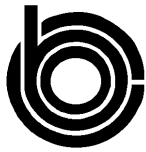

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

May 1, 2000

S. 2087
Military Health Care Improvements Act of 2000

As introduced on February 23, 2000

SUMMARY

S. 2087 contains several provisions to improve health care benefits for current and former military personnel and their families. The bill would extend or expand three demonstration projects that offer improved health care to retirees and their dependents, including Medicare subvention and coverage under the Federal Employee Health Benefits Program (FEHB). S. 2087 would waive copayments under the Department of Defense's (DoD) managed care program known as Tricare Prime for dependents of personnel on active duty. The bill would also improve pharmacy benefits and other aspects of health programs of DoD.

CBO estimates that implementing the bill would cost $109 million in 2001 and $830 million over the 2001-2005 period, assuming appropriation of the necessary amounts. Enacting the bill also would raise direct spending by $28 million in 2001 and by $457 million over the 2001-2005 period. Because the bill would affect direct spending, pay-as-you-go procedures would apply.

The bill contains private-sector and intergovernmental mandates; however, the costs of those mandates would not exceed the thresholds as specified in the Unfunded Mandates Reform Act (UMRA).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 2087 is shown in Table 1. The costs of this legislation fall within budget functions 550 (health), 570 (Medicare), and 050 (national defense).

TABLE 1. ESTIMATED COSTS OF S. 2087

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
CHANGES IN DIRECT SPENDING						
Estimated Budget Authority	0	28	47	98	130	154
Estimated Outlays	0	28	47	98	130	154
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	0	137	151	185	197	217
Estimated Outlays	0	109	142	175	193	211

Direct Spending

The bill would raise direct spending from provisions that would extend or expand certain demonstration projects, including Medicare subvention and health coverage under FEHB. The direct spending costs of those provisions are shown in Table 2.

Demonstration of Medicare Subvention. DoD provides health care to almost 350,000 retirees and survivors who are over age 64 and eligible for Medicare. This health care is provided at military treatment facilities (MTF) on a space-available basis and includes some services that Medicare does not cover, primarily prescription drugs. Under current law, DoD cannot bill Medicare for the cost of providing health care to those beneficiaries over age 64 except in a demonstration project.

The Congress authorized a demonstration project at up to six sites beginning in January 1998 and ending in December 2000. Under that demonstration, DoD provides care to Medicare-eligible beneficiaries and is reimbursed under certain conditions by the Health Care Financing Administration (HCFA), which administers Medicare. The most important condition is the requirement that DoD maintain a level of effort; any additional care is reimbursable by HCFA up to a cap set in law. This care and reimbursement procedure is known as Medicare subvention.

TABLE 2. ESTIMATED DIRECT SPENDING UNDER S. 2087

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
DIRECT SPENDING						
Cost Increases in Medicare						
Spending Under Current Law						
Estimated Budget Authority	195,113	211,518	217,077	234,887	250,997	274,149
Estimated Outlays	195,113	211,518	217,077	234,887	250,997	274,149
Proposed Changes						
Medicare Subvention						
Estimated Budget Authority	0	20	35	45	60	80
Estimated Outlays	0	20	35	45	60	80
FEHB Demonstration Project						
Estimated Budget Authority	0	1	1	4	6	6
Estimated Outlays	0	1	1	4	6	6
Tricare Senior Supplement						
Estimated Budget Authority	0	0	0	1	1	1
Estimated Outlays	0	0	0	1	1	1
Subtotal-Proposed Changes						
Estimated Budget Authority	0	21	36	50	67	87
Estimated Outlays	0	21	36	50	67	87
Spending Under S. 2087						
Estimated Budget Authority	195,113	211,539	217,113	234,937	251,064	274,236
Estimated Outlays	195,113	211,539	217,113	234,937	251,064	274,236
Costs of Premium Payments Under FEHB						
Spending Under Current Law						
Estimated Budget Authority	5,012	5,456	5,906	6,352	6,826	7,338
Estimated Outlays	5,012	5,456	5,906	6,352	6,826	7,338
Proposed Changes						
Estimated Budget Authority	0	7	11	48	63	67
Estimated Outlays	0	7	11	48	63	67
Spending Under S. 2087						
Estimated Budget Authority	5,012	5,463	5,917	6,400	6,889	7,405
Estimated Outlays	5,012	5,463	5,917	6,400	6,889	7,405
Changes in Direct Spending						
Estimated Budget Authority	0	28	47	98	130	154
Estimated Outlays	0	28	47	98	130	154

S. 2087 would increase the number of sites where HCFA reimburses DoD for care to include all major medical centers, and would extend the demonstration project for five more years, through the end of 2005. CBO estimates that these provisions would cost $20 million in 2001 and about $240 million over the 2001-2005 period. In the current demonstration project, enrolled beneficiaries use substantially more care than civilians enrolled in Medicare managed care plans. While the high use rate might decline, CBO expects that DoD would provide more care to those enrolled in a subvention program relative to the civilian population. Current Medicare-eligible beneficiaries who now receive space-available care at MTFs and choose not to enroll in the subvention program would use the MTFs less frequently. Those beneficiaries would receive more care in the private sector, which would raise costs in the Medicare program.

FEHB Demonstration Program. Under current law, military retirees under the age of 65 are eligible to either enroll in Tricare Prime or use one of Tricare's insurance programs (Standard or Extra). Those who use Tricare Standard or Extra may also seek care at an MTF on a space-available basis. Once retirees turn age 65, they are no longer eligible to use Tricare, though they may continue to seek care at an MTF when space is available. The same eligibility rules apply to survivors, who are primarily widows and widowers.

S. 2087 would extend a current demonstration project by three years (through December 2005), increase the number of eligible sites, and allow new or extended enrollment in all sites. The demonstration allows up to 66,000 people to enroll in FEHB at up to 10 sites, though only about 2,000 people are currently enrolled. Because there would be more sites and increased familiarity with the program, CBO estimates that the program would eventually cover a total of about 13,000 people; 10,000 in existing sites and 3,000 in new sites under S. 2087. Expanding coverage to new sites would cost $18 million over 2001 and 2002, and extending the demonstration project for three more years would cost an additional $178 million over the 2003-2005 period.

In addition, extending the demonstration would tend to raise Medicare costs because better insurance coverage often leads to greater use of health care services. That increase would cost an estimated $18 million over the 2001-2005 period.

The government's contribution toward FEHB premiums for beneficiaries under S. 2087 would be direct spending because the bill would add an entitlement benefit. The costs of that new entitlement are thus shown as an increase in direct spending.

Tricare Senior Supplement. The Congress authorized a demonstration program at two sites during a period ending December 2002 where Tricare acts as second-payer to Medicare for those beneficiaries who have enrolled in the program. Enrollment for the demonstration program began in March of 2000. Enrollees must pay a fee and are no longer eligible to use MTFs. CBO estimates that extending the provision for three more years would cost

$17 million over the 2001-2005 period and an additional $3 million in 2006. Those costs would be discretionary, but extending this demonstration program would also raise Medicare costs because better insurance tends to increase the use of health care. CBO estimates that the Medicare costs of Tricare Senior Supplement would be about $1 million a year for the three-year extension period.

Spending Subject to Appropriation

S. 2087 would also raise DoD's discretionary costs, assuming appropriation of the estimated amounts. The estimated changes in spending subject to appropriation are shown in Table 3.

Expansion of Pharmacy Program. Under current law, pharmacy benefits are somewhat limited in scope for military beneficiaries who are eligible for Medicare. Retirees and survivors over age 64 who use MTFs can have their prescriptions filled for free if the MTF pharmacy carries the pharmaceutical products. All beneficiaries over age 64 are eligible, but only retirees who live close to MTFs tend to use this pharmacy benefit intensively.

During the 1990s, many MTFs were closed as a result of base closures. Those beneficiaries over age 64 who lived near an MTF that was closed or who relied on the base to fill prescriptions have additional ways to fill prescriptions, often called the BRAC benefit (where BRAC is short for base realignment and closure). Those retirees can use the military's national mail order pharmacy (NMOP) and have a prescription filled for 90 days for a copayment of $8. If those retirees use a pharmacy in DoD's network they can have a 30-day prescription filled for 20 percent of the network's cost. Retirees who use out-of-network pharmacies are responsible for the full cost of the prescription. In 1996, about 450,000 people were eligible for the BRAC benefit. According to DoD, about one-third of those eligible used the NMOP benefit and filled about 600,000 prescriptions. Eligible beneficiaries also filled a little over 900,000 prescriptions at network pharmacies.

S. 2087 would extend the NMOP portion of the BRAC benefit to Medicare-eligible beneficiaries nationwide. CBO estimates that extending the NMOP benefit to those beneficiaries would cost $22 million in 2001 and $324 million over the 2001-2005 period. Although this proposal would apply to almost all beneficiaries over age 64, those who currently use MTFs to fill their prescriptions would be unlikely to use the benefit. Having one's prescription filled at an MTF is free, and current users would be unlikely to switch. Beneficiaries with health insurance that covers prescription drugs would be ineligible to participate, though some of those people would likely drop that portion of their health insurance in favor of the NMOP benefit. After adjusting for MTF use patterns, those who already have prescription drug insurance, and those who do not use prescription drugs, CBO estimates that a little more than 360,000 additional people would use the NMOP benefit if S. 2087 became law.

TABLE 3. ESTIMATED SPENDING SUBJECT TO APPROPRIATIONS UNDER S. 2087

	By Fiscal Year, in Millions of Dollars					
	2000	2001	2002	2003	2004	2005
SPENDING SUBJECT TO APPROPRIATION						
Spending Under Current Law for the Defense Health Program						
Estimated Authorization Level[a]	16,500	16,500	16,500	16,500	16,500	16,500
Estimated Outlays	16,500	16,500	16,500	16,500	16,500	16,500
Proposed Changes						
National Mail Order Pharmacy Program						
Estimated Authorization Level	0	28	49	77	91	107
Estimated Outlays	0	22	44	70	86	102
Copayments Under Tricare Prime						
Estimated Authorization Level	0	38	39	39	39	40
Estimated Outlays	0	31	37	38	39	40
Tricare Prime Remote						
Estimated Authorization Level	0	50	52	54	55	57
Estimated Outlays	0	40	49	52	55	56
Tricare Senior Supplement						
Estimated Authorization Level	0	0	0	4	6	7
Estimated Outlays	0	0	0	4	6	7
Redesigned Pharmacy Program						
Estimated Authorization Level	0	1	1	1	1	1
Estimated Outlays	0	b	1	1	1	1
Patient Safety						
Estimated Authorization Level	0	20	10	10	5	5
Estimated Outlays	0	16	11	10	6	5
Subtotal-Proposed Changes						
Estimated Authorization Level	0	137	151	185	197	217
Estimated Outlays	0	109	142	175	193	211
Spending Under S. 2087 for the Defense Health Program						
Estimated Authorization Level[a]	16,500	16,637	16,651	16,685	16,697	16,717
Estimated Outlays	16,500	16,609	16,642	16,675	16,693	16,711

a. The 2000 level is the estimated amount appropriated for that year. The current law amounts for the 2001-2005 period assume that appropriations remain at the 2000 level, without adjustment for inflation. If they are adjusted for inflation the base amounts would increase by about $400 million a year, but the estimated changes would remain as shown under "Proposed Changes."

b. Less than $500,000.

CBO uses survey data from DoD and information from the Office of Personnel Management on prescription drug use by Medicare-eligible annuitants to estimate how intensively new beneficiaries would use the NMOP benefit. CBO estimates that usage would initially be about two mail-order prescriptions per beneficiary in 2001. Because of rising prescription drug prices and increased familiarity with the program, CBO estimates that six mail-order prescriptions per beneficiary would be filled by 2010.

Copayments Under Tricare Prime. Under current law, beneficiaries who use MTFs do not need to make any copayments, but beneficiaries enrolled in Tricare Prime, the military health care system's HMO option, are required to make copayments whenever they visit a civilian doctor. In 1999, dependents of active-duty personnel who are enrolled in Tricare Prime saw a civilian doctor about 2.4 million times. S. 2087 would eliminate the requirement for those copayments. (Beneficiaries who use Tricare Standard or Extra would still have to pay the applicable co-insurance amounts for each civilian visit.)

CBO estimates that this change would cost $185 million over the 2001-2005 period. Reimbursing Tricare insurance providers for lost revenue would compose about 70 percent of DoD's cost. The remaining 30 percent of the estimated cost results because the lack of cost sharing would likely increase the number of visits to civilian doctors.

Tricare Prime Remote. Under current law, members of the armed forces on active duty who live far enough away from MTFs are eligible to participate in what DoD calls Tricare Prime Remote. This program allows such personnel to receive care without facing the co-insurance and deductibles that they would otherwise face if they used Tricare Standard, the fee-for-service option. To implement the program, DoD either establishes a network of providers for the active-duty personnel, or it waives the copayments and deductibles when claims are filed under Tricare Standard. In many cases, where the cost of setting up networks is more costly than the cost of waiving such payments, DoD just waives the deductibles and co-insurance.

S. 2087 would grant the Tricare Prime Remote benefit to dependents of members of the armed forces on active duty and to other members of the uniformed services (e.g., uniformed members of the Public Health Service) and their dependents. Using data from DoD, CBO estimates that roughly 71,000 people in these remote locations already use Tricare Standard or Extra. DoD's only cost for those beneficiaries would come from waiving the co-insurance and deductibles. CBO expects that almost 4,000 people who do not currently use Tricare insurance would enroll in Tricare Prime Remote because of the lower out-of-pocket costs. Those beneficiaries would cost DoD significantly more per person. In total, CBO estimates that establishing Tricare Prime Remote for those new beneficiaries would cost about $250 million over the 2001-2005 period.

Tricare Senior Supplement. This program involves Tricare Standard and Extra in a demonstration project for retirees over age 64 and their dependents. The costs to DoD for those programs are treated as discretionary, but expanding them to cover beneficiaries of Medicare would raise direct spending. Thus, the provision of S. 2087 on Tricare Senior Supplement is discussed above with other provisions that would raise direct spending.

Redesigned Pharmacy Program. DoD is also beginning to implement a pilot program that extends the full BRAC benefit to Medicare-eligible beneficiaries in two sites, one in Kentucky and one in Florida. That program requires enrollees to pay an annual fee of $200 to have access to both the NMOP benefit and the retail network. Enrollment began in April 2000.

S. 2087 would require DoD to lower the enrollment fee for the pilot program. CBO estimates that lowering the enrollment fee would cost roughly $4 million in outlays over the 2001-2005 period, assuming that the enrollment fee would drop from $200 to $100. Enrollment fees are used to partially offset the cost of the pharmacy program. Thus, lowering the enrollment fee would raise DoD's need for appropriated funds to finance the current caseload. Costs would also rise because lower enrollment fees would lead to increased caseload.

Patient Safety. S. 2087 would require DoD and the Department of Veterans Affairs (VA) to set up a joint process for tracking and reporting mistakes in the provision of health care that endanger patient safety. VA is already working on reporting and tracking medical mistakes, and CBO believes that those efforts would satisfy most of the requirements of this provision. DoD is also working on reporting and tracking medical mistakes, but is not as far along as VA. Simple reporting is part of DoD's current effort to improve services, but more complex reporting would likely require substantial investments in information technology. CBO estimates that this provision would cost DoD about $50 million over the 2001-2005 period.

Custodial Care. Under current law, DoD may provide coverage to certain individuals who need custodial or domiciliary care. Barring a change in their health status, DoD will provide custodial and domiciliary care under the individual case management program until the person turns 65. According to DoD, about 10 individuals were provided this type of care before DoD began its individual case management program. S. 2087 would allow DoD to continue paying for the care of those individuals after they turn 65 if they are enrolled in the Medicare subvention demonstration program. CBO estimates that this provision would only apply to a few people and that the cost of such care would be less than $500,000 per year.

S. 2087 would also cap total expenditures by DoD for the individual case management program at $100 million per year. Using data from DoD, CBO estimates that 1999

expenditures in this program were about $5 million. Accordingly, CBO does not believe that this cap would have any effect on expenditures.

Other Provisions. S. 2087 contains other provisions that CBO estimates would have little or no budgetary impact. Section 203 would require that the Tricare program implement several business practices by October 1, 2001, and that DoD report on its plan to implement those practices by March 15, 2001. DoD is already working on implementing these proposals and the only change is the October deadline.

Section 303 would require two different studies of accrual financing and how it might be used in providing health care for military retirees. One of the studies would be done by DoD and the other by an independent organization, and both would be due to the Congress by February 8, 2001.

Section 402 would require DoD and VA to develop a system for using bar codes to identify pharmaceuticals and would require their use in the mail order pharmacy program. CBO believes that the requirements of this provision are part of current efforts by DoD and VA to improve business practices. CBO understands that the private company that operates DoD's mail order pharmacy already uses bar code technology.

PAY-AS-YOU-GO CONSIDERATIONS

The Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays that are subject to pay-as-you-go procedures are shown in Table 4. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

TABLE 4. ESTIMATED IMPACT OF S. 2087 ON DIRECT SPENDING AND RECEIPTS

	By Fiscal Year, in Millions of Dollars										
	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Changes in outlays	0	28	47	98	130	154	40	0	0	0	0
Changes in receipts	Not applicable										

PREVIOUS CBO ESTIMATES

CBO recently prepared estimates for four other bills that address DoD's health care programs. Three of those bills, H.R. 2966, H.R. 3573, and S. 2003, address participation by military retirees, their dependents, and their survivors in FEHB. Another bill, H.R. 3655, is similar to S. 2087 in that it addresses only a demonstration project to provide FEHB coverage along with a number of other matters in DoD's health care program.

H.R. 3655 would extend the demonstration program for one year and allow all who enrolled to keep their insurance after the demonstration program ends. The estimate prepared on April 10, 2000, for that bill was based on a literal reading of the law and assumed that the project would have only one period of enrollment. But CBO now understands that DoD is interpreting the law to allow for annual enrollment periods, and this estimate for the demonstration program under S. 2087 is based on DoD's interpretation of current law. On that basis, CBO estimates that the FEHB provision in H.R. 3655 would cost $19 million in 2001, $463 million over the 2001-2005 period, and $1.1 billion over the 2001-2010 period.

S. 2087 and H.R. 3655 also contain four other proposals that are similar. While S. 2087 would extend the current Medicare subvention demonstration for five years and add major medical centers to the demonstration, H.R. 3655 would make subvention permanent, expand it to be a nationwide program, and allow fee-for-service billing. Both bills would extend coverage under Tricare Prime Remote to family members, but S. 2087 would allow for wider participation. Both bills would abolish copayments for visits to a civilian doctor or care provider by dependents of personnel on active duty who are enrolled in Tricare Prime. Fourth, S. 2087 would allow all military beneficiaries age 65 and over to use DoD's NMOP benefit, but H.R. 3655 would allow those beneficiaries to use both NMOP and DoD's network pharmacies.

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

Section 106 of the bill would extend the length of and expand a provision in current law that contains private-sector and intergovernmental mandates. Specifically, it would require insurers, under certain circumstances, to issue medigap policies to Medicare enrollees who chose to drop coverage from DoD's FEHB demonstration program. The bill would also prohibit insurers from discriminating in the pricing of such policies based on an individual's health status or use of care, or from using coverage exclusions for preexisting conditions as long as any lapse in coverage was no more than 63 days. These requirements would be private-sector and intergovernmental mandates as defined in UMRA. However, because of the relatively small number of people that could be affected by the provisions, the direct costs of the mandates would not exceed the thresholds as specified in UMRA ($109 million

in 2000 for private sector and $55 million in 2000 for intergovernmental, adjusted annually for inflation).

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