine expanding this demo to nationwide with this kind of complexity. Now, the way we do it for other retirees has worked abominably. We capped Medicare, Medicare is a capped program. It has a target. If seniors use more services than the target anticipated, we cut rates. And that is what you are doing to TRICARE. You are saying the cap is 65 million, if you go over it, you eat the cost. And that is the risk you take.

Now, this does not work very well in Medicare, because we do not have anyone to take the risk, except ourselves, so the rates go down. That is what happens. And people lose access.

But if you make a mistake, and your 65 million is too low, it is fine to say we have capped it. The fact is people are going to get lousy care, because the risk will be too great.

So it seems to me that giving retirees the choice of TRICARE or of other managed care plans in the area, serves them far better and particularly in terms of the national demonstration project, because you are not going to have a lot of people, retirees, who are going to live near military hospitals. As you said, we have already closed 30 of them, and I think you are demonstrating the wrong thing. You are demonstrating just military retirees, near military hospitals, only ones who have been served, and all we are going to do is try to shift the real cost of that service to Medicare.

Dr. JOSEPH. Ma'am, giving the military—giving the dual eligible beneficiary that choice that you described is exactly what the demonstration does.

Mrs. JOHNSON. So you are going to give them more than a TRICARE plan? Can they choose any plan?

Dr. JOSEPH. They have the option to either stay with or join any of the Medicare options they already have, plus——

Mrs. JOHNSON. They have a Medicare fee-for-services option. In these areas, do they have Medicare HMOs?

Mr. VLADECK. Yes, they do, and in each of the metropolitan areas in the demonstration, there are a range of Medicare HMOs, including several with zero premium.

Mrs. JOHNSON. And then they will have a TRICARE HMO?

Dr. JOSEPH. And they will have a TRICARE HMO option.

Mrs. JOHNSON. Now, the ideal thing would be to give them the other HMOs. I mean, that is what we are trying to do in Medicare Plus is to give them other HMOs that guarantee the proper services.

Dr. JOSEPH. I do not understand how they would not have that option.

Mrs. JOHNSON. Well, they would have that option under Medicare Risk Programs, and under yours. What we are saying is that there are a lot of PPOs out there that are very good, and they ought to have that option, too, because it might provide better services than we are able to provide under HMO models, which both of these are.

And so if you are going to demonstrate, why do you not demonstrate HMO access, and PPO access as long as the PPOs guarantee the services that you have to have under Medicare or for retirees?

Dr. JOSEPH. Well, I think there is another aspect of this you might also consider. I heard this morning some preliminary figures that looked at a sample of Medicare eligible DOD retirees hospitalized in a San Antonio military hospital, and the preliminary numbers I got were that 30 percent of them were also enrolled in other health care for which Medicare was paying. So you are paying for it twice now.

Mr. VLADECK. We do have exactly that concern. It is part of the evaluation. But I would only say on the PPO issue, Mrs. Johnson, as you know, we are trying to do the most straightforward kinds of demonstrations we can. We are testing the availability of Medicare and PPOs through our Choices Demonstration Program.

Mrs. JOHNSON. But we did discuss that, that you needed authority in the Choices Demonstration. We are not going to pass that authority this year, so why do you not get the authority to at least test that in this demo as you are doing it——

Mr. VLADECK. No, Mrs. Johnson, I believe you may not be remembering correctly. We believe that we have the authority for the Choices Demonstrations. We are proceeding to enter into these contracts right now.

Mrs. JOHNSON. Well, my recollection was that you can proceed to a certain degree, but there are areas, ways, in which you cannot proceed because you do not have the legal authority. Why do you not get that whole legal authority to do that in this closed dem-

onstration so you can pilot, really, all the managed care plans out there, because for the same premium, they are growing and expanding, and offering far more benefit. And we ought to have that option for our retirees as well, rather than restricting them in a sense to government controlled options.

Mr. VLADECK. Well, Mrs. Johnson, if I may, I think doing so puts us on the track of the question and the discussions which we have had with this Committee and the leadership as to whether we wanted to take the part of the budget bills, specific to Medicare demonstration projects and moving these separately from the reconciliation process or in a separate process this year.

Mrs. JOHNSON. I understand that, but if you are doing——

Mr. VLADECK. I think we all decided not to do that.

Mrs. JOHNSON. If you are doing a demo that is Medicare eligibles, the goal is to give Medicare eligibles as much choice as they want, and as they care to take advantage of. And if you are going to give them now Medicare risk products, and Medicare fee-for-service, and the military HMO product, why not at the same time offer them any other product in the Bremerton area?

Thank you.

Chairman THOMAS. Thank you gentlelady.

Dr. Joseph, you have talked about the dual eligible. You have that now, obviously. We are dealing with dual eligible, correct?

Dr. JOSEPH. Yes, that is correct, sir.

Chairman THOMAS. And the military pays a portion? Let us take somebody in the Seattle area right now. Does the DOD pay a portion of their Medicare eligibility? Do they assume a portion of the cost?

Dr. JOSEPH. No, sir.

Chairman THOMAS. Medicare is carrying that price totally?

Dr. JOSEPH. Yes, sir.

Chairman THOMAS. Can that military retiree avail themselves of the military hospital on a space available basis?

Dr. JOSEPH. Space available basis.

Chairman THOMAS. And some are?

Dr. JOSEPH. And many are. As many as can get in are, yes, sir.

Chairman THOMAS. You are not now being reimbursed by Medicare?

Dr. JOSEPH. That is correct.

Chairman THOMAS. What you want to do is create not a fee-for-service, but an HMO structured reimbursement from the Medicare?

Dr. JOSEPH. Exactly, sir, under the belief that we can do that at a lower cost to Medicare than Medicare is currently carrying.

Chairman THOMAS. And this demonstration project is to simply take the Medicare portion of the dual eligible and send it through the DOD?

Dr. JOSEPH. This demonstration is to give a choice to those Medicare eligibles, to come into DOD on a space guaranteed basis with their care financed with those moneys that Medicare would expend for them otherwise.

Chairman THOMAS. And how did we arrive at a 93-percent reimbursement rate?

Mr. VLADECK. I think it is fair to say, Mr. Thomas, that it was essentially a negotiated figure. The Department of Defense initially suggested it. We subsequently suggested a lower percentage——

Chairman THOMAS. Suggested pulling the GME out of it? Who suggested pulling the GME out of it? Who suggested that?

Mr. VLADECK. We did that.

Chairman THOMAS. You did that. And then you negotiated the second and the third year at 90 percent?

Mr. VLADECK. That is correct.

Chairman THOMAS. What happens if you are wrong?

Mr. VLADECK. Well, again, that is why we have a process to annually review the demonstration to determine if it is working and the opportunity——

Chairman THOMAS. But those percentages are locked into the legislation. They are not negotiable.

Mr. VLADECK. I believe the review process is also ensured by the legislation.

Mrs. JOHNSON. Would the gentleman yield?

Mr. VLADECK. It is the reconciliation process that would then——

Chairman THOMAS. I understand, but the reconciliation process will take place outside of the 93 and 90 percent. What you have just told me is that perhaps 93 is too high, and you will then pay back some money, notwithstanding the fact that you keep the 93 percent in place. Or more appropriately, in the second and third year, since you knew from the first year that maybe the 93 percent was too high, you may work out a reconciliation process in which you reconcile dollars but you are legislatively locked into the 90-percent payment. Why do you lock in a specific payment rate? Why do you not make that part of the reconciliation so that we can have a true understanding of what that amount would be?

Mr. VLADECK. Mr. Chairman, if we did in fact do that in the way in which the legislation was drafted, then we should not have drafted it that way, and we need to correct it.

Dr. JOSEPH. It is a 3-year demonstration period.

Chairman THOMAS. That is the reason I have been pointedly making the comment that a Committee without the jurisdiction to adjust the Medicare reimbursement rate passed legislation which readjusted the Medicare reimbursement rate, and changed what was included in the AAPCC for this demonstration project, which I believe, Mr. Vladeck, HCFA was very pleased to use as a wedge in attempting to get in reality numbers which do not now exist, and for which you would have to go through this Committee to get. By doing this, you do not. My concern is the amount that you have locked in is in fact more than you should be paying, and I am very, very, concerned about the math and the structure for which DOD will account for its portion of the dual eligibility aspect to be fed back through. I know you have got a number of checks on that, and one of the reasons I would like to go ahead with the project is to begin to look at these kinds of numbers. They may not be sufficiently compelling, but it is very interesting in terms of what those numbers might be.

I hope that the 93 for the first year, and the 90 for the second and third year were not completely the subject of negotiations. I assume you have some facts, charts, understanding, of regions 6 and

11 as to what might be an appropriate average adjusted per capita cost payment with the takeouts, carve-outs that have been involved.

Do you have data to support your——

Mr. VLADECK. We do not have data specific to the area, Mr. Chairman. We have some research which we have recently published, and it is consistent with the earlier research done by Mathematica Incorporated. This research suggests that on average, 95 percent of AAPCC for the Medicare Risk Program is probably too high given the actual selection of risk experienced by Medicare HMOs through 1994, rather something between 90 and 91 percent is probably a more appropriate estimate of the relative risk. This is where that number comes from.

Chairman THOMAS. Explain to me the logic of locking in a specific reimbursement rate, different in the last 2 years than the first year, but providing a reconciliation structure if in fact that payment is too high.

Mr. VLADECK. Well, it is not the payment which the reconciliation addresses, and that is——

Chairman THOMAS. What happens then if the payment is too high?

Mr. VLADECK. If the payment is too high, again, the two Department Secretaries would have the opportunity under the agreement to annually revisit the payment rate. We had ensured this provision in the agreement. If the legislation is drafted differently, then we need to correct it.

Chairman THOMAS. Why do we not eliminate any specific numbers in the legislation so that you can work it out and adjust it so it can be a true demonstration project. If you believe the current rate is too high, you can move it to wherever you want with the figures, and if they are substantiated, it would certainly be a very useful argument to present as to what the appropriate AAPCC percentage should be for HMOs.

Mr. VLADECK. Mr. Chairman, it was our perception that a specification of the reimbursement mechanism in the legislative proposal would facilitate favorable Congressional Budget Office scoring of the legislation. However, our perception appears to have been incorrect.

Chairman THOMAS. And you felt that the discussion in the National Security Committee on the AAPCC rate, and the 93 percent shifting to 90, and the withhold on the DSH payments was an enlightening one? I am sure they went into that discussion on the way you had structured it.

Mr. VLADECK. Mr. Chairman, I was not present for that discussion. I must say, however, that——

Chairman THOMAS. A discussion, anyone who was present there?

Dr. JOSEPH. The technical discussion you describe was not—did not take place.

Chairman THOMAS. I did not think there would be.

Mr. VLADECK. I am not familiar with the way in which Congress establishes the order in which Committees with overlapping jurisdiction act on proposals, but as I am sure you can understand, we never had any belief, desire, or illusion that this legislation would go forward without the Committee on Ways and Means acting on

it. Please understand that we have no confusion or illusions about jurisdiction over the Medicare Program, and—from our perspective, the timing of the two, of the work of the two Committees, is unrelated to our understanding of your jurisdiction over anything having to do with Medicare.

Chairman THOMAS. Would you assume that the numbers that you worked out with DOD on this particular subvention program would be appropriate numbers for the veterans VISN Program?

Mr. VLADECK. Yes, we have talked about the same kind of numbers for the capitated part of the veterans program.

Chairman THOMAS. And have your discussions reached the stage that you would have geographic regions in mind similar to the way in which you selected regions 6 and 11 for veterans, or is that a bit more informally spread out?

Mr. VLADECK. Well, that is just a part of the discussion that is not as far along with the Veterans Affairs as with the DOD. We have not yet gone to the level of specifying sites for the demonstration with the VA.

Mrs. JOHNSON. I would like to clear up one issue. Can the TRICARE plans contract with any hospital in the area they choose to?

Dr. JOSEPH. The managed care support contractor develops a preferred provider network, and essentially has freedom of choice in the development of that network. I can consider a situation that if we thought that a provider was not——

Mrs. JOHNSON. Yes, there is a problem here you are overlooking. The TRICARE managed care provider will not be able to contract with the medical center in Washington, because they do not have any ability to compensate for the costs of teaching medical education, because you have taken that out. Have you made any provision for where TRICARE plans need to use teaching hospitals for those teaching hospitals to get a special separate supplemental payment to cover the cost of medical education?

Dr. JOSEPH. Actually, Mrs. Johnson, the most recently concluded managed care support contractor in the upper Midwest and Rocky Mountain West, the alliance of providers in that network includes a number of the university teaching hospitals in those States, so I do not think that you are—and in other regions as well, there are university medical centers who are part of the provider network. So your point is not correct.

Mrs. JOHNSON. Well, it may be correct that we are letting managed care hospitals negotiate and include medical centers in their negotiated rate, but it is also true that that rate does not include the medical education provision, or if it does, it goes into profit, and it is absolutely true that this is stripping dollars out for medical centers across America.

So I am concerned that you would by law take the medical education portion out and then not have any way to feed it back into our teaching centers. If a patient needs to go to that component of a managed care system, it is not healthy for the managed care system to be reimbursing the teaching hospital the same way it reimburses other hospitals, and this is a bomb waiting to explode in the Medicare system as HMOs take more and more of the business.

So I do not want to see that bomb planted in your demo, and I would want to see some provision for an additional payment from HCFA, for any patient referred to and treated in a medical center. That is an issue I would consider very open in this legislation.

Thank you.

Chairman THOMAS. Dr. Joseph, I am interested in your response to Mrs. Johnson about the fact that the statement that she made was not true. Having expanded on it, do you believe that her statement is not so?

Dr. JOSEPH. My comment that her statement was not correct was with respect to the fact that we do provide services through academic health centers in our existing managed care support contracts.

Chairman THOMAS. What we have in front of us is a demonstration project that specifically pulls out of the reimbursement those payments with no structure for feeding it back through—all of the direct medical education, the disproportionate share and 40 percent of the indirect.

Dr. JOSEPH. The pullout in the demonstration is I believe a different issue than the one Mrs. Johnson raised. The pullout in the demonstration is with respect to what Medicare reimburses to the DOD for our direct medical—graduate medical education, and related costs.

Chairman THOMAS. And if you do contract with a teaching hospital in the greater Seattle area, how do they get their payment?

Mrs. JOHNSON. Does Medicare have any obligation to reimburse in addition to what they are reimbursing you outside of your reimbursement system? See, if this demonstration project does not address that, I understand for you, it does not matter. For health quality in America, it matters a lot. Not only do those medical centers have teaching costs, they have the highest disproportional share, often because they have the really poor patients who are terribly, terribly, ill, and require intensive care.

So you really have to look at that from the larger policy area, Mr. Vladeck, and I think we need to look at that if this is going to go forward.

Mr. VLADECK. Mrs. Johnson, that is exactly why the impact of this demonstration on the other providers of service in the communities served is so central a part of our evaluation.

Mrs. JOHNSON. But Mr. Vladeck, we are already seeing that this is harming our medical centers. Would it be responsible to put a 3-year demonstration project in place that clearly denied them reimbursement for 3 years for anyone covered under this when we already see it? I hear it out there in the real world from my medical centers that managed care is negotiating out their medical reimbursement dollars, and they are hurting.

So I think we cannot ignore it in structuring this demonstration project.

Mr. VLADECK. Well, if I may, Mrs. Johnson, our expectation is that the bulk of the inpatient hospital services in this demonstration will be provided in the military hospitals which do conduct medical education activities, supported by appropriated funds.

Therefore, the issue of taking these funds out for purposes of this demonstration is an issue of avoiding double payments.

Mrs. JOHNSON. Well, that is why I asked whether these TRICARE plans only were going to deal with military hospitals. I understand that military hospitals have different funding streams. Nonetheless, you need to make provision in this for when nonmilitary hospitals provide sophisticated care, when medical centers that provide medical education provide sophisticated care, they need to be guaranteed a medical education reimbursement because we did not pass the Medicare Preservation Act which began to separately fund medical education. We have no system for separately funding medical education.

So it would be irresponsible to have a demonstration project that took those dollars out, and then did not give them back to the very institutions that we wrote the law to fund.

And likewise, in disproportionate share. You cannot get care—maybe not the teaching hospital, but if TRICARE includes any county hospital which may or may not be teaching, it has a high disproportionate share, and you cannot just ignore that. So I do want to look at the reimbursement structure for the nonmilitary hospitals that TRICARE contracts with, and make sure that they get a fair level of reimbursement. That is my only point. And I think that has to be addressed before this goes forward. This is the problem with a nonreimbursement-oriented committee because this is a terrible quagmire now in our law. But other Committees do not talk about it. I do not blame them. It is terribly boring. But it is terribly important.

So I think we have to get HCFA back involved in a more honest reimbursement structure, reimbursement payment system, for the nonmilitary hospitals involved.

Thank you.

Chairman THOMAS. If in fact we are using military hospitals as the anchor, and you assume the single contractor you have already negotiated with will provide a lot of the ancillary necessities for Medicare beneficiaries—skilled nursing facility, home health care, and so on—what comfort level do you have that the military hospitals are in fact able to provide the full medical hospital component, geriatrics, and so forth, for the retirees, and that you may not have to contract out, and what provision are you going to include for those individuals—and I wish some of my colleagues from the other side of the aisle were here—are you going to include an "any willing provider" structure in your HMO package called TRICARE?

Dr. JOSEPH. On your first point, I think we feel confident and in part, it is a matter of the beneficiaries who have voted with their feet to try and get into the space available structure, that those services which we do provide, and in our larger hospitals, that really is a full range of services from a quality—from a quality point of view, or entirely adequate. We have—we can provide you with lots of material that supports that assertion.

As to your second question, Mr. Chairman, I do not believe we have in any willing provider a clause in any of our TRICARE managed support contracts, but I need to check that to be sure, and we will get back to you. I do not believe——

Chairman THOMAS. And you are utilizing the military hospitals as the primary anchor.

Dr. JOSEPH. Yes.

Chairman THOMAS. I guess my concern would then go back partially to the Ranking Member's question earlier, to the degree this is a successful program, and your military hospitals cater to a larger number of military retirees, and your hospitals begin to—perhaps specialize is too strong a word—but clearly meet the needs of competition, because as you said, these military retirees are going to vote with their feet, and if you do not maintain military hospitals at least on a minimum par with what is going on in the private sector for retirees, you may in fact be devoting authorized appropriated dollars through the DOD to change the military hospitals gradually or significantly to meet those military retirees' needs, to maintain the program for the reimbursement from the regular Medicare Program; and the last time I checked, in terms of military preparedness, geriatrics was not a significant aspect of military preparedness for field operations, which was one of your earlier rationales for doing it.

Dr. JOSEPH. Well, it is still one of my very strong rationales, and I think that your statement and mine both bear a little closer examination. To go to war, we need well prepared neurosurgeons, chest surgeons, orthopedic surgeons. I will leave out the primary care issues for the moment. To be a well prepared neurosurgeon, or a chest surgeon, you have to do neurosurgery or chest surgery on a frequent basis; you have to do it with complicated cases; you have to do it with sick people; and particularly relevant to the wartime requirement setting, you have to do it with patients who have multiple, multiorgan system problems. I think you would agree with that.

You do not find that range or level of intensity of problems in healthy 23-year-old active duty military persons. So I could draw out many more examples. I think there is a very strong case to be made. I am not trying to——

Chairman THOMAS. I understand the direction you are going. I think your arguments are valid in my instances. The problem is this, when you convert from peacetime to military medical needs, in the old system, the large universe of your patients went with you. You were tied to the military, you were like the camp structure, you packed up and went with them.

What you are now proposing is to move far more radically into taking care of those who do not move with you when the camp moves for military purposes and you have structured your hospitals and those doctors who do all those cases are still going to have to do all those cases if you are going to maintain your military retiree profile through your structure that you have established, and then you are going to come back and ask for even more people when you have got to decamp and go on to a military structure. And my concern is, you are building in an establishment structure which you cannot take with you, which is the primary argument you have made, even in terms of working on those patients. Those patients are not going with you. They are going to be back there, they are going to have demands on the system, and they are going to want people in the hospital taking care of them.

Dr. JOSEPH. No, sir. Two points. One point is that the reserve medical structure, and now the responsibilities of the managed care

support contractor are to backfill those requirements when a medical contingent moves out, and deploys.

In fact, again, I can give you specific figures referring to the deployment in Bosnia. There was basically no sag in our ability to maintain access, both in Germany, and in the United States because of that. That backfill structure is very important to us.

My second point, the other side of that practice, availability to have sick complicated patients to keep that surgeon sharp, the other side of that is the ability to recruit, to retain, to keep professionally satisfied the quality of people that we want and need in the system. And in some contrast to previous decades—and again, I can give you specifics on this if you wish—we have by any standards of measure and accreditation, an extraordinarily well qualified medical and health professional cadre in the military.

Without the kind of broad population experience, interest, if I may sort of in the jargon, we would not be able to recruit and retain that quality young orthopedist, or critical care nurse, or neurosurgeon. That is the other side of the requirement to have a full up round, busy complicated, medical practice, in our setting.

Chairman THOMAS. Now, that is a rationale that has not been completely explored, and I understand that argument.

I guess we have come largely full circle, because on your previous arguments, I did not understand why when you are going to rely on the private sector to backfill, and that was——

Dr. JOSEPH. And reserves, sir, excuse me.

Chairman THOMAS. I understand. The point is, why not simply allow the military retirees to be what triggered this whole Medicare discussion in the first place; that is, 65 years old and Medicare eligible. All of the others are secondary criteria, and you are trying to create a new structure, which will take the secondary criteria and elevate it to the primary criteria. We are concerned that these people ought to go rather than to have the backfill structure available when you pull up your operation and leave, they should be at the backfill structure to begin with, private sector.

Your argument about attracting people because their medical practice is more interesting because we have been able to fund military retirees coming back to the bases and therefore it is a little bit like bombers and airplane pilots, they get to fly multiengine jets and transports, which has a direct applicability to the private sector in getting a pilot's ticket to fly, and these doctors will come out of the military more fully prepared to enter the private sector having had this kind of training.

That is an argument that we will have to look at through all of the numbers that are being generated, because if in fact, all of this synergistic positive stuff that you are talking about can be carried out at no additional cost, or preferably, at a savings, then I am interested in looking at it.

My problem is right now, the way the numbers go together with dual eligibles, and what you are asking for and what you may run through your appropriated structure to take care of it, and especially CBO's analysis about the question of adverse risk selection from the fee-for-service into this kind of a program does not give me a level of confidence that in fact it will be budget neutral, zero cost, on this demonstration project, or if in fact, this were fully im-

plemented, and we have got to work with these numbers to get a little higher comfort level than I have right now.

Dr. JOSEPH. If I may, Mr. Chairman, just add one factor to that chain you drew, I think quite accurately, of this complicated synergistic stuff, you have left out one very important thing, it is that the dual eligible beneficiaries want to be cared for in the military health system, and that is what starts that change.

Chairman THOMAS. You should not have placed that on the table, Dr. Joseph. The problem we have has been too many people "want." We do not have enough money to fund the needs. We are going to have to go back in and make some very, very, difficult judgments about what people are going to be able to receive as far as benefits, how much they are going to have to pay. And for you to come before this Subcommittee dealing with Medicare and say you want to structure this program because somebody wants to do it this way is in no way a rationale that this Subcommittee, this Full Committee, or this Congress, will entertain. If it saves money, if in fact there are benefits to it without costing money, then we can talk about moving forward with the program.

But to come here and justify a program because somebody who has a particular position in life wants it, and therefore they should get it even if it costs more money, is not a rationale that should be provided at all.

Dr. JOSEPH. No, sir. A poor choice of words on my part. The needs remain the same wherever the dual beneficiaries get their care——

Chairman THOMAS. And our goal is the most cost effective way of delivering it, and——

Dr. JOSEPH. Yes, sir.

Chairman THOMAS [continuing]. All your other arguments ought to be presented. Do not present that one.

Dr. JOSEPH. I think wisdom says I will hold my response to that, but I think it is an accurate response.

Chairman THOMAS. I understand. And coming where you are coming from, I understand that as an argument as well. Because just as unions like the idea of what we proposed, a seamless transfer from the workplace to retirement so that they could maintain their seniors' affinity to the hiring hall and the structure that it provides in a social as well as an economic and health care way is an argument that is applicable to the military as well. And I understand that. But that is way down on our list of making changes in the system.

The gentlewoman from Connecticut.

Mrs. JOHNSON. Yes, I just wanted to pursue your comments about preparing a medical capability to serve an at war force in peacetime. I think this is a very big problem. I think you are right about that. And I am glad to see you sort of beginning to plan. I do not think that this demonstration goes very far to satisfy that, because you are limiting it to people who have already had care in the military hospital.

Now, if they have had a transplant, they are unlikely to have another one, or if they have had hip replacement. I mean, what you really need is new people coming in. So this demonstration is not central to the solution to that problem. Eventually, what you are

going to need is to have some arrangements with other hospitals in the area where your surgeons work there, or they feed people in, because you are absolutely right, if your people are not doing complicated surgery regularly, when they get out in the battlefield circumstances, they will not be good. And we cannot afford that.

So I appreciate the problem, and some aspects of how this will address it, but it does concern me that this demonstration is limited only to those who have already used military hospitals.

Now, I know you are trying to control costs, but could we not figure out some way that those who have been cycled out, new ones could come in?

Dr. JOSEPH. Well, I think I am really stealing a little bit from Mr. Vladeck's expertise here. But the purpose of that was to assure that the demonstration itself did not attract into the military so-called "ghosts," people who had never, or did not use it before, and now would use it. And with respect to your first point, I would have to respectfully say that if I have routine care or care for my mild hypertension last June, and now I have carcinoma of the pancreas, that does not make me any less—that is not any less interesting a patient or important a patient to the MTF.

Mrs. JOHNSON. There is an impact on the nature of your population, since it is the same, and as you do more and more medical service to it, you get less and less experience. That is the only point I was making. And I think you ought to at least consider how you could write this so that as people either die off, or cycle out, or move and go someplace else, maybe you get some refreshment of your pool. I understand the risk selection problems.

Thank you very much for your patience.

Chairman THOMAS. I want to thank you folks. We are supposed to be budget neutral in this. And any numbers that you can get to us as quickly as you can, Bruce, so that we can get a comfort level—obviously, the third gentleman at the table that I called up is someone that I am looking for a comfort level from, Mr. Van de Water. CBO has done an outstanding job of trying to stay on top of this changing legislation. The fact that we have a $65 million stop loss in there does not give me a comfort level of budget neutrality. You need to look at these numbers. If you need a letter to do it, we will authorize it. And I guess at the same time, if you can piggyback the veterans bill so that we can see from any kind of a proposed timeline, we will have to look at this legislation which looks to me like it was written primarily by taking the Hefley legislation, pulling out DOD, and writing in "Veterans Administration." That is a quick way to write a bill. I do not know if it produces the result that we are looking for with the VA.

Bruce, I guess we will be asking HCFA also if you have been carrying out those negotiations to give us some comfort level on as accurate a timeline as possible for moving it into a similar program. I assume through their VISN managed care structure, and we have got to do this in a relatively short period of time so that we can try to make some decisions.

Thank you very much.

The Subcommittee hearing is adjourned.

[Whereupon, at 4:30 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

STATEMENT OF KAREN IGNAGNI
PRESIDENT AND CEO
AMERICAN ASSOCIATION OF HEALTH PLANS

The American Association of Health Plans represents 1,000 HMOs, PPOs, and similar network health plans. Together, AAHP member plans provide care for over 100 million Americans nationwide.

Over the past two years, the number of beneficiaries enrolled in Medicare HMOs has grown by twenty-five percent. Today, nearly 4.4 million Medicare beneficiaries have chosen to enroll in Medicare HMOs. HMO Medicare enrollees benefit from the many advantages offered by our plans, including an emphasis on preventive services and early intervention when health conditions arise, affordable and predictable out-of-pocket costs, little or no paperwork, and access to a coordinated care system. These advantages are the foundation for the success of the present Medicare HMO contracting program and reflect our philosophy of care: quality, affordable health care from health plans where the patient comes first.

The Department of Health and Human Services (HHS) and the Department of Defense (DoD) have entered into a Memorandum of Agreement (MoA) on the terms of a demonstration project under which military retirees who are Medicare-eligible would be permitted to elect enrollment in DoD's TriCare program. The demonstration is intended to test Medicare subvention -- Medicare reimbursement to DoD for services provided to Medicare-eligible military retirees in military treatment facilities (MTFs).

The American Association of Health Plans has serious concerns about this demonstration. Our concerns focus on MTFs' readiness for a managed care demonstration, the standards of care placed upon MTFs under the demonstration, and the impact of the cost of the demonstration on the Medicare Trust Funds.

First, before the military enters the Medicare risk contract business, DoD and HHS need to ensure that MTFs are adequately prepared to meet the challenges of serving Medicare beneficiaries through a risk contracting program. MTFs are not accustomed to operating as an HMO, nor are they experienced in meeting the needs of an older population. As our health plans can attest, managing a Medicare risk contract can be complex. Many of our health plans have spent years developing prevention services, education and outreach programs, and provider networks tailored to the needs of Medicare beneficiaries.

As the range of offerings to Medicare beneficiaries expands, it is critical to maintain strong and comparable standards for all options. Medicare beneficiaries need assurances that all plans they are choosing among have comparable standards related to access, quality of care, and consumer protection. Beneficiaries enrolled under the proposed demonstration should have the same consumer protections guaranteed to over 4 million Medicare beneficiaries enrolled in the risk contracting program. While the Memorandum of Agreement between HHS and DoD holds Military Treatment Facilities (MTFs) accountable to many of the same requirements placed on Medicare risk contractors, in some cases, the MoA appears to place lesser standards on these facilities. In fact, under the MoA, DoD is required to meet or *will be deemed to meet*, the applicable and agreed upon requirements similar to those required of Medicare risk HMOs. AAHP opposes a demonstration that would use deeming to excuse the military health system from meeting the same standards placed on Medicare risk contractors.

For example, AAHP is especially concerned regarding the MoA's requirement for a DoD quality assurance program. Medicare risk contractors must have an ongoing, internal, quality assurance program that includes a written quality assurance plan, a process for review by the plan's Board of Directors, and an active quality assurance committee. The MoA states that DoD has a "corporate program for ensuring quality of care in the MHSS" thus satisfying quality assurance program requirements. We have concerns that DoD's quality assurance program is not sufficient to monitor the quality of care provided to Medicare beneficiaries at different MTF locations. Such a centralized program lacks the dedicated personnel to conduct continuous quality assurance activities that stress health outcomes. This section of the MoA appears to place a lower standard on DoD than on Medicare risk contractors and raises concern that MTFs lack the strong quality assurance and utilization review programs necessary for effective care management.

Under the demonstration, DoD must maintain its current expenditure level (adjusted for

inflation) for dually eligible military retirees in the geographic area of the demonstration. AAHP has serious concerns about the methodology that DoD plans to use to estimate its baseline "Level-of -Effort" (LOE) for the demonstration, making it difficult to assure cost neutrality. The Memorandum of Agreement itself discusses the difficulties of estimating service utilization and costs of outpatient care for Medicare beneficiaries at military facilities. We do not believe that HCFA has sufficiently studied or addressed the possible disruptive impact that the payment or benefit design of this demonstration will have on markets covered by the demonstration. The payments to MTFs may permit them to offer significant incentives to beneficiaries to elect the option available under the demonstration rather than existing options offered by Medicare risk contractors. Unless this is an explicit goal of the demonstration, this impact should be of concern to all parties.

During his statement before the Subcommittee on Health, House Committee on Ways and Means on September 17, 1996, Bruce Vladeck, HCFA Administrator, commented that the payment methodology under the demonstration reflected HCFA's thinking on the direction of payments to Medicare risk contractors. The payment levels established for the purposes of the demonstration were the result of negotiations between DoD and HHS and reflected the unique characteristics of the MTFs and the link between DoD and Medicare funding streams. AAHP strongly cautions against using a demonstration of this type to establish future policy on AAPCC payments to Medicare risk contractors that are substantially dissimilar in their delivery networks, quality assurance programs, and financing structures to MTFs.

Although this demonstration program was not enacted by Congress, this type of demonstration program will likely be considered during the next session. The Association is looking forward to working with members of the committee to ensure consumer protections and a sound financing mechanism for any future demonstration.

STATEMENT OF CDR MIKE LORD, USN (RET.), AND LCDR VIRGINIA TORSCH, MSC, USNR MILITARY COALITION

MISTER CHAIRMAN AND DISTINGUISHED MEMBERS OF THE COMMITTEE:

The Military Coalition (TMC) would like to express appreciation to the Chairman and distinguished members of the House Ways and Means Committee's Subcommittee on Health for allowing TMC to express its views on this health care imperative for retired service members and their families. This statement provides the collective views of the following military and veterans organizations which represent approximately 5 million current and former members of the seven uniformed services, officer and enlisted, active, reserve and retired plus their families and survivors.

- Air Force Association
- Army Aviation Association of America
- Association of Military Surgeons of the United States
- Association of the United States Army
- Chief Warrant Officer and Warrant Officer Association, United States Coast Guard
- Commissioned Officers Association of the United States Public Health Service, Inc.
- Enlisted Association of the National Guard of the United States
- Fleet Reserve Association
- Jewish War Veterans of the United States of America
- Marine Corps League
- Marine Corps Reserve Officers Association
- National Guard Association of the United States
- National Military Family Association
- National Order of Battlefield Commissions
- Naval Enlisted Reserve Association
- Navy League of the United States
- Reserve Officers Association
- The Military Chaplains Association of the United States of America
- The Retired Enlisted Association
- The Retired Officers Association
- United Armed Forces Association
- United States Army Warrant Officers Association
- United States Coast Guard Chief Petty Officers Association
- Veterans of Foreign Wars

INTRODUCTION

For nearly two centuries, uniformed services retirees have been led to believe that they have a right to medical care in military facilities following retirement. In brief, this lifetime right had its genesis in 1798, when service members in the U.S. Marine Corps, and then the U.S. Navy, made a monthly contribution to the Hospital Fund to pay for such care for a period of more than 145 years -- a contribution that continued after retirement. Records indicate that money from the Hospital Fund was used to build the Brooklyn, Philadelphia and Chelsea Naval Hospitals. When the contribution was discontinued by Congress in 1943, Congressional hearings made clear that members were to retain the right to care. It is equally clear that members of the other services have always been led to believe they would be provided care for life in military treatment facilities. The assurance of such care was one of the important factors in inducing service members to endure the extraordinary demands and personal sacrifices inherent to a career in uniform.

In 1965, Congress enacted Medicare legislation. One year later, as a means of further improving the military health benefit for non-active duty beneficiaries, Congress established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In adopting this legislation, which terminated CHAMPUS eligibility at age 65, the House Armed Services Committee reasoned "... **military retirees would continue to have two medical programs upon reaching age 65 -- the use of the military medical facilities on a space-available basis and the Social Security Medicare program. Under the circumstances, it appears that the two remaining medical sources would provide a fair program of assistance.**"

If retired service members did not have an implied right to hospital care, the government would have no responsibility to provide such care. The fact is, however, that for more than three decades, key officials have acknowledged the government's responsibility in this area. It was affirmed clearly by Dr. William Gorham, the Deputy Assistant Secretary of Defense for Special Projects, Office of the Assistant Secretary of Defense for Manpower, during hearings on the 1963 military pay bill. During this hearing the following exchange took place between Representative Charles Gubser of California and Dr. William Gorham:

MR. GUBSER: *Now I realize that the Department of Defense as of the early part of this month has initiated a study by which they are going to thoroughly explore the question of retired persons. Are you at liberty to say whether or not the fact that this study has been instituted is a recognition that there is a responsibility to retired persons on the part of the government?*

MR. GORHAM: *I don't think there is any question about that, Mr. Gubser.*

MR. GUBSER: *I am not asking for a prediction, because you don't know what that study is going to reveal, but would you presently anticipate that insofar as medical care is concerned is there going to be something provided for retired personnel in the future?*

MR. GORHAM: *Yes.*

MR. GUBSER: *In other words, we are not going to be put in the position of raising their retired pay in this bill and then taking it away by taking away fringe benefits?*

MR. GORHAM: *Absolutely not.*

In a statement announcing the above-mentioned study, the Department of Defense said,

> *"Health care for retired military personnel and their dependents in military hospitals is a traditional military benefit. In the statute which specifically authorizes this benefit, Congress indicated that its purpose is '...to create and maintain high morale in the uniformed services'."*

In the completed version, the study clearly established the Government's moral obligation to provide medical care to military retirees and their dependents. Considerable evidence of the government's commitment is cited in the Department of Defense's study, **Medical Care for Retired Military Personnel and Their Dependents,** dated June 1964. On page 21 of that study are the following quotations from official service recruiting publications:

> *"And let's not forget those many other benefits of this act which go a long way toward providing the SECURITY that both you and your family want, and lifetime security and protection for you and yours --- even after retirement through guaranteed medical care at military facilities."*
> *(From "Army Benefits" Department of Army, 1956,611-180-RPC)*

> *"He retires -- while still a young man -- equipped to start a second career. He has retirement pay, benefits and full medical care." (From "Your Son's Future", Department of the Army 1962, me 62--125B, 250M)*

> *"As a Navy man, you ..... receive free medical and dental care now and after retirement." (From "Figuring Your Future", Department of Navy NRAF--26502)*

> *"Just think when you do retire or go into Fleet Reserve, you retain almost all of the benefits you enjoyed while on active duty, including HOSPITALIZATION for you AND YOUR DEPENDENTS for life." (From Navy Career Appraisal Team Representation Guide", Department of Navy, NAVPERS 15897-A)*

The Department of Defense study also concedes that there is a legal obligation on the Government's part to provide care to those retirees who paid into the old Naval Hospital Fund.

Subsequent hearings before the House Armed Services Committee, March 1966 shed more light on the commitment.

> *"After careful study of the Secretary of Defense's proposal to provide medical care for retired military personnel and their dependents, we find that the proposal does not address itself to the correction of the inequities of the space-available language of Chapter 55, Title 10, U.S.C., specifically, Sections 1074(b), 1076(b), and 1083. The problem of medical care for retirees came about because of a legislative misinterpretation of the language in those two sections. The Special Subcommittee in its report (No. 67), dated 30 September 1964, stating the Subcommittee's findings of its comprehensive hearings recommended: That amendatory language be added to the Dependents' Medical Care Act, making it unmistakably clear that the so-called space-available concept may not be used as a vehicle to limit or eliminate space available for retired military personnel and their dependents in military facilities."*

> ***Therefore, the language should be changed from its present, permissive nature by substituting the word SHALL for the word MAY in those sections. This change would clarify and establish the right to such care for military retirees and their dependents.'***

In 1965, Congress enacted Medicare legislation. One year later, as a means to further improve the military health benefit for non-active duty beneficiaries, Congress established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In adopting this legislation, the House Armed Services Committee reasoned:

> ***"(a) The benefits of this legislation should be considered a transitional civilian program for retirees, who now enter the rolls at about age 44, until they become eligible for Social Security Medicare at age 65.***
> ***(b) ... military retirees would continue to have two medical programs upon reaching age 65 -- the use of the military medical facilities on a space-available basis and the Social Security Medicare program. Under the circumstances, it appears that the two remaining medical sources would provide a fair program of assistance." (Emphasis added)***

More recently, this obligation was reaffirmed in remarks made by Dr. Stephen Joseph, Assistant Secretary of Defense for Health Affairs, at a hearing before the House Government Reform and Oversight Committee's Subcommittee on Civil Service. On September 12, 1995, Dr. Joseph acknowledged that recruiters and commanders had led members to believe that they had a lifetime commitment to military health care. While Dr. Joseph did not stipulate that the commitment was a contractual obligation, he stated that there was an implied moral commitment to provide health care to those currently serving and those who retired following their service careers. A review of recruiting and retention literature further corroborates the commitment to lifetime health care by the Services to all uniformed services beneficiaries. The following provides indisputable evidence that the free lifetime medical promise was being made as late as 1993.

Marines, Life in the Marine Corps- **(Undated, but in use)**

> ***"Benefits... These are only a few of the great extras you'll find when you join the Marine Corps. And the nice part is, should you decide to make a career of the Corps, the benefits don't stop when you retire. In addition to medical and commissary privileges, you'll receive excellent retirement pay..."***

Air Force Pre-reenlistment Counseling Guide. **(Chapter 5 Medical Care, Section 5-2.f., dated 1 April 1986)**

> ***"One very important point, you never lose your eligibility for treatment in military hospitals and clinics."***

United States Coast Guard Career Information Guide. **(USGPO 1991-)**

> ***"Retirement -- Most career Coast Guardsmen retire after serving between twenty and thirty years of service. Current retirement programs allow you to collect about half of your base pay at twenty years and up to three-fourths base pay at thirty years.***
>
> ***"Retirement benefits mean more than pay too. You continue to receive free medical and dental treatment for yourself plus***

> *medical care for dependents. You also remain welcome at military commissaries, clubs and exchanges. Free space-available travel on some military flights allows retirees to travel to exotic foreign lands..."*

Guide to the Commissioned Corps Personnel System, March 1985

> *"Noncontributory medical care during active duty and retirement for both officer and dependents."*

Army Recruiting Brochure, "Army Benefits
(RPI 909, November 1991)(Still in use by recruiters in 1993).

> *"Superb Health Care. Health Care is provided to you and your family members while you are in the Army, and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement."* **(Emphasis added)**

As further evidence of the lifetime health care commitment, it is instructive to reflect on a 1991 study by the Congressional Research Service, titled Military Health Care/CHAMPUS Management Initiatives , prepared by David F. Burrelli, an analyst in National Defense, Foreign Affairs and National Defense Division, on May 14, 1991.

> **".....The Dependents' Medical Care Act (P.L. 84--569; June 1956; 70 Stat. 250) described and defined retiree/dependent eligibility for health care at military treatment facilities (MTFs) as being on a space-available basis. Thus, for the first time, the dependents of active duty personnel were entitled to health care at MTFs on a space-available basis. Authority was also provided to care for retirees and their dependents at these facilities (without entitlement) on a space-available basis.....Although no authority for entitlement was extended to retirees and their dependents, the availability of health care was almost assured, given the small number of such persons. Therefore, while not legally authorized, for many the "promise" of "free" health care "for life" was functionally true. This "promise" is widely believed and it was and continues to be a useful tool for recruiting and retention purposes**

MEDICAL COVERAGE SECOND TO MOST?

Unfortunately, the American public -- and many in Congress -- have the misperception that uniformed services retirees have better-than-average health care benefits. This is correct in terms of the quality of care for those who are able to access military treatment facilities. However, for an ever increasing number of beneficiaries, particularly those age 65 and older, this access is a myth. The Department of Defense is virtually the only large employer that terminates its retirees' health coverage when they turn 65.

In contrast, nearly all of the largest U.S. corporate and government employers provide their retirees substantial employer-paid health coverage in addition to Medicare. Data from a 1994 survey by Hay Associates (one of the nation's most-respected firms in the area of employee benefits), indicates that the majority of corporate employers provide at least some employer-paid coverage in addition to Medicare -- and the larger the employer, the more they provide. The Department of Defense -- America's largest employer -- does not stack up well in this department. The gap is even wider when the uniformed services' health care package is compared to the benefit afforded to employees who have retired from the very largest private sector corporations. For example, the four largest

U.S. corporations either fund virtually the entire health care premium (including heavily subsidized prescription drug benefits) or cap their retirees' out-of-pocket medical expenses at modest levels.

Health Plans of the Four Largest U.S. Corporations for Their Retired Medicare-Eligible Employees

		Employer Subsidized Health Plan					Other Subsidized Coverage		
Corp.	No. of Ret	Ret	Fam	Employer Paid Share of Premium	Retiree Deductible Single/Fam	Retiree Cost Share	Rx Drug	Dental	Vision
GM	350,000	Yes	Yes	75-80%	$300/600	Zero*	Yes	Yes	Yes
Ford	90,000	Yes	Yes	100%	$200/250	20% off visits; $500 out-of-pkt cap for all other	Yes	Yes	Yes
IBM	74,000	Yes	Yes	100%	$250 ($340 hosp)	20% outpatient 0% inpatient	Yes	Yes	Yes
GE	80,000	Yes	Yes	100%	N/A	20% of Medicare copay	Yes	No	No

* GM plan pays all charges above Medicare payment

In a similar vein, the United States Government provides significantly subsidized health care insurance coverage for retired Federal civilian employees and their families -- including retired Members of Congress and retired Congressional staff members. Yet, over the years, Administration and Congressional cost containment efforts have progressively stripped older uniformed services retirees of nearly all DoD-funded health benefits.

For generations, military health care has been touted as second to none. It is past time to recognize that, compared to what is provided by other large employers, Medicare-eligible uniformed services beneficiaries' health care has become second to almost all others. Service members who have given their country decades of service and sacrifice deserve better.

TRENDS FOR ACCESS TO CARE IN MILITARY TREATMENT FACILITIES (MTFs) (1996-2000)

The greatest problem facing all retirees and their families who rely on military medicine for their health care is the increasing decline of access to care in military treatment facilities (MTFs). A Congressional Budget Office (CBO) report (Restructuring Military Medical Care, July 1995) states that although 70% of the total eligible uniformed services population currently lives within 40 miles of a military hospital, only 55% of the age 65 and older Medicare-eligible population live this close. This situation will be exacerbated by continuing base closures which have closed or will close 39 MTFs and downsize many others. GAO reports that the military drawdown has also resulted in an 8 percent reduction of military medical personnel since 1991 and will further reduce it by another 8 percent by the year 2000.

Approximately 1.168 million uniformed services beneficiaries age 65 and older are entitled to Medicare insurance coverage (projected to increase to 1.436 million by 2002). They are also eligible to receive health care in DoD operated

military treatment facilities, but only on a "space available" basis. Although exact figures are not available, DoD estimates that an equivalent of about 30 percent, or 324,000 of these dual-eligible beneficiaries, regularly use the military health care system. DoD pays an estimated $1.4 billion per year out of its annual appropriations to deliver health care services to this population. Most of the remaining beneficiaries use providers in the civilian community under standard Medicare.

To meet the needs of CHAMPUS-eligible beneficiaries, DoD, with Congressional direction, is implementing the Tricare program throughout CONUS by September 1997. Tricare Prime is designed to provide improved access to health care in MTFs for CHAMPUS-eligible beneficiaries at a lower cost for many than under Tricare Standard. If these expectations are met, Tricare will provide improved access to health care in MTFs for CHAMPUS eligibles who enroll in Tricare Prime. However, Medicare-eligible beneficiaries have been set out adrift and will be denied the opportunity to enroll in Tricare unless Congress intercedes. Space-available care in the MTFs is becoming increasingly limited for those beneficiaries who do not, or cannot, enroll in Tricare Prime because hospital commanders are required to provide care in the MTF on a priority basis to Tricare Prime enrollees. An aggravating side effect is that as space-available care becomes limited, so too will access to the military pharmacy - a major loss for Medicare-eligible beneficiaries who do not have CHAMPUS and its prescription benefit as a fall-back.

The Military Coalition has already begun to hear reports about the decrease in availability of care for those who do not or cannot enroll in Tricare Prime. For example, military beneficiaries who currently receive care in the Eglin AFB, FL Family Practice Clinic Program recently received notices from the Eglin AF Hospital that unless they enrolled in Tricare Prime, the hospital would not be able to guarantee that it could continue to offer beneficiaries regular participation in Family Practice Clinic. A Medicare-eligible retiree who has always been able to receive care on a space-available basis from the McDill AFB hospital was told in June that he can no longer make any appointments for medical care because he is not eligible to enroll in Tricare Prime. Another 70 year-old retiree who had a heart attack and numerous catherizations and desperately needed to see a cardiologist at the Naval Medical Center San Diego (NMCSD) received a letter from that facility that said ".. Unfortunately, current staffing in that clinic [cardiology] does not allow us to make available all of the care we would like to provide... I must therefore regretfully inform you of the need to disengage you from NMCSD for this care ..."

Communications like these reflect a dispassionate callousness, though unintended, that is demoralizing. The retirees bearing the brunt of these decisions are those who served without equivocation in WW II -- Iwo Jima, Bataan, Corregidor and Normandy to name a few, and they cannot fathom why Uncle Sam would now turn his back on them during their twilight years. Regrettably, the Coalition receives these reports on almost a daily basis.

Not only is the health care lockout for Medicare-eligible retirees seriously eroding morale, it is in some cases, spawning drastic action. For example, two class action lawsuits are already underway with more sure to follow. The bad press associated with these actions will deny us the services of our best recruiters - the retired community - and is sure to adversely impact on the propensity of young men and women to serve in the uniformed services.

MEDICARE SUBVENTION

The Military Coalition has sought legislation for the past six years, and mounted a particularly intensive effort in the 104th Congress, to change Section 1876 of the Social Security Act (42 U.S.C. 1395) to allow the Health Care Financing

Administration (HCFA) to reimburse DoD for the care provided to Medicare-eligible uniformed services retirees and their spouses in the Military Health Services System (MHSS), a concept called Medicare subvention. Current law prohibits Medicare payments to federal providers of health care services and, therefore, precludes the Department of Defense from being reimbursed for the care provided to Medicare-eligible uniformed services beneficiaries. If DoD is reimbursed for such care, it should be able to allow Medicare-eligibles to enroll in Tricare Prime and otherwise use the full range of services available through the Military Health Services Systems. Since DoD's care is less costly than private sector care, Medicare subvention will actually save Medicare money--a win-win-win situation for Medicare, the taxpayers, and Medicare-eligible beneficiaries.

We've said this earlier, but it's worth reemphasizing. **Without subvention, beneficiaries under age 65 who are enrolled in Tricare Prime will be pushed out of the program when they become Medicare-eligible at age 65 and join those already disenfranchised**. Further, as military and civilian networks are sized to meet the health care needs of the enrolled population, access to "space available" care in MTFs will diminish greatly. The net effect is that older retirees and their spouses will be shut out of a system of health care they thought would always be there for them, unless Congress amends the law to permit Medicare subvention.

Legislation:

The Military Coalition has sought Medicare subvention legislation for the past six years and was finally successful in January 1995 when Rep. Joel Hefley (R-CO) introduced HR 580 to implement subvention nation-wide. However, the Congressional Budget Office (CBO) contended that H.R. 580 would increase Medicare expenditures by $1.4 billion (the amount that DoD now spends to provide "space available" care to Medicare-eligible retirees) and the bill was not considered in committee. To overcome this impasse, DoD has agreed to maintain its current level of funding effort for Medicare-eligible beneficiaries currently provided space available care in the military health care system, and to seek reimbursement only for beneficiaries who are now using their Medicare benefits in the civilian sector at Medicare's expense. Four bills have now been introduced to test this new concept of Medicare subvention.

Despite the obvious safeguards to preclude Medicare from paying any costs for retirees currently using military medical facilities, the CBO has scored these proposals as having a negative impact on Medicare. From our perspective, the CBO cost rationale relies on faulty premises to make its case. The following examples, extracted from a March 4, 1996 letter from Dr. Steven Joseph to HCFA are illustrative:

- **CBO Analysis:** -- The CBO paper states that 50 percent of the costs will be shifted from DoD to the Medicare program and implies that, irrespective of law, DoD will move to shift and increase Medicare's costs for the Health Care Financing Administration (HCFA).

  DoD Analysis -- As clearly delineated in both Senator Dole's legislation and the DoD/HCFA draft demonstration legislation, the demonstration cannot increase costs for either Medicare or DoD. To increase costs would clearly violate the law. DoD does have adequate management controls to assure that costs do not increase.

- **CBO Analysis:** -- CBO implies that DoD and Medicare might both agree to allow DoD to shift costs to Medicare.

  DoD Analysis -- Clearly, Medicare has a disincentive against allowing DoD to shift costs to Medicare and has the authority to end the

demonstration. Even if Medicare were to change its mind and allow DoD to shift costs, the DoD/HCFA draft demonstration legislation tasks the General Accounting Office to provide an independent audit of the demonstration to the Congress. This GAO audit would determine whether or not DoD and/or HCFA were in violation of law.

- **CBO Analysis:** -- DoD will enroll a disproportionate share of healthy Medicare-eligible individuals and/or current MTF-reliant Medicare-eligible individuals. Both of these groups currently cost the Medicare program very little. If DoD enrolls these individuals and exceeds its current level-of-effort, the Medicare program would be obligated to pay DoD the adjusted AAPCC rate which is much higher than current Medicare costs for these individuals.

  DoD Analysis -- Since DoD'S baseline costs are based on the current Medicare population served by MTF's and the baseline is based on dollars expended and not enrollees served, DoD does not get any benefit in the demonstration from having served healthier beneficiaries during the baseline period. As for the operational part of level of effort and the cost per enrollee, DoD will be reimbursed at the adjusted AAPCC rate and, like any private HMO, will be reimbursed by enrollee cohorts (reducing the opportunity for "skimming"), and will offer Medicare an additional two percentage point discount. In addition, because DoD as a federal agency cannot make a "profit" off another federal agency, DoD and Medicare will reconcile their costs each year to ensure that Medicare costs are not increasing due to favorable selection.

- **CBO Analysis:** -- The estimate assumes an annual rate of increase ranging from 7.4 to 8.5 percent.

  DoD Analysis -- The above annual rate of increase is three to four percentage points higher than the DoD medical program budget for the years 1997-2001.

To overcome the problems created by CBO's scoring and to eliminate other potential roadblocks, an amendment has been adopted in the FY 1997 Defense Authorization Bill which directs DoD/HCFA to develop a detailed plan by September 6 to implement Medicare subvention in one or more Tricare regions. Once the plan has been submitted, and the House and Senate Oversight Committees and the CBO have had a chance to closely examine it, the intent is to have additional legislation enacted in September to actually authorize a Medicare subvention test in 1997.

The Coalition was elated to hear that on September 4, DoD and HCFA signed the agreement to test Medicare subvention. We are encouraged that with timely submission of this plan, we now have a chance to get implementing legislation introduced in the House and Senate and signed into law before Congress adjourns for the year.

The Coalition has had the opportunity to review the proposed test and is generally pleased with its parameters, although the proposed test represents a significant compromise from the initial thrust of the Medicare subvention initiative advocated by The Military Coalition. Traditionally, when Medicare subvention was defined, it was in the context of having Medicare reimburse DoD for care provided to Medicare-eligible beneficiaries on both a capitated and a fee-for-service basis. Under this fundamental definition of subvention, when a Medicare-eligible beneficiary is enrolled in Tricare Prime, that individual would be able to use the entire network of providers, as well as the MTF. Those not enrolled would be allowed to use MTFs on a space available basis with Medicare reimbursing DoD for the cost of such care that they would otherwise bill to

Medicare for visits to private sector providers. The Coalition recognizes that in order to move forward at all, a compromise may be required. Accordingly, under the plan contemplated by the Authorization Bill, the Medicare subvention test would extend only to Medicare-eligible beneficiaries who agree to enroll in Tricare Prime. However, the conference agreement directs DoD/HCFA to submit a study to Congress (by January 3, 1997) on the feasibility of extending the subvention concept to fee-for-service care, too (i.e., case-by-case health care provided to service retirees and family members who are not enrolled in Tricare Prime).

Mr. Chairman, after reviewing the DoD/HCFA proposal, the Coalition believes DoD has bent over backwards to accommodate HCFA's concerns. For example, DoD has agreed to accept a discounted capitation rate as reimbursement, and has agreed that the rate can be further reduced by backing out the costs of Graduate Medical Education, Indirect Medical Education, capital building, and disproportionate share hospital costs that go into the formula for the capitation rate. DoD has also agreed to exclude its costs for outpatient pharmacy services and the USTF program from its level of effort computations, which is also advantageous to HCFA.

These concessions clearly reinforce the most fundamental point we wish to underscore again. Medicare cannot be financially damaged by subvention. The test is just that, a test, with a sunset period and a statutory guarantee that Medicare will not lose. Therefore, Mr. Chairman, the Coalition requests your assistance in ensuring that the Medicare subvention test is implemented without delay. The Coalition respectfully requests this Committee to support implementing legislation to actually authorize the test in time to allow final passage prior to adjournment of the 104th Congress. DoD has indicated it is prepared to go forward with its implementation plan on a moment's notice. Conducting a test demonstration will be the only way to resolve the funding question and validate the financial viability of subvention.

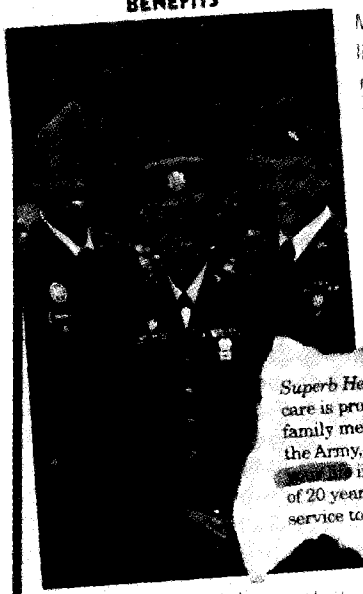
Before closing Mr Chairman, the Coalition would also like to see one important provision incorporated into final implementing legislation. Medicare-eligible beneficiaries who participate in the test must be afforded some protection in case the test must be ended prematurely for some reason. Therefore, **Tricare Prime must be designated a Medicare at risk HMO** so that Medicare-eligible beneficiaries will be able to renew their Medigap supplemental policies without incurring pre-existing condition limitations. Without this designation, Medicare-eligible beneficiaries will not be able to drop their supplemental policies, and will be financially penalized compared to other Medicare-eligibles who join other Medicare at-risk HMOs. The requirement to keep supplemental insurance would also likely decrease the incentive to participate in Tricare Prime.

CLOSING COMMENTS

This Committee has a great challenge to restore the health benefit to a level equal to what most employees of large corporations have and to that available for all retired federal civilians have. The Coalition stands ready to work with this Committee to reform military health care without jeopardizing military readiness or the national security. But, the time has now come to honor the commitments that were made to those who served their country when they were called to do so. Mr. Chairman, the Coalition is grateful for your continuing support and appreciates the opportunity to present its views on this topic which is so vital to retired service members.

ARMY BENEFITS

Documenting the Lifetime Health Care Commitment



Many contend that the government never promised lifetime health care to service members. The record shows otherwise:

1798: Marines and then sailors are required to contribute 20 cents per month to the Hospital Fund for their future health care. The practice continued for 145 years until 1943, when, at the height of World War II, Congress decided it was unfair to impose health care charges on members whose duties were so hazardous.

1956: The first documented evidence of the services advertising "free health care for life" in recruiting and retention literature. Such advertisements continued until 1993 (see graphic), when retiree protests that DoD was reneging on the promise led the Army to change the wording in its brochures.

1966: Congress declines to extend CHAMPUS eligibility beyond age 65, asserting that the abundance of space available medical care in military facilities plus Medicare offered uniformed services retirees a viable "two-track" health care system.

1991: Congressional Research Service report concludes that the "free health care for life" promise was functionally true and had been used to good advantage for recruiting and retention.

1995: Stephen Joseph, M.D., assistant secretary of defense (health affairs), testifies before Congress that DoD has an "implied moral commitment" to provide health care to all eligible beneficiaries.

STATEMENT OF
COLONEL CHARLES C. PARTRIDGE, U.S. ARMY (RET.), AND
CHIEF MASTER SERGEANT JAMES LOKOVIC, USAF (RET.)
NATIONAL MILITARY/VETERANS ALLIANCE

Mr. Chairman and distinguished members of the Committee, the National Military and Veterans Alliance would like to express its appreciation to you for holding these important hearings. The testimony provided here represents the collective views of our members.

The Alliance includes 13 military and veterans organizations. These organizations represent over 3,500,000 members of the seven uniformed services, officer and enlisted, active duty, reserve, National Guard and retired plus their families and survivors. These organizations are listed below:

Air Force Sergeants Association
American Military Retirees Association
American Retirees Association
Korean War Veterans Association
Military Order of the Purple Heart
Military Order of the World Wars
National Assn for Uniformed Services
Naval Enlisted Reserve Association
Naval Reserve Association
Non Commissioned Officers Assn
Tragedy Assistance Prog for Survivors
Veterans of Foreign Wars
Women Marine Association

Surveys of military personnel and their families consistently show that medical care along with adequate pay and inflation protected retired pay and commissaries are the top concerns of the military community. In fact, with base and hospital closures and reductions in medical personnel, the increasing lack of available health care is a major concern to active and retired personnel alike.

The promise of lifetime medical care for career service members, their families and survivors is contained in law and tradition and dates back to the 18th century. Later, in 1885 the 48th Congress provided in a War Department Appropriations Bill that, "The Medical Officer of the Army and Contract Surgeon shall, whenever practicable, attend the families of officers and soldiers free of charge."

Prior to the early 1950s the promise to provide military medical care for retired military personnel was not questioned because throughout their military careers and in retirement, medical care was provided in military treatment facilities for personnel who

could use those facilities. During the early 1950s and since that time the services used the lifetime promise of free medical care as a recruitment and retention incentive for the large military force required to fight the Cold War.

In 1956 Congress made space available medical care an entitlement for active duty dependents by the enactment of The Dependents' Medical Care Act (P.L. 84-569; June 7, 1956; 70 Stat. 250). Authority was also provided to care for retirees and their dependents at these facilities (without entitlement) on a space available basis.

Also in 1956, Congress concluded that the direct care medical system was inadequate to care for the dependents of active duty personnel and enacted legislation authorizing the defense department to contract with private sources to supplement the inadequate in-house care for dependents of active duty members who due to travel distances or other reasons could not use MTFs. This was the forerunner of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) enacted by Congress to be effective in 1967. With the enactment of CHAMPUS, military retirees, their families and survivors were included.

The CHAMPUS program was designed to provide a quality health care benefit comparable to "Federal Employees Health Benefits Program hi-option Blue Cross/Blue Shield or hi-option Aetna health insurance", (The Military Medical Act, P.L. 89-614).

- CHAMPUS required the Defense Department to pay 80 percent of medical costs for active duty dependents and 75 percent of the cost for retired members under age 65, and their dependents. CHAMPUS beneficiaries were required to pay the remaining balance of the cost of the medical care they received from private sector providers.

- Changes in the CHAMPUS program over the years have been disastrous for beneficiaries. In many areas, physicians consider CHAMPUS beneficiaries as charity patients. This is embarrassing and insulting to our military personnel and their families.

Exhibit A is an extract of some of the promises made in recruiting and retention literature over the years. Despite these promises, the availability of health care continues to be a problem. Deep cuts in both military and civilian medical personnel have left military medical treatment facilities (MTFs) severely understaffed. Physicians are preparing examining rooms and performing administrative tasks which means they see fewer patients than do private sector physicians who have adequate nursing and administrative help available to them. Meantime, patients not seen in MTFs must be referred to more expensive CHAMPUS or *TRICARE* contractor care.

To correct the problem facing military medical beneficiaries today no single option will solve the problem of providing medical care to DoD's diverse beneficiary population. However, improving access to cost effective, top quality care while meeting wartime training and mobilization requirements can be accomplished at reasonable cost. The proposal we have been asked to comment on today is:

Medicare Reimbursement (Subvention)

The promise of lifetime medical care in exchange for a career of military service has been proven and acknowledged. Despite this, military retirees, their families and survivors are the only Federal employees who lose their entitlement to medical care from their employer at age 65 upon becoming eligible for Medicare. This is age discrimination on a huge scale which disenfranchises hundreds of thousands of retired veterans and their families.

Retirees especially resent the fact that after earning what they thought was free lifetime medical care by a military career of 20 to 35 years they are now being turned away from that care. They cannot use a military hospital with Medicare paying part of the costs even though they paid mandatory Medicare payroll deductions from their active duty military pay since January 1, 1957, and most of them participate in Medicare Part B paying $42.50 per month or $510 per year per person. In addition, many have purchased Medigap supplemental policies at $100 or more per month or $1200 per year. The ultimate irony is that the MTFs bill their Medicare supplemental

insurance plan but not the basic Medicare benefit.

Over the past two decades the Congress and various Administrations have expressed interest in requiring the Health Care Financing Administration (HCFA) which administers the Medicare Trust Fund to reimburse the military treatment facilities for care given to Medicare-eligible beneficiaries.

In 1995, Dr. Joseph, ASD(HA) and Dr. Bruce Vladeck, Director, HCFA, agreed to conduct a joint DoD/HCFA HMO Medicare Demonstration Project. Unfortunately, the Department of Health and Human Services perceived legal restrictions which prevented these agencies from conducting the test without legislation.

Senator Gramm introduced legislation calling for a demonstration project S. 1487; shortly thereafter, Senator Dole introduced S. 1639. Companion bills were introduced by Representatives Hefley H.R. 3142 and J.C. Watts, H.R. 3151. These bills followed earlier legislation by Representatives Cunningham and Hefley which would have provided for Medicare reimbursement. In June of this year President Clinton, in a meeting with The National Military/Veterans Alliance and other association representatives, expressed the determination to "make a Medicare reimbursement demonstration project happen". Even with this clear direction, objections and delays by the Department of Health and Human Services have slowed progress and forced compromises by the Department of Defense that are not in the best interests of beneficiaries. In addition, cost analyses by CBO have inhibited development of a demonstration project that will meet the needs of military beneficiaries. However, congressional support has been made abundantly clear (See Exhibit B). We know this committee has long supported Medicare reimbursement and we urge you to support a demonstration project. There are features which we believe should be incorporated into Medicare subvention as the demonstration proceeds. We understand that DoD and HCFA have worked for over a year on this and have a carefully structured plan. We understand the need for each Department to represent its interests. However, this demonstration and departmental considerations should not be used to rule out innovations that could improve care for beneficiaries and provide beneficiaries with

choice and flexibility. Therefore, Congress should ensure that legislation does not restrict the opportunity to test innovative ideas and in fact we urge you to include language that would assure both HHS and DoD that you encourage testing innovative solutions and that they have the authority to do so.

Some features which we recommend be incorporated into Medicare subvention include:

- A fee-for-service option. The current demonstration would limit participation to those who are willing to give up their Medicare benefit except as part of the DoD TRICARE-Prime program. We believe those who do not want to enroll in TRICARE-Prime should be allowed to use military treatment facilities on a space available basis and the MTF should be allowed to bill Medicare for treatment at a DoD/HCFA negotiated rate.

- Waive TRICARE-Prime enrollment fee for Medicare eligibles. Currently, Medicare HMOs require no enrollment fee for beneficiaries. We believe "fee stacking" by requiring participation in Part B Medicare and payment of TRICARE enrollment fees will place the TRICARE-Prime out of reach for some beneficiaries. A couple would pay $1,020 for Medicare Part B plus $460 for the enrollment fee for a total of $1,480 per year. This would be before co-payments and other fees required under the TRICARE program.

- Solve Medicare Part B premium problems. Waive Medicare Part B penalties for Medicare eligibles who do not have Medicare Part B, but would like to enroll in Part B and participate in the joint DoD/Medicare demonstration project.

- Authorize TRICARE-Prime network contractors to act as Primary Care Managers for Medicare eligible beneficiaries. Currently DoD believes that to do so would require rebidding the TRICARE contract. For purposes of the demonstration project, the requirement to rebid the contract should be waived so that the subvention concept can be tested in areas where there are no MTFs. Unless this is done, there will be no test involving contractors as PCMs in areas outside of MTF

catchment areas.

- Ensure that Medicare eligible beneficiary enrollees are given the same priority care that other enrollees receive.

- Include authority for all uniformed services Medicare eligibles to participate, not just those of the Armed Services.

- Provide clear guidance and safeguards to make participation in the demonstration and any follow-up program completely voluntary. Some retirees are in satisfactory health care programs and would object to any provision that would require participation in a Medicare subvention program.

In the course of our Medicare subvention campaign some officials have asked if enacting Medicare subvention will settle the military medical care issue. The answer is no. It is one element of the military health care system that should be fixed but it does not completely solve the problem.

Medicare subvention will benefit some 35% of Medicare eligible beneficiaries. However, 65% will receive no benefit. For this huge majority of older military retirees and their families, there is no military medical benefit despite the promises. Therefore, in addition to Medicare subvention, military retirees need a solution not tied to location of MTFs nor dependent on DoD's ability to set up managed care networks. Such a solution exists. It has been proven to be cost effective and it's beneficiaries are satisfied with it. That is the Federal Employees Health Benefits Program. The Alliance (except the Non Commissioned Officers Association) strongly recommends that retired military beneficiaries be allowed to participate in FEHBP as an option.

Mr. Chairman, military beneficiaries want choice and flexibility in their health program. Some like HMOs, some like the freedom of a fee-for-service system, some like the options provided by preferred provider organizations. They want the freedom to choose as other federal employees have. We believe it can be done without sacrificing cost effectiveness.

Finally, the Military/Veterans Alliance thanks this committee for its support of Medicare reimbursement, for holding this hearing and its interest and concern for our service members, their families and survivors.

EXHIBIT B

MEDICARE REIMBURSEMENT (SUBVENTION)

I. On 23 March 1995, Dr. Stephen C. Joseph, M.D., M.P.H., Assistant Secretary of Defense (Health Affairs) before the Subcommittee on Personnel, Committee on Armed Services, United States Senate, made the following statement in his testimony...

> "With continuing reductions in military medical facilities and end-strength, our 'space available' will decline. As this occurs, there is little doubt that our Medicare-eligible patients will be forced to seek care from civilian providers under the Medicare system. First, this may turn out to be more costly for the government. Second, we believe there is a moral obligation for DoD to care for these former members of the Armed Forces and their families and survivors. Third, this older group of patients presents the wealth of clinical workload needed by our military medical personnel to maintain their skills for readiness missions."

II. Over the past years Congress has expressed interest in requiring the Health Care Financing Administration (HCFA) which administers the Medicare Trust Fund to reimburse the military treatment facilities for care given to Medicare-eligible beneficiaries. The following are two recent examples:

- Sec. 726, FY93 National Defense Authorization Act (P.L. 102-284):

  "It is the sense of Congress that-

  (1) members and former members of the uniformed services, and their survivors, should have access to health care under the health care delivery system of the uniformed services regardless of the age or

health care status of the person seeking the health care;

(2) such health care delivery system should include a comprehensive managed care plan;

(3) the comprehensive managed care plan should involve medical personnel of the uniformed services (including reserve component personnel), civilian health care professionals of the executive agency of such uniformed services, medical treatment facilities of the uniformed services, contract health care personnel, and the Medicare system;

(4) the Secretary of Defense, the Secretary of Health and Human Services, and the Secretary of Transportation should continue to provide active duty personnel of the uniformed services with free care in medical treatment facilities of the uniformed services and to provide the other personnel referred to in paragraph (1) with health care at reasonable cost to the recipient of the care; and

(5) the Secretaries referred to in paragraph (4) should examine additional health care options for the personnel referred to in paragraph (1) including, in the case of persons eligible for Medicare under title XVIII of the Social Security Act, options providing for-

(A) the reimbursement of the Department of Defense by the Secretary of Health and Human Services for health care services provided such personnel at medical treatment facilities of the Department of Defense; and

(B) the sharing of the payment of the cost of contract health care by the Department of Defense and the Department of Health and Human Services, with one such department being the primary payer of such costs and the other such department being the secondary payer of such

costs."

- Sec. 718, FY96 National Defense Authorization Act (P.L. 104-106) "Sense of the Congress Regarding Access to Health Care Under TRICARE Program for Covered Beneficiaries Who are Medicare Eligible.

(a) Findings - Congress finds the following:

(1) Medical care provided in facilities of the uniformed services is generally less expensive to the Federal Government than the same care provided at Government expense in the private sector.

(2) Covered beneficiaries under the military health care provisions of chapter 55, United States Code, who are eligible for Medicare under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) deserve health care options that empower them to choose the health plan that best fits their needs.

(b) SENSE OF CONGRESS - In light of the findings specified in subsection (a), it is the sense of Congress that-

(1) the Secretary of Defense should develop a program to ensure that such covered beneficiaries who reside in a region in which the TRICARE program has been implemented continue to have adequate access to health care services after the implementation of the TRICARE program; and

(2) as a means of ensuring such access, the budget for fiscal year 1997 submitted by the President under section 1105 of title 31, United States Code, should provide for reimbursement by the Health Care Financing Administration to the Department of Defense for health care services provided to such covered beneficiaries in medical treatment facilities of the Department of Defense."

ARMY

BENEFITS

ARMY BENEFITS

HEALTH CARE, HOUSING, SHOPPING AND SCHOOLING

Superb Health Care. Health care is provided to you and your family members while you are in the Army, and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement.

Housing, shopping, schooling and recreational facilities. The Army provides them all – plus excellent pay – to give you a high standard of living in an attractive and wholesome environment.

Maybe the most personally rewarding Army feature of all is the special pride you'll feel performing a valuable service for your country.

Ask your Army Recruiter for more details on all these benefits and how they can benefit you.

ARMY. BE ALL YOU CAN BE.

MILITARY MEDICAL CARE PROMISES

Army Recruiting Brochure, "Superb Health Care. Health care is provided to you and your family members while you are in the Army, and for the rest of your life if you serve a minimum of 20 years of active Federal service to earn your retirement." [RPI 909, November 1991 U.S.G.P.O. 1992 643-711]

Life in the Marine Corps, p. 36. "Benefits...should you decide to make a career of the Corps, the benefits don't stop when you retire. In addition to medical and commissary privileges, you'll receive excellent retired pay..."

Guide for Educators and Advisors of Student Marines, p. 35. "Retired Marines are generally eligible to receive any type of health and dental care at those facilities provided for active duty personnel."

Navy Guide for Retired Personnel and Their Families. p. 51. "Covered under the Uniformed Services Health Benefits Program (USHBP) are retired members, dependents of retired members and survivors of deceased active duty or retired members. This care is available anywhere in the world either in a uniformed services medical facility (meaning Army, Navy, Air Force and certain Public Health Service facilities) and under the part of the USHBP called CHAMPUS." [NAVPERS 15891D November 1974]

The Bluejackets Manual, p. 257. "What Navy Retirement means to you - pay. Continued medical care for you and your dependents in government facilities." [1969]

Air Force Preretirement Counseling Guide, Chapter 5 Medical Care 5-2f.. "One very important point, you never lose your eligibility for treatment in military hospitals and clinics." [1 April 1986]

Air Force Guide for Retired Personnel, Chapter 1. "Treatment authorized. Eligible retired members will be furnished required medical and dental care." [1 April 1962]

United States Coast Guard Career Information Guide, USGPO. "Retirement...You continue to receive free medical and dental treatment for yourself plus medical care for dependents." [1991]

U.S. Coast Guard Pamphlet Be Part of the Action, "Reap the Rewards...You can earn retirement benefits - like retirement income...Plus medical, dental care..." [1993]

Hearings on CHAMPUS and Military Health Care, HASC No. 93-70, 93rd Congress "...the government has a clear moral obligation to provide medical care to retired personnel and their dependents...this Committee has found numerous examples of recruitment and retention literature which pledged.. medical care for the man and his family following retirement." [Oct-Nov 1974]

STATEMENT OF

DAVID M. TUCKER, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

FOR THE RECORD OF THE

HEALTH SUBCOMMITTEE

OF THE

COMMITTEE ON WAYS AND MEANS

REGARDING H.R. 4068

"THE VETERANS MEDICARE SUBVENTION DEMONSTRATION PROJECT ACT"

SEPTEMBER 17, 1996

Mr. Chairman, and members of the Subcommittee, the Paralyzed Veterans of America (PVA) appreciates this opportunity to share our views regarding the creation of a demonstration project to explore the feasibility of allowing the Department of Veterans Affairs (VA) to retain Medicare reimbursement for health care provided to Medicare-eligible veterans in certain geographic areas. Allowing the VA to retain third-party reimbursements in general, and Medicare reimbursements in particular, remains an important goal of PVA. Medicare subvention is a significant tool in enabling the VA to meet the health care challenges of the present, and the challenges facing it in the future. Of primary concern to PVA is the retention and improvement of specialized services, such as spinal cord injury and disease medicine, that are the hallmark of the VA system, and the key to its survival. Medicare subvention is an important step in this process.

Specialized services within the VA are a unique resource, one not easily obtained nor matched in the private-sector health care universe. The VA's noted leadership in areas such as spinal cord medicine and sustaining care is a resource that should not be squandered, and a leadership that should not be forsaken. PVA has worked tirelessly and diligently to protect specialized services within the VA reform movement, and we shall continue to do so. We shall continue in our endeavors to promote over-all reform in the VA medical system. We must take steps to ensure that this system provides eligible veterans with the health care they deserve, while ensuring that the VA becomes ever-more effective and efficient in the provision of this care.

We believe that Medicare subvention will strengthen the VA system, yet not cause harm to the Medicare trust funds. In fact, the demonstration project established by H.R. 4068 would help protect these precious trust fund dollars. By establishing the rate of reimbursement at less than that established for private-sector providers, Medicare would preserve resources while ensuring that veterans receive needed health care. We believe that the VA will be able to provide cost-effective care to Medicare-eligible veterans while providing veterans with care that is often not matched in the private sector.

PARALYZED VETERANS OF AMERICA
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Although PVA believes that Medicare subvention will result in ultimate cost-savings to American taxpayers while ensuring the best possible care to veterans, especially those veterans in need of specialized services, we are also cognizant of the fact that data to support these contentions are scarce. It is for this reason, and also to ensure that current and future veteran users are afforded the very best medical care, that we support the demonstration project as established in H.R. 4068. Let it be demonstrated that Medicare subvention works for the betterment of veterans, and does indeed lead to efficiencies in the allocation of federal health care dollars. The evaluation process contained within H.R. 4068 should provide us with these answers. Once we are assured that this demonstration project is successful let us not hesitate to move boldly forward.

H.R. 4068 provides reimbursement only for new users of the VA medical system within the demonstration areas. This ensures that the federal government is not billed twice for care granted to veterans. By encouraging new users, the entire VA health care system would be strengthened, while not reducing the quality of care given to veterans who currently rely upon the system. H.R. 4068 is a strong step forward in the ongoing attempt to reform and revitalize the VA health care system while guaranteeing that veterans, especially veterans in need of specialized services, receive the very best health care that their service to this country has earned.

Mr. Chairman, and members of the Subcommittee, PVA strongly urges the passage of H.R. 4068. PVA stands ready to assist this Committee, Congress, and the Administration as we explore ways to improve health care for veterans, never forgetting their service, and their sacrifice, as we move forward to meet the challenges of the coming century. PVA appreciates this opportunity to present our views regarding this vital issue.

STATEMENT OF HON. WILLIAM SARPALIUS
SISTERS OF CHARITY OF THE INCARNATE WORD
HEALTH CARE SYSTEM

Dear Mr. Chairman:

I appear before you today at the request of the Sisters of Charity of the Incarnate Word Health Care System in Houston, Texas and the other six Uniformed Services Treatment Facilities (USTFs). I want to express the strong support of the Sisters of Charity and the other USTFs for the Medicare Subvention Demonstration Project proposed by the Department of Defense (DoD) and the Health Care Financing Administration (HCFA).

I want to take this opportunity to make two important points. First, if the USTFs are included, the USTFs will make the demonstration a success and lower health care costs for both DoD and the Medicare Trust Funds. Second, I want to explain the importance of this demonstration project to military beneficiaries and the Sisters of Charity and the other USTFs.

Before I comment on these two points, I want to describe the possible plight of an enrollee in the Texas USTF as an example why subvention is needed. Mrs. IO is 64 years old and soon will become Medicare eligible. If she was enrolled in TRICARE Prime, she would be forced out of Prime when she reaches 65 and would face significant out of pocket costs.

As you know, Medicare does not cover prescription drugs and this individual, because of her medical condition, needs prescriptions costing over $200 per month. On a limited income, this is a real burden. Fortunately, she is enrolled with the USTF Program so her enrollment will not be canceled, as would have happened if she was enrolled in TRICARE Prime without Medicare Subvention.

However, Mrs. IO's situation is repeated many times and other military beneficiaries will face her problem. If Medicare subvention is enacted and the USTFs are included in the demonstration, other individuals will be able to join the USTF program, with the cost of their care split between Medicare and DoD. Subvention will allow Medicare-eligible military beneficiaries to obtain the benefits they earned, often at great personal sacrifice.

The USTFs can make the subvention demonstration a success. The USTFs have the administrative and medical systems in place now and can accommodate additional military beneficiaries who want to join. The experience of the USTFs make these facilities logical additions to the demonstration. In fact, Pacific Medical Clinics in Seattle has been consulted by Madigan Army Medical Center in Region 11 during its planning for implementation of the subvention demonstration.

As private sector organizations, although with a special designation as USTFs and a fifteen year commitment to military beneficiaries, these organizations have significant experience with Medicare HMO risk contracts and all aspects of managed care. In addition, the USTFs are full service programs serving not only military beneficiaries but also many other individuals through Medicare, Medicaid and various HMO and commercial insurance plans. St. Joseph's Hospital, operated by the Sisters of Charity, is the second largest Medicare provider in Houston.

The USTFs have a unique position in the Military Health Services System (MHSS). The USTFs are deemed to be facilities of the Uniformed Services for purposes of Chapter 55 of Title X. Because of the leadership of this subcommittee, the FY 1997 Defense Authorization legislation, approved by both Houses of Congress and now awaiting the president's signature, continues the special status of the USTFs as designated providers within the MHSS.

This legislation is based on a set of Guiding Principles accepted by both DoD Health Affairs and the seven USTFs. Principle #6 states that the USTF can enroll additional DoD beneficiaries because of Medicare Subvention, "if there is a demonstration project in place between DoD and HCFA that is operational in an area in which the USTF is located."

The USTFs, at the request of the staff of the Senate Finance committee, have submitted proposed language describing how the USTFs would fit into subvention demonstration legislation that committee is preparing. A copy of this proposed language is included with my written testimony.

This demonstration is important for both DoD and the USTFs in Texas and Seattle. These USTFs should be included in the demonstration because TRICARE is operational in their regions. These two USTFs now serve the largest number of Medicare eligible military beneficiaries in their regions. The USTF in Texas serves 5,919 individuals 65+ and the USTF in Seattle serves 5,719. These individuals and their current costs would be part of DoD's continued level of effort and are not part of the

demonstration. However, any new enrollees at these two USTFs who are 65 or older would be in the demonstration as well as current enrollees who become Medicare beneficiaries.

The demonstration project will allow the Sisters of Charity and Pacific Medical Clinics to continue to accept military beneficiaries as new enrollees into their programs, avoiding the unfortunate situation I described earlier. If the USTFs are not in the demonstration, many DoD beneficiaries will not have access to military facilities, and will use their Medicare benefits, at higher costs to the federal government and significantly higher costs to themselves, which many cannot afford. Without the USTFs, these individuals will not have access to the benefits they earned as military personnel in service to their country.

It is only right and just that these individuals, who did so much for their country, have access to the benefits they earned. Space is limited in military treatment facilities (MTFs) in the Seattle area for Medicare beneficiaries and there are no MTFs in Houston. The USTFs in these locations can accommodate additional military beneficiaries, allowing these individuals access to the benefits they so richly deserve.

Besides allowing the military beneficiaries access to their benefits, participation of the USTFs in the demonstration will lower health care costs for both Medicare and DoD. For beneficiaries enrolled in the subvention demonstration, the USTFs will accept the same payment Medicare pays to HMOs. Thus, the Medicare trust funds will save on all individuals who enroll in this demonstration at the USTFs.

Unlike other TRICARE programs, the USTFs will be fully at risk for the cost of care provided to individuals in the subvention demonstration, just as the USTFs are now fully at risk for other enrollees in the USTF Program. There cannot be any cost overrun for DoD or HCFA. The USTFs are fully at risk, not with risk corridors, not with any risk sharing between the USTFs and DoD; there is no cap on potential risk for the USTFs.

Because the USTFs are fully at risk, the subvention demonstration, that includes the USTFs, will allow a reduction in the federal budget. This is a significant benefit for the federal government and is indicative of the direction health care financed by the federal government is going: reliance on the private sector which is fully at risk.

To illustrate the risk the USTFs have assumed, I return to the example I cited earlier in my testimony. This individual has serious health problems but, fortunately, she is enrolled in the USTF at St. Joseph's Hospital in Houston and thus does not face significant out of pocket costs. However, the cost of the her care during the past twelve months is $44,817.41 and the USTF has received capitation payments in the amount of $2,730 from DoD as compensation for this individual. The Sisters of Charity have assumed this risk for Mrs. IO and consider this as part of their mission to care for those in need.

In closing, I want to thank the Members for the opportunity to address this subcommittee on the important issue of Medicare Subvention and the inclusion of the USTFs in the project. The involvement of USTFs will benefit both the USTFs and the federal government. More importantly, this subvention demonstration and the participation of the USTFs will be a very significant benefit for the many military beneficiaries in Texas and Seattle.

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