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The Department of Defense's TRICARE Health Benefits Program as a Critical Plank in the Federal Platform for Health Care Reform

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INTRODUCTION

The U.S. military health system has matured over the past two centuries in direct support of this nation's evolving military, humanitarian, and nation-building capability and direction. Furthermore, in the past three decades, the military health system has both responded to, and often been charged with, providing a platform for evaluating various approaches for reforming the organization, delivery, and financing of this large segment of the federal health benefits program.

The influence of U.S. military medicine on America's public health and health care capabilities has been extensively chronicled elsewhere, including contributions to sanitation, infectious and pandemic disease, tropical medicine, telemedicine, casualty care and trauma surgery, the medical library, emergency medical systems, and aeromedical evacuation.[1] The purpose of this paper, however, is to provide a brief history of how the U.S. military health care system and, in particular, its health benefits program known today as TRICARE, have been systematically modified and evaluated over the past three decades to reform one of the largest and most complex health care organizations in the United States and the world. Military health care reform has often been adapted from initiatives in the private sector but has sometimes been on the leading edge of health care reform in the United States.

BACKGROUND

Medical personnel have provided the American warrior with critical life-saving health care services since the beginning of this country's first formal military, the First Continental Army.[2] The Army Medical Department and the Medical Corps trace their origins to July 27, 1775, when the Continental Congress established the Army Hospital headed by a "Director General and Chief Physician."[3] The Army medical corps provided care only in times of war or emergency until 1818, when a permanent military medical department was established.

For many years, health care was seen mainly as a wartime necessity to maintain the readiness of service members for duty. Although there were exceptions when care was provided to active-duty family members, care for family members was not formalized until 1884.[4] There was very little change until 1943, when Congress authorized the Emergency Maternal and Infant Care program to provide maternity and infant care (up to one year of age) for wives and children of service members in the lower four pay grades. This supportive legislation was consistent with health insurance emerging as a fringe benefit during World War II in the face of price and wage controls.[5]

Although the capacity of the military health care system had been greatly expanded during World War II and into the Cold War era, the concomitant expansion of health care benefits to a larger beneficiary population made it difficult for some to obtain space-available care. The Korean conflict further strained the capabilities of the military health care system and made it evident that military treatment facility (MTF) capacity was insufficient to handle the health care needs of a sizable number of non-active duty beneficiaries. In 1956, Congress enacted the Dependents Medical Care Act (DMCA),[6]

which authorized the DoD to contract with civilian providers for the care of active-duty family members and retired service members. Although retirees and their family members had previously been granted permissive access to free military health care on a space-available basis, the passage of the DMCA marked the first time that access had been enshrined in law.

In 1965, the Social Security Act Amendments[7] established Medicare, which was designed to provide health care for people age 65 and over. At about this time, the first wave of post-World War II and Korean War veterans with over 20 years of service began to retire in sizable numbers. Most of these retirees were under 65 and too young to participate in Medicare. The increased number of beneficiaries again placed additional strains on the military health care system, making it more difficult for retirees and active-duty family members to obtain space-available care at MTFs. Additionally, many retirees did not live near an MTF and had no military health care options. To address these inequities and disparties, Congress created the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS),[8] a fee-for-service plan modeled after the Blue Cross/Blue Shield high option. Effective October 1, 1966, the law authorized ambulatory and psychiatric care for active-duty family members; on January 1, 1967, care was extended to retirees, their family members, and certain surviving family members of deceased military sponsors.

The nature of military health care changed further in 1973, with the advent of the "All Volunteer Force (AVF)." Whereas the previous focus had been on casualty care and maintaining readiness, emphasis was now expanded to providing a peacetime health care benefit, consistent with other compensatory and non-compensatory benefits changes, necessary to recruit and retain high caliber volunteers. The increased number of women under the AVF also required the DoD to broaden the scope of its health care benefit to meet the needs of this population.

NATIONAL HEALTH CARE REFORM

Comprehensive national health care reform has been on the public agenda from time to time since the early 20th century.[9] The recent economic woes besetting America and the rest of the world have only served to heighten the current Administration's call to consider the need for reforming this country's health care capability consistent with other efforts to ensure competitiveness in the changing world economy.[10] The renewed debate over reform of America's health care has typically attempted to redress issues of inequitable access to quality health care services, increasingly unaffordable prices to the patient and payer, and the diminishing competitiveness of businesses sponsoring health insurance. At the same time, reform efforts have focused on promoting consumer rights, high levels of public health, and timely and quality information, while preserving the diversity of America's pluralistic systems in the organization, financing, and delivery of health care and public health services.[11]

Within this environment, the federal government has played the role of negotiator and rule-maker, arbitrating diverse proposals, and preserving pluralistic options. Its sheer size has given it enormous power to shape the health care marketplace. The federal government is the single largest health care provider in the United States, furnishing or

financing health care for over 100 million individuals,[12] or about one third of the entire U.S. population. It is the primary payor for 44 million Medicare enrollees, and a joint federal-state payor for 53 million Medicaid and State Children's Health Insurance Program enrollees (in 2007). Moreover, the federal government serves disparate roles as employer, provider, and payor for the Department of Defense's (DoD) health care program known as TRICARE (over 9 million beneficiaries), the Veteran's Health Administration (part of the Department of Veterans Affairs, serving 5.8 million users in 2009), the Indian Health Services (supporting a population of almost 2 million) and the Federal Employees Health Benefits Program (with 8 million enrolled federal civilian employees and annuitants and their families using private-sector health plans).

The Military Health System (MHS) is one of the largest and most complex health organizations in the country, supporting not just the health care needs of more than 9 million beneficiaries worldwide[13] but also responsible for meeting the health care needs of nearly 3 million Reservists and National Guard members and their families when they are mobilized for federal military duty and gain eligibility for the military health benefit. With the notable exception that its entire population is insured, the MHS has faced many of the same issues that the private sector has faced, especially since the 1980's. These include rapidly escalating costs and inconsistent beneficiary access to unevenly distributed health care services. The MHS has responded by shifting from predominantly high-cost inpatient facilities to outpatient sources, and by switching from a single indemnity-based plan to multiple-option coverage oriented towards managing care.

The MHS is complex in mission and in organization. It is responsible for two missions supporting the DoD:[14] (1) its primary mission of maintaining operational readiness of service members in preparation for conflict, and casualty care during and resulting from conflict (this role has expanded over time to include missions other than war, to include peacekeeping or nation-building and humanitarian missions such as disaster relief); and (2) providing peacetime health care for families of service members, retirees and their family members, and survivors. This dual-mission requirement is reflected in a complex organizational structure of military facilities providing medical, dental, veterinary, and public health services through a worldwide system of medical centers, hospitals, and ambulatory care facilities. The facilities are managed by the military Services with congressionally-appropriated centralized funding through the DoD's Office of the Assistant Secretary of Defense for Health Affairs. The MHS supports members and family members of the seven legislatively designated uniformed services—the Army, Navy, Air Force, Marine Corps, Coast Guard, commissioned corps of the Public Health Service, and National Oceanic and Atmospheric Administration. The MHS is also an employer and payor of health care services, supplementing the military installation-based system with networks of civilian health care providers.[15] The MHS operates a 4-year medical university and extensive graduate medical education program, manages specialized wartime training programs, and conducts medical research on social and environmental diseases and operational medicine.

THE DOD AS A TEST BED FOR REFORM

The current military health benefit reflects the evolving nature of health care in the United States over the past several decades, as the military benefit changed to meet the challenges of rising costs and to keep faith with its retired beneficiaries claiming they were promised free health care for life. What emerged is an entirely different DoD health care benefit and a system of providing care that ultimately came to be known as the Military Health System, responsible for delivering the peacetime health care benefit known today as TRICARE.

In the 1960s, health care costs grew rapidly, and pressure mounted for federal government intervention. As part of a strategy to promote the growth of prepaid plans as a way of improving the capacity and efficiency of the nation's health system, Congress enacted the HMO Act of 1973,[16] which authorized federal funds to help develop HMOs, a prepaid health plan that contracts with a network of providers who "manage" the care of its enrollees. The emerging role of managed care in the U.S. did not escape DoD's notice. Because CHAMPUS was an entitlement program under Section 10 of the U.S. Code, the Services were required to pay for all authorized claims, even if their budgets were exceeded. With health care costs in the 1980s escalating rapidly, the Services frequently found their CHAMPUS appropriations to be insufficient and had to pay for the shortfalls out of their operational, non-medical budgets, at least until a supplemental appropriation could be enacted.

In an effort to control escalating costs while maintaining beneficiary access to quality health care, the DoD conducted a series of demonstration programs designed to test managed care options and alternatives. These programs, many conducted simultaneously, were attempts to identify "best practices" in the organization, delivery, and financing of military health care. Because responsibility for the delivery of health care rested with the individual military departments, each Service ran the demonstrations in a manner consistent with its own culture. The lack of an overall, unified command structure limited the DoD's ability to establish common study parameters but had the advantage of allowing it to evaluate each Service's adaptation of the demonstrations.

One of the first such demonstrations, called the Contracted Provider Arrangement, was conducted in the Tidewater, Virginia area beginning in October 1986,[17] and was limited to mental health services. The demonstration examined whether a capitation-like approach could reduce costs for mental health services without diminishing quality of care. The idea behind the demonstration was to place a contractor at risk for the cost of care, while granting the contractor the ability to manage the care by using less costly forms of delivery. The project was successful at reducing costs but did not provide evidence that some of its alternative treatment measures produced acceptable levels of clinical outcomes.[18]

In 1987, the DoD proposed and Congress authorized the CHAMPUS Reform Initiative (CRI).[19] In February 1988, DoD awarded a contract to Foundation Health Corporation to conduct a CRI demonstration program in California and Hawaii, which continued until 1993. CRI offered beneficiaries a triple-option benefit—an HMO option (called CHAMPUS Prime) requiring enrollment but with a considerable reduction in beneficiary

cost sharing, a PPO option (called CHAMPUS Extra) that did not require enrollment but offered beneficiaries discounted rates, and the standard CHAMPUS benefit. In authorizing the demonstration, Congress mandated an independent evaluation of CRI, which DoD awarded to RAND. The evaluation found that for the average adult beneficiary, costs to the government were 9 percent higher with CRI than with the standard CHAMPUS benefit. The increase in government costs was due almost exclusively to higher costs (57 percent) for Prime enrollees.[20] As the General Accounting Office (GAO, now known as the Government Accountability Office) noted in testimony before the Senate, it was monitoring DoD's extremely ambitious efforts to reform its health care as it attempted to contain CHAMPUS costs for both the government and beneficiaries, increase beneficiary access to health care, improve coordination between CHAMPUS and the military treatment facilities, assure quality of care, and simplify CHAMPUS administrative procedures.[21]

Although very popular with beneficiaries because of its generous benefit structure and low out-of-pocket costs, CRI failed to meet the statutory requirement for budget neutrality to DoD. In an attempt to address concerns about CRI's impact on the budget, DoD authorized the expansion of the CRI demonstration in 1993 to the areas of Carswell and Bergstrom Air Force Bases in Texas and England Air Force Base in Louisiana. While maintaining the general design of the original CRI demonstration, the Carswell/Bergstrom/England demonstration featured increased beneficiary cost sharing, including enrollment fees for retirees and family members.[22] It also implemented the use of civilian primary care physicians to serve as "gatekeepers" to control access to nonemergency outpatient services at military treatment facilities by CHAMPUS Prime enrollees.

In 1988, Congress directed the DoD to begin another major cost containment initiative, the Catchment Area Management (CAM) program. The goal of the CAM demonstrations was to determine whether the escalating costs of CHAMPUS could be contained by giving the local hospital commander fiscal responsibility for and management authority over all care delivered in the catchment area.[23] CHAMPUS funds were turned over to the local military hospital commander, who managed the health care for all catchment area beneficiaries, regardless of whether they received their care at the military hospital or in the civilian community. The CAM programs offered beneficiaries a choice of either standard CHAMPUS (without the PPO option) or an HMO plan (Air Force) and a PPO plan (Navy).

In September 1991, the Army began implementing its version of the DoD Coordinated Care Program, called Gateway to Care. Gateway to Care drew heavily on the lessons learned from the CAM and CRI demonstrations. The centerpiece of the program was a local health care delivery system based on arrangements between military hospitals and civilian health care organizations managed by the MTF commander. Beneficiary enrollment allowed local managers to plan and provide care to a defined population. A primary care manager was used to refer enrolled beneficiaries to other sources of care as needed. The program also emphasized improved education of beneficiaries regarding their health care options and in maintaining and improving their health through family risk management, beneficial lifestyle choices, and appropriate use of health services.

The DoD's first attempt at a tri-service coordinated care program was conducted in the Tidewater area of Virginia, beginning in October 1992, with the Navy serving as lead agent. The purpose of the demonstration project was to show the effect of pooling medical assets on the efficiency of health care delivery. The program provided a triple-option benefit (i.e., an HMO, a PPO, and standard CHAMPUS) similar to that of CRI.

Establishment of TRICARE

Evidence from the CHAMPUS demonstration programs, which had high levels of patient satisfaction, led Congress to mandate[24] that DoD implement a uniform health care benefit that would extend and improve the concepts of CRI nationwide. The new program, known as TRICARE, was implemented on a regional basis across the United States.

The TRICARE benefit offers beneficiaries three primary options:

- TRICARE Standard is the non-network benefit, formerly known as CHAMPUS, open to all eligible DoD beneficiaries, except active duty service members and most Medicare-eligible beneficiaries. An annual deductible (individual or family) and cost shares are required.
- TRICARE Extra is the network benefit for beneficiaries eligible for TRICARE Standard. When non-enrolled beneficiaries obtain services from TRICARE network professionals, hospitals, and suppliers, they pay the same deductible as TRICARE Standard, but TRICARE Extra cost shares are reduced by 5 percent. TRICARE network providers file claims for the beneficiary.
- TRICARE Prime is the HMO-like benefit offered in many areas. Each enrollee chooses or is assigned a primary care manager (PCM), a health care professional who is responsible for helping the patient manage his or her care, promoting preventive health services (e.g., routine exams, immunizations), and arranging for specialty provider services as appropriate. Access standards apply to waiting times to get an appointment, and waiting times in doctors' offices.

Because of the size and complexity of the program, the DoD phased in the implementation of TRICARE region-by-region over approximately a 3-year period, beginning with the Northwest Region (Washington and Oregon) in March 1995. Health care was arranged under Managed Care Support contracts that supplemented the care provided in MTFs. An MTF commander in each region was designated as Lead Agent. The Lead Agents were responsible for coordinating care within their regions and ensured the appropriate referral of patients between the direct-care system and civilian providers. They also had oversight responsibility for delivering care to both active-duty and non-active-duty beneficiaries.

The original TRICARE contracts were implemented through seven different contractors covering 11 geographic regions. Because of problems with the contracts' size, complexity, and prescriptive requirements, the GAO found that the contracts limited innovation and competition among contractors.[25] In 2004, DoD negotiated the next generation of TRICARE contracts to improve the cost, quality, and accessibility of services for its beneficiaries, and consolidated the number of health care delivery contracts from eleven to three. The new contracts offer stronger inducements for customer satisfaction, especially

for enrolled beneficiaries. These financial incentives are part of a business approach called "pay for performance," in which contractors are rewarded for the quality of healthcare services they provide. Under this approach, providers are rewarded for meeting pre-established targets for delivery of healthcare services, motivating them to focus on important measures like improved preventive care and increased quality outcomes. The contracts also include financial incentives for detection of fraud, waste, and abuse, increased electronic claims processing, and cost savings.

With the implementation of the next generation of contracts in 2004, TMA and the military services also made substantial changes to the management and oversight of TRICARE's purchased and direct care systems through the joint development of a governance plan. This plan established a new, regional governance structure, including the creation of TRICARE regional offices (TRO) to manage each of the three TRICARE regions (North, South, and West). The TROs are each led by a director, who reports to the Deputy Director of TMA. According to the governance plan, TRO directors are considered the health plan managers for the regions and are responsible for managing the new contracts, including ensuring network quality and adequacy, monitoring customer satisfaction outcomes, and coordinating appointment and referral management policies. TRO directors are also responsible for supporting MTF commanders in their efforts to maximize the use of MTFs and for providing other assistance as needed.

Disease Management

Today, the vast majority of private sector payers employ disease management (DM) programs in an effort to control costs even though no standard methodology yet exists for measuring whether DM programs actually work.[26] In September 2006, the DoD began its own DM program for patients with asthma and congestive heart failure, with diabetes added in June 2007. Additional diseases (chronic obstructive pulmonary disease, major depression/anxiety disorders, and some cancer screenings) will be added in 2009. In a recent study conducted for TMA,[27] the Lewin Group found that patient outcomes were improved as measured by reduced use of emergency and inpatient services, increased use of appropriate preventive care, improved clinical results, and beneficiary satisfaction with and perceived usefulness of DM services received. The study also estimated the cumulative return on investment in terms of the benefit-to-cost ratio is 1.43—or $1.43 in medical savings per $1.00 invested in DM.

THE DOD AS HEALTH CARE REFORM INNOVATOR

Although DoD reforms have often mirrored those in the private sector, it has sometimes led the way with several key innovations. The DoD was one of the first organizations to recognize the potential benefits to both the government and the beneficiary of a comprehensive nationwide mail-order pharmacy program. In November 1994, DoD contracted with Value Rx for two mail-order pharmacy demonstration programs. One targeted beneficiaries no longer able to get free prescription drugs because of military base closures and the other targeted those living where TRICARE mail-order pharmacy services were not yet available. In March 1995, DoD began requiring TRICARE contractors to provide mail-order pharmacy services. To secure discounted drug prices and help control TRICARE contractors' rising pharmacy costs, DoD replaced the contractors'

mail-order pharmacy programs with a separate national mail-order contract service in October 1997.[28] On March 1, 2003, a new TRICARE Mail Order Pharmacy (TMOP) contract replaced the expired contract.

Several years before Congress authorized a prescription drug benefit (Medicare Part D) for seniors, the DoD recognized the inequity of a benefit that offered low-cost prescription drugs to its beneficiaries under age 65, who then lost their access to retail pharmacies once they became eligible for Medicare. That recognition was prompted by base realignment and closures (BRAC) undertaken as part of the restructuring of the Defense Department in the post-Cold War period, which led to a reduction in the number of MTFs by 35 percent between 1987 and 1997.[29] When the MTFs were closed, many retired military personnel who were receiving their prescription drug benefits at those facilities lost their access to free pharmaceuticals. The problem was particularly acute for Medicare-eligible retirees, who were not eligible for TRICARE. To address their needs, Congress created the BRAC pharmacy benefit, which allowed certain Medicare-eligible beneficiaries over age 65 to take part in the TRICARE retail network and mail order pharmacy programs.

In 2000, Congress replaced the BRAC pharmacy benefit with a benefit for all Medicare-eligible beneficiaries age 65 and older enrolled in Medicare Part B.[30] The new benefit, called the TRICARE Senior Pharmacy (TSRx) Program, was implemented on April 1, 2001. The TSRx Program authorizes eligible beneficiaries to obtain low-cost prescription medications from the TMOP and TRICARE network and non-network pharmacies. Beneficiaries may also continue to use military hospital and clinic pharmacies. On October 1, 2001, the TSRx Program was absorbed into the new TRICARE for Life benefit, which offers comprehensive Medicare wrap-around coverage for seniors.

From both a clinical and management efficiency perspective, the DoD made an even greater fundamental business process reform with the development of an electronic data exchange that brings to the provider's desktop all of a patient's prescription transaction information from all sources provided or funded by the Department. The Pharmacy Data Transaction Service (PDTS), operational since 2002, links all points of service worldwide—from military treatment facility outpatient pharmacies, to claims from civilian retail network pharmacies, to the TRICARE mail order program. This data exchange provides near real-time feedback to the provider reviewing the need for prescriptions, presenting potential contraindications or redundancies. The Department's PDTS has visibility of all points of service with no other system like it in the U.S. today. Further, the information collected by PDTS supports the Department's syndromic surveillance capability since the vast majority of pharmacy claims are paid electronically.

Although varying forms of Electronic Health Records (EHRs) have been around for some time, the government has only recently begun promoting them as a key component of health care reform.[31] Adoption of EHRs in the private sector continues to be a significant problem due to issues of cost, scalability, and efficiency. While some hospitals are in the process of implementing electronic systems, physician practices have a very low adoption rate (17 percent according to some studies). Of physicians who have implemented EHRs, only 4 percent have fully functioning systems for electronic recordkeeping.[32]

The MHS has been an innovator in the development of a fully-integrated large scale EHR system called AHLTA (Armed Forces Health Longitudinal Technology Application), which was deployed worldwide by December 2006. By providing around-the-clock access to a single data repository of all treatment episodes provided to TRICARE beneficiaries, AHLTA is able to support a longitudinal electronic record that extends the concept of portability far beyond that reached by other EHRs with its global capability and data exchange with the Department of Veteran Affairs healthcare system.

CONCLUSIONS

Throughout its history, the DoD has been an active participant in national health care reform, serving either as a proving ground for alternative ways of structuring, delivering, quality, safety, disease management, health information exchange, and financing health care, or as an innovator and leader. From early adoption of a nationwide mail order pharmacy program to the development of a fully-integrated large scale EHR to testing large scale, multi-state, at risk contracting, the DoD has been in the vanguard of health care reform in America.

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14. ABSTRACT

As this nation's systems of health care evolved, and as its military capability matured, military health care support matured with it, consistent with, and often as much in response to, the varying national agenda for health care reform. This paper provides a historical summary of the development of the U.S. Department of Defense's medical benefits program known as TRICARE within the evolutionary context of health care reform in America. TRICARE today is the result of decades of pluralistic responses to reforming the federal sector's health benefits programs in terms of structure, delivery, financing, quality, safety, prevention, disease management, and outcomes.

15. SUBJECT TERMS

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