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The Honorable Carl Levin
Chairman
The Honorable John Warner
Ranking Minority Member
Committee on Armed Services
United States Senate

The Honorable Bob Stump
Chairman
The Honorable Ike Skelton
Ranking Minority Member
Committee on Armed Services
House of Representatives

The Honorable Donald H. Rumsfeld
The Secretary of Defense

Subject: *Financial Management: Department Of Defense Regulations Establishing Methods to Calculate Amounts To Be Transferred from Department of Defense Medicare Eligible Retiree Health Care Fund*

This report addresses a legislative mandate to report on regulations issued by Department of Defense (DOD) to cover transfers from a new fund created by the Congress to finance the cost of expanded health care programs' benefits for Medicare-eligible uniformed services[1] retirees and their eligible dependents. These health care programs include pharmacy benefits and coverage of the deductible portion of Medicare benefits.

The Floyd D. Spence National Defense Authorization Act (NDAA) for Fiscal Year 2001 (as amended by NDAA for Fiscal Year 2002, and codified 10 U.S.C. Section 1111, *et. seq.* (2002)) established in the U.S. Treasury the Department of Defense Medicare Eligible Retiree Health Care Fund (the Fund). Beginning on October 1, 2002, the Fund will finance DOD's liabilities under the uniformed services retiree health care programs for Medicare-eligible beneficiaries. The legislation requires (1) the Secretary of Defense to establish by regulation the method(s) for calculating amounts

[1] These regulations currently only apply to DOD, but provisions exist for making them applicable to other uniformed services, such as U.S. Coast Guard, for their future participation in the Fund. For the purpose of this letter, DOD's uniformed services retirees will be referred to as military retirees.

to be transferred periodically from the Fund to applicable appropriations that incur the programs' costs and (2) the Comptroller General to report to the Secretary of Defense and to Congress on the adequacy and appropriateness of these regulations within 30 days of receiving them from the Secretary.[2] Our objectives were to determine (1) whether the Secretary of Defense issued regulations that satisfy Congress' criteria for making these transfers from the Fund and (2) whether DOD's regulations are adequate and appropriate, with respect to the method(s) they prescribe for calculating the amounts of such transfers.

Results in Brief

As required by the law, regulations establishing the methods for calculating transfers from the Fund to finance eligible health care costs were issued in July 2002, in sufficient time to begin making transfers upon activation of the Fund on October 1, 2002. The regulations describe the procedures for transferring amounts from the Fund to reimburse the applicable appropriations from which the costs of military retiree health care programs provided at military treatment facilities (MTFs) and other non-DOD providers are to be paid.

DOD regulations for establishing the methods for calculating transfers from the Fund appear to be adequate and appropriate and provide a framework for the transfers to be implemented upon activation of the Fund. Whether there will be any implementation problems or the degree of these problems will be unknown until DOD has some experience in the Fund's operation.

Under these regulations there are to be daily transfers from the Fund to cover amounts disbursed to non-DOD providers, such as civilian health care providers and retail pharmacies, based on claims transactions. One challenge that DOD will face in paying non-DOD providers is to mitigate the risk of improper payments.

The regulations also provide the methodology for calculating transfers to cover the cost of MTF care to the intended beneficiaries. Because MTFs' cost accounting systems do not presently have the capacity to record or generate cost data on a per patient basis, aggregated cost and patient clinical data are to be used for the calculation. In this regard, based on our and the DOD Inspector General's prior work, the reliability of the underlying cost and patient clinical data could limit DOD's ability to reliably assign costs and bill DOD for services to DOD Medicare-eligible retirees and their eligible dependents.

Scope and Methodology

To satisfy the mandate, we reviewed the DOD regulations issued in July 2002. We also reviewed the documentation supporting the regulations and analyzed the methods of calculating the amounts to be transferred from the Fund, and discussed them with cognizant DOD officials. We obtained oral comments from DOD on a draft of this letter and have incorporated its views as appropriate. We performed our work

[2] We received the regulations on August 1, 2002.

in July and August 2002, in accordance with generally accepted government auditing standards.

Background

DOD provides care to military services retiree Medicare-eligible beneficiaries through a combination of direct care at its MTFs and care purchased from non-DOD providers, such as civilian providers. In addition to inpatient and outpatient treatment, those beneficiaries also qualify for pharmacy benefits.

Starting October 1, 2002, all health care costs of DOD Medicare-eligible retirees and their eligible dependents provided at MTFs will be covered by the Fund. Payments to civilian providers for health care for these beneficiaries will be covered by the Fund as a supplemental payer; Medicare will be the primary payer. The pharmacy benefit cost, less any copay at retail pharmacies or National Mail Order Pharmacy (NMOP) will be covered entirely by the Fund. To obtain health care benefits from civilian providers, retail pharmacies and NMOP, the Medicare-eligible beneficiaries must[3] be enrolled in Medicare Part B.[4] In addition, the Fund will be available to cover administrative costs of the uniformed services retiree health care programs, such as claims processing.

Contributions to the Fund will be from two sources. Based on an actuarial calculation, the Department of the Treasury will contribute amounts from the General Fund for the costs of health care benefits attributable to military service rendered prior to October 1, 2002, and DOD from its appropriation will contribute for health care benefit costs accruing after that date. Under this arrangement, Treasury will fund the costs for all current retirees and their dependents, and that portion of the future retiree health care benefits of current active military members and their eligible dependents for military services prior to October 1, 2002.[5] DOD's appropriation will fund the costs of Medicare-eligible retiree health care associated with all military service after October 1, 2002, for those currently in the military services and future entrants and their eligible dependents.

Treasury's contribution from the General Fund to the Fund is to be based on its actuarial liability, amortized over a number of years yet to be determined. DOD is to calculate its share of the contribution to the Fund based on the monthly end strength of each service and actuarially calculated per-capita rates for both full-time and part-time personnel. It will transfer its contribution to the Fund monthly from its existing Military Personnel appropriation accounts or from other applicable accounts. DOD

[3] Medicare-eligible beneficiaries who were age 65 or older as of April 1, 2001, the start date for pharmacy benefit for the new program, were "grandfathered" and are not subject to this requirement.
[4] Medicare is a combination of two programs, Part A (Hospital Insurance) and Part B (Supplementary Medical Insurance). Part A coverage is usually provided automatically to Medicare-eligible beneficiaries, whereas Part B coverage is optional and subject to monthly premium payments by beneficiaries.
[5] Treasury will also contribute to the Fund to cover amounts reflecting any future changes in health care benefits and actuarial assumptions, and any resulting actuarial gains and losses.

estimated the present value of the total long-term liability of the Fund as of September 30, 2002, to be $451 billion.[6]

Adequacy of Fund Regulations

DOD's regulations satisfy the legislative criteria for transfers from the Fund and appear to be adequate and appropriate and provide a framework for the transfers to be implemented upon activation of the Fund. Until DOD has some experience in the Fund's operations, whether there will be any problems with fund transfers will be unknown.

DOD's July 2002 regulations governing Fund operations are comprised of a DOD Directive and a DOD Instruction.[7] The Directive[8] requires that health care for Medicare-eligible beneficiaries be funded in accordance with the law establishing the Fund, sets out policies, and assigns responsibilities for implementation. The Instruction[9] implements the Directive and provides details on the operations and management of the Fund, including the procedures for making contributions to and transfers from the Fund.

The new regulations require transfers from the Fund to cover health care program costs to be made using the health care and financial management systems and processes currently in place at DOD. All transfers from the Fund must be made from the new Treasury account to the existing Defense Health Program appropriations from which DOD's costs of non-DOD provider or MTF care are presently paid.

The regulations require the validation of civilian provider daily claims costs to ensure that only costs attributable to Medicare-eligible beneficiaries have been paid. Also, after fiscal year-end, the amounts transferred from the Fund for MTF care are to be compared to actual costs and patient clinical data for that year.

Payments for Health Care Purchased from Non-DOD Providers

The DOD regulations specify that daily transfers will be made from the Fund to cover civilian provider and retail pharmacy benefit costs based on daily claims transactions attributable to Medicare-eligible beneficiaries. Funds are to be transferred monthly to cover payments to National Mail Order Pharmacy providers. All claims processing costs are to be transferred from the Fund on a biannual basis. For the Uniformed Services Family Health Plan (USFHP),[10] funds are to be transferred biannually to

[6] This amount includes $388 billion for pre-October 1, 2002, service liability, which Treasury is responsible for funding, and $63 billion for post October 1, 2002, service of current active military members, which DOD is responsible for funding.
[7] This is consistent with DOD policy and practice, as set out in DOD Directive 5025.1, subject: DOD Directives System, July 27, 2000.
[8] DOD Directive 6070.1, subject: DOD Medicare Eligible Retiree Health Care Fund, July 17, 2002.
[9] DOD Instruction 6070.2, subject: DOD Medicare Eligible Retiree Health Care Fund Operations, July 19, 2002.
[10] DOD has contracts with network providers under the Uniformed Services Family Health Plan. The provider is paid a fixed amount based on enrollment estimate and per-person monthly capitation and assumes total financial risk for higher than expected costs.

cover the contract-specific capitation rates for Medicare-eligible retirees and their eligible dependents enrolled in USFHP.

One challenge that DOD will face in paying civilian providers is to mitigate the risk of improper payments. DOD presently pays for the health care services for its military members and their dependents provided by the civilian health care sector under certain circumstances. Therefore, it has the payment structure in place for paying civilian providers' claims. Because the new program will likely substantially expand the volume of health care services obtained from civilian providers, DOD needs to be aware of known vulnerabilities so it can assess any increased risk of improper payments. This risk could be substantial, as shown by U.S. Department of Health and Human Services' Inspector General study that reported about 6.3 percent of Medicare-fee-for-service claims were paid improperly in fiscal year 2001.[11] Overpayments to civilian providers under the Medicare program administered by Health and Human Services have been on our high-risk list since 1990.[12]

Payments for Health Care Provided in Military Treatment Facilities

Transfer amounts for MTF care are to be calculated annually based on most recently reported fiscal year costs and patient clinical data, and are to be distributed by DOD and the military departments to MTFs using DOD's current budget execution process. The instruction does not specify how frequently transfers will be made from the Fund to DOD or when distributions will be made to the MTFs.

A major challenge in paying for care provided at MTFs is that their existing cost accounting systems do not have the capacity to record or generate cost data for each patient.[13] As a result, the calculation of transfer amounts for MTF care is not based on patient level cost and is not age, sex, or individual patient specific for costs. Instead, the regulations call for transfer amounts to be calculated annually based on recently reported fiscal year aggregated cost for all MTF activities and aggregated patient specific clinical data, extracted from individual patient records, for Medicare-eligible patients treated in each facility. According to DOD officials, DOD plans to develop itemized billing for individual patients.

In addition, the reliability of the underlying cost, patient clinical and demographic data to identify Medicare-eligible patients to be used to calculate the estimated amounts to be transferred from the Fund is questionable. We and the DOD Inspector General have previously reported[14] that underlying MTF costs, as well as patient

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[11] Office of the Inspector General, Department of Health & Human Services, *Improper Fiscal Year 2001 Medicare Fee-for-Service Payments*, A-17-01-02002 (Washington, D.C.: Feb. 15, 2002).
[12] U.S. General Accounting Office, *High-Risk Series: An Update*, GAO-01-263 (Washington, D.C.: Jan. 2001)
[13] U.S. General Accounting Office, *Medicare Subvention Demonstration: DOD Costs and Medicare Spending*, GAO-02-67 (Washington, D.C.: Oct. 2001).
[14] U.S. General Accounting Office, *U.S. Government Financial Statements: FY 2000 Reporting Underscores the Need to Accelerate Federal Financial Management Reform*, GAO-01-570T (Washington, D.C.: Mar. 30, 2001). Office of the Inspector General, Department of Defense, *Beneficiary Data Supporting the DOD Military Retirement Health Benefits Liability Estimate*, D-2001-154 (Washington, D.C.: Jul. 5, 2001); Office of the Inspector General, Department of Defense,

clinical and demographic data used for calculating payments to these facilities are not reliable. For example, the cost data in MTFs' cost accounting system was not being reconciled to its source systems, the patient clinical data for outpatient visits was not reliable, and demographic data had ineligible, unable to be verified, or incorrect critical data. The net effect is that there are uncertainties about the numbers and type of patient care provided, which under the contemplated billing process could result in either under or over billing for the Medicare eligible client base. DOD has established a management improvement plan and implemented several recent initiatives designed to improve data quality. It is too soon to assess whether these actions have resulted in the needed improvements.

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We are sending copies of this report to the Chairmen and Ranking Minority Members of the Senate and House Appropriation Committees. We will also make copies available to others upon request. In addition, the letter will be available at no charge on the GAO Web site at http://www.gao.gov.

If you have any questions, please contact me at (202) 512-8365 or solisw@gao.gov, or Linda P. Garrison, Assistant Director, at (404) 679-1902 or garrisonl@gao.gov. Key contributors to this letter were Shawn Ahmed, Francine Delvecchio, Francis Dymond, and Kristi Peterson.

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Defense Capabilities and Management

Internal Control and Compliance with Laws and Regulations for the FY 1999 Financial Statements for Other Defense Organizations-General Funds, D-2000-103 (Washington, D.C.: Mar. 16, 2000).