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DEFENSE HEALTH CARE

New Managed Care Plan Progressing, but Cost and Performance Issues Remain

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The Honorable Dan Coats
Chairman
The Honorable Robert C. Byrd
Ranking Minority Member
Subcommittee on Personnel
Committee on Armed Services
United States Senate

The Department of Defense (DOD) is implementing a sweeping reform of its $15 billion per year health care system. TRICARE, DOD's new nationwide managed health care program, will significantly alter health care delivery for DOD's 8.3 million beneficiaries. As we testified on March 7, 1996, before the House Committee on National Security's Subcommittee on Military Personnel, TRICARE's implementation is occurring in a rapidly changing military environment.[1] Post-cold war contingency planning scenarios, efforts to reduce the overall size of the nation's military forces, federal budget-reduction initiatives, and base closures and realignments have all heightened scrutiny of the size and makeup of DOD's health care system. How well DOD implements and operates TRICARE may define and shape military medicine for years to come.

Because of TRICARE's complexity, large scale, and impact on beneficiaries, you requested that we review the program, focusing on (1) whether DOD's experiences with early implementation produced the expected results, (2) how early outcomes may affect costs, and (3) whether DOD has defined and is capturing data needed to manage and assess TRICARE's performance.

To assess DOD's experiences with early implementation, we visited four TRICARE regional administrators and eight military medical facilities within those regions. We also met with TRICARE contractors who provide health care support to the DOD medical facilities. These officials described their experiences with the beneficiary education, marketing, and enrollment phases of TRICARE implementation. They also described their efforts to identify and disseminate information about the problems they encountered and the solutions they found in order to facilitate TRICARE implementation in other regions. To analyze cost implications, we reviewed studies projecting TRICARE costs and discussed these studies

[1]Defense Health Care: TRICARE Progressing, but Some Cost and Performance Issues Remain (GAO/T-HEHS-96-100, Mar. 7, 1996).

with Office of the Assistant Secretary of Defense for Health Affairs staff, their TRICARE cost consultant, and representatives of the Congressional Budget Office. We discussed management data needs with DOD officials at the headquarters and regional levels, focusing on those unmet needs that emerged during early TRICARE implementation.

We did our review between June 1995 and March 1996 in accordance with generally accepted government auditing standards.

Results in Brief

Progress has been made during early implementation of TRICARE, DOD's far-reaching effort to bring managed health care to one of the nation's largest health care systems. TRICARE is intended to improve access to care for the military community while maintaining quality and controlling costs. This initiative involves a unique partnership between the military and civilian health care communities, including seven multistate managed care support contracts worth about $17 billion over 5 years.

As DOD intended, large numbers of beneficiaries have enrolled in DOD's managed health care program, and many have chosen to receive care from military providers. Implementation of such substantial changes has not been problem-free, but both DOD and its contractors have worked hard to deal with problems as they arise, as well as to disseminate information on lessons learned from the early stages of TRICARE implementation so that other areas of the military health care system can more easily overcome the same obstacles.

Although progress has been made, issues regarding TRICARE's cost and performance have emerged during implementation that require DOD's attention. Containing costs is critical to TRICARE's success, but it appears DOD's efforts to do so may be hindered. DOD's ability to save money through resource-sharing agreements and utilization management, two critical cost-saving features of TRICARE, is uncertain and may be impeded because of implementation problems. DOD and contractor staffs do not fully understand how to effectively use resource-sharing agreements. Also, there have been delays in the implementation of utilization management.

Although DOD is defining TRICARE performance measures, it is not collecting key data on either beneficiary access to care or enrollment. The Congress and DOD will need these data to determine whether DOD is fully achieving TRICARE's goals. For example, DOD needs access data to measure how well it is meeting TRICARE access standards, such as

timeliness of appointments. Similarly, DOD needs enrollment data to identify the cost implications of attracting new beneficiaries who were not using DOD health care and would not now be using the military health system were it not for TRICARE.

Background

DOD's primary military medical mission is to maintain the health of 1.7 million active duty service personnel[2] and to be prepared to deliver health care during times of war. Also, as an employer, DOD offers health care services to 6.6 million non-active duty beneficiaries such as dependents of active duty personnel and military retirees. The bulk of the health care is provided at more than 600 military hospitals and clinics worldwide, which are operated by the Army, Navy, and Air Force. DOD's direct health care system is supplemented by a DOD-administered insurance-like program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). In fiscal year 1996, DOD expects to spend about $11.8 billion providing care directly to its beneficiaries and about $3.6 billion for CHAMPUS.

In response to such challenges as increasing health care costs and uneven access to care, in the late 1980s DOD initiated, under congressional authority, a series of demonstration programs to evaluate alternative health care delivery approaches. In the National Defense Authorization Act for Fiscal Year 1994 (P.L. 103-160), the Congress directed DOD to prescribe and implement, to the maximum extent practicable, a nationwide managed health care benefit program modeled on health maintenance organization (HMO) plans. The Congress specifically required that this new program could not incur costs greater than DOD would incur in the program's absence and that beneficiaries enrolling in the managed care program would have reduced out-of-pocket costs. Drawing from its experience with the demonstration projects, DOD designed TRICARE as its managed health care program.

TRICARE is designed to give beneficiaries a choice among TRICARE Prime, which is similar to an HMO; TRICARE Extra, which is similar to a preferred provider organization; and TRICARE Standard, which is the current CHAMPUS fee-for-service-type benefit. Beneficiaries who select TRICARE Prime must enroll to receive care under this option. The program uses regional managed care support contracts to augment the capabilities of military hospitals by having contractors perform some

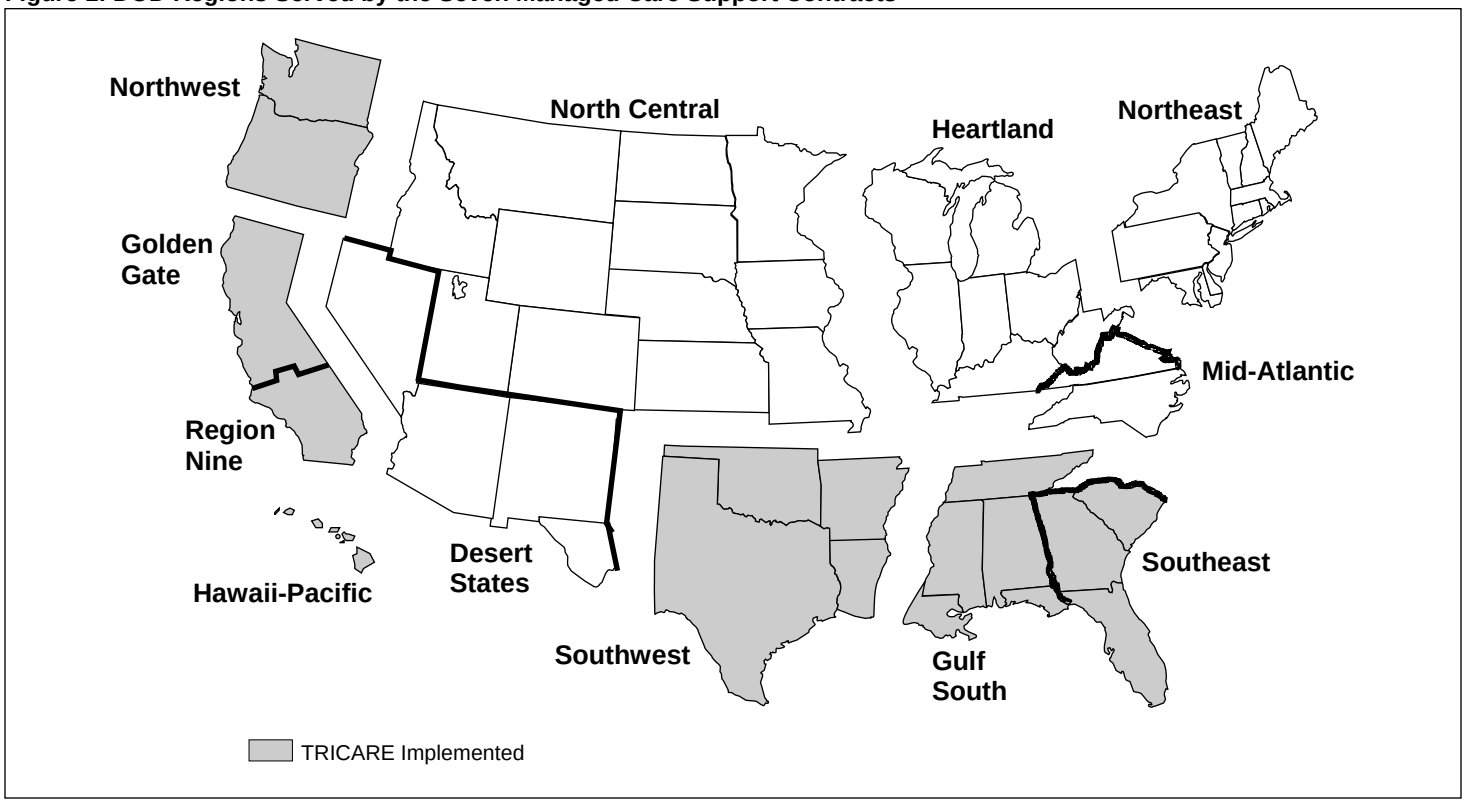
[2]Also includes members of the Coast Guard and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration, who are also eligible for military health care.

managed care functions as well as arrange for care in the civilian sector. There will be seven managed care support contracts covering the 12 TRICARE regions. To coordinate the services and the contractors and monitor health care delivery, each region is headed by a joint-service administrative organization called a lead agent. DOD has estimated that the managed care support contracts will cost about $17 billion over the 5-year contract period. DOD has awarded four contracts and plans to have all contracts awarded and the TRICARE program fully implemented by September 1997. Background on the TRICARE program is in appendix I.

The Northwest Region was the first region to begin enrolling beneficiaries in March 1995. Three regions, the Golden Gate Region, the Hawaii-Pacific Region, and Region Nine,[3] began enrolling beneficiaries in October 1995, followed by the Southwest Region in November 1995. While the contract has been awarded for the Southeast and Gulf South Regions, they are not scheduled to begin health care delivery under TRICARE until July 1996. Figure 1 shows the DOD regions covered by the seven managed care support contracts. The shaded areas are the regions where TRICARE has been implemented in various stages as of March 1996.

[3]Region Nine covers the Southern California area.

Figure 1: DOD Regions Served by the Seven Managed Care Support Contracts



Note: Managed care support for Alaska will be addressed separately from these regions.

DOD has experienced difficulties in awarding its managed care support contracts. Each of the contracts awarded thus far has been protested. The protest of the first contract, encompassing the Golden Gate Region, Hawaii-Pacific Region, and Region Nine, was sustained, and DOD was required to recompete the contract. The protests for the Northwest Region's and Southwest Region's contracts and the contract including both the Southeast and Gulf South Regions were denied.

Last year, in response to congressional concerns about DOD's difficulties with an early contract award covering California and Hawaii for which GAO[4]

[4]Under the Competition in Contracting Act of 1984 (31 U.S.C. 3551-56 (1988)), GAO is required to consider bid protests and determine whether a challenged federal solicitation, contract award, or proposed award complies with applicable statutes and regulations.

sustained a protest,[5] we reviewed problems identified by the bid protest experience. We reported that while DOD had taken steps to improve future contract awards, several areas of concern remained. Among our recommendations—which DOD agreed to adopt—were that DOD consider the potential effects on competition of such large TRICARE contracts and weigh alternative award approaches to help ensure competition during the next procurement round. We also urged that DOD try to simplify the next round's solicitation requirements and seek to incorporate best-practice, managed care techniques in the contracts. We further recommended that DOD establish general qualification requirements for its board members who evaluate contractors' proposals.[6] We plan to follow up on these issues and begin a study of how well DOD's contractors are performing under the current contracts.

Despite Setbacks, Early Implementation Is Under Way

Despite unanticipated obstacles, DOD's early implementation of TRICARE is progressing in line with DOD expectations. DOD has enrolled large numbers of beneficiaries in TRICARE Prime, including many of the active duty dependents DOD particularly wants to enroll. It has also succeeded in encouraging TRICARE Prime enrollees to select military health care providers—the source of care that DOD believes is more cost-effective than civilian-provided care. In addition, DOD is addressing implementation problems that early on caused confusion for beneficiaries and difficulties for military health care managers.

Early Enrollment Results

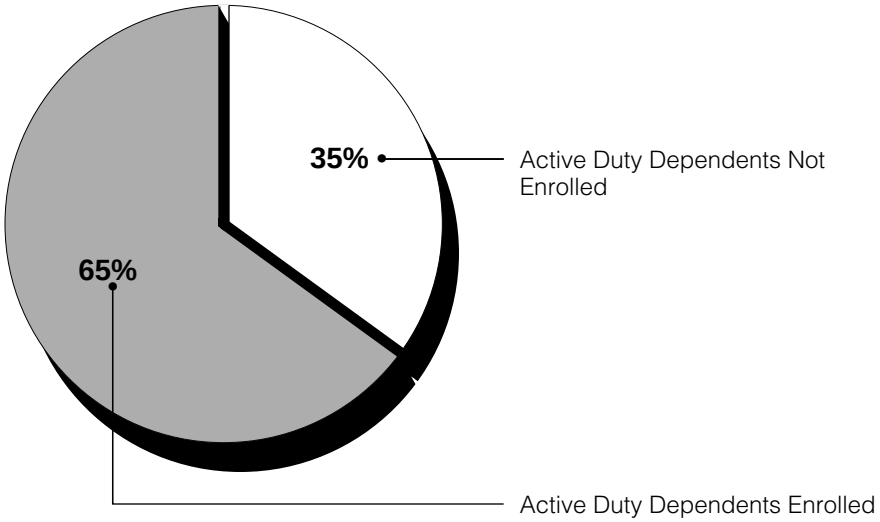
As DOD intended through its marketing efforts, many beneficiaries have enrolled in TRICARE Prime, particularly the target population of active duty dependents that tends to rely heavily on the DOD health care system. As of January 31—after almost 12 months of operation in the Northwest Region and fewer than 4 months in four other regions—more than 400,000 people had enrolled in TRICARE Prime.[7] In the Northwest Region, about two-thirds of active duty dependents have chosen this option, as shown in figure 2.

[5]Foundation Health Federal Services, Inc; QualMed, Inc., B-254397.4, et al., Dec. 20, 1993, 94-1 CPD ¶ 3.

[6]Defense Health Care: Despite TRICARE Procurement Improvements, Problems Remain (GAO/HEHS-95-142, Aug. 3, 1995).

[7]The 400,000 enrollees does not include more than 300,000 active duty military personnel who are automatically enrolled in TRICARE Prime.

Figure 2: Northwest Region's Active Duty Dependent Enrollment in TRICARE Prime

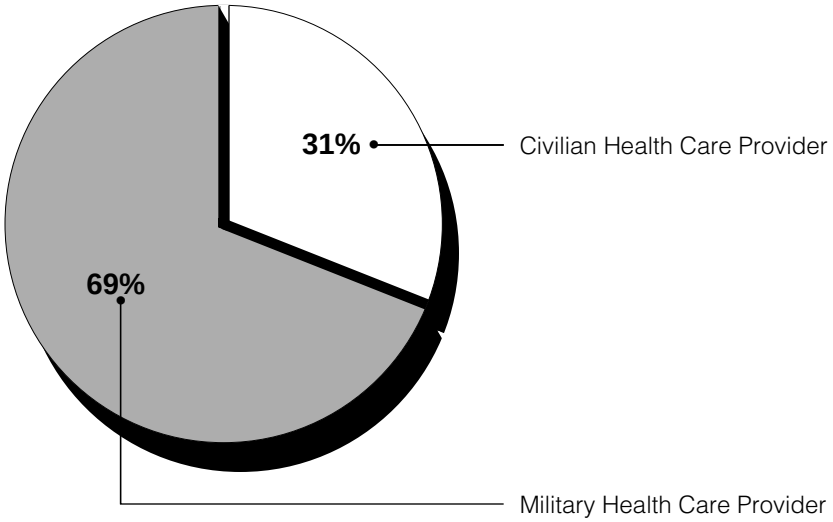


Note: Enrollment data are as of January 31, 1996.

Source: DOD data.

Also, in those regions under way, the bulk of beneficiaries choosing TRICARE Prime have enrolled with military, rather than civilian, health care providers. This enhances DOD's goal of fully utilizing its military medical facilities and providing care in the less expensive military setting. Figure 3 shows that in the Northwest Region, over two-thirds of the beneficiaries have chosen to enroll with a military health care provider.

Figure 3: TRICARE Prime Enrollment With Health Care Providers in the Northwest Region



Note: Enrollment data are as of January 31, 1996.

Source: DOD data.

DOD Is Addressing Early Implementation Obstacles

During the period from the contract award through the start of health care delivery, DOD encountered and addressed various start-up problems. A delay in the TRICARE benefits package and higher than expected early enrollment together led to initial beneficiary confusion. Also, computer system problems have hindered DOD's ability to manage the enrollment process.

One early setback was the delay in the approval of the TRICARE benefits package, which details the beneficiaries' fees and copayments for health care services. DOD did not approve the benefits package until just 2 months before the Northwest Region began enrolling beneficiaries. Military facilities had already begun their marketing and education efforts with the proposed benefits; however, the approved benefits package changed the enrollment fees. Because of this, people became confused, and DOD and the contractor had to explain the changes. This confusion did not occur in other regions, because the TRICARE benefits package was in place before marketing and education began.

Despite the benefits package delay, the Northwest Region had more people wanting to enroll than it anticipated. Although the contractor had projected that 28,000 beneficiaries would enroll during the first year, approximately 58,000 beneficiaries enrolled during the first 4 months. The contractor responsible for managing the enrollment process was understaffed and had to hire temporary employees. The temporary employees were not adequately trained and could not sufficiently address beneficiaries' questions about TRICARE, which further confused beneficiaries. Later, DOD and the Northwest Region shared their experiences through an extensive lessons-learned effort with other regions. Thus, the Southwest Region contractor hired temporary employees and trained them with its regular employees before enrollment began. Although the Southwest Region also experienced higher enrollment than anticipated, DOD and the contractor avoided much of the beneficiary confusion that the Northwest Region experienced.

During the enrollment process, DOD has also encountered problems stemming from the inability of its medical information system to interact with the contractors' systems. Because of their configurations, the systems cannot communicate, meaning that data cannot be transferred from one system to another. As a result, according to lead agent officials, DOD does not have a complete database of all beneficiaries enrolled in TRICARE Prime, and regional officials must rely on the contractor to provide enrollment data. However, DOD is addressing the problem by having the Northwest contractor provide special reports from its system and, in the Southwest Region, having the contractor put beneficiary enrollment data in both the DOD and contractor systems. DOD plans to address this problem by amending the contracts to require contractors' medical information systems to exchange information with DOD's system.

Implementation Issues May Affect TRICARE Costs

The degree to which cost savings can be achieved under TRICARE remains uncertain and depends on DOD's ability to operate the system as it is designed to work. Issues have emerged during early implementation that may hinder DOD's efforts to contain costs. TRICARE depends on managed care to achieve maximum efficiency of its military facilities and control rising health care costs by using techniques such as sharing resources with the support contractor and managing beneficiaries' use of health care services.

Resource-Sharing Details Not Well Developed or Understood

DOD has estimated that resource sharing could save $810 million over 5 years, but DOD and contractor officials responsible for entering into specific resource-sharing agreements have told us they do not fully understand the potential cost implications of such agreements. This lack of understanding continues to impede implementation of resource sharing under TRICARE, and the effectiveness of the program remains uncertain.

Resource sharing is a feature of the TRICARE contracts that allows the contractor, through agreements with DOD, to provide personnel, equipment, and/or supplies to a military facility to improve its capability to provide care. DOD officials believe that providing health care to military beneficiaries in military facilities is less expensive than comparable care in the civilian sector, so maximizing the use of military facilities results in savings to both DOD and the contractor. For example, the contractor might provide an anesthesiologist to a military hospital so that more surgeries could be performed there rather than at a more costly private facility at DOD expense, thereby reducing overall costs. Similarly, contractor costs for the service provided are reduced by using the military facility and supporting resources.

Evaluating the cost-effectiveness of resource-sharing agreements is very difficult and complex. Each agreement must be analyzed to determine whether the savings from providing care in the military facility offset increased facility costs under the agreement, such as the cost of supplies, staff, or support services that would not have been used if the agreement had not been established. Also, the extent of resource-sharing savings will be a factor in future regional contract price adjustments, which further adds to the complexity of these agreements.

DOD has given regional officials, military facility commanders, and contractors a financial analysis worksheet to help determine the cost-effectiveness of the agreements. DOD has also provided some training sessions in the regions. Despite these efforts, DOD and contractor officials remain confused about making appropriate decisions regarding the financial implications of these agreements. According to lead agent officials, they are uncertain about how individual agreements may affect future contract price adjustments. Because of this, some regions have been slow to enter into agreements, and the anticipated savings may not be achieved.

DOD officials told us that they recognize this deficiency and plan to address it. They said that DOD is currently developing a formal training program for

resource sharing and that they also plan to provide military treatment facility commanders with a new computer-based analytical tool to enable them to determine the potential effects of resource-sharing agreements.

There is, however, a more direct, less confusing means to accomplish contractor support of direct care in military facilities. Using a different program called task order resource support, military facility commanders can contract separately with the managed care support contractor for particular resources to augment their direct care capabilities. DOD officials told us that, in the past, very little resource support has taken place because hospital commanders did not have the level of control over CHAMPUS funds they needed to enter into these agreements. Now, however, DOD has proposed an alternative financing mechanism for the managed care support contracts. If adopted, this financing method would give facility commanders more control of CHAMPUS funds along with their direct care funds and, therefore, more flexibility to enter into resource support agreements. With this flexibility, DOD managers would be able to directly buy the services they need to avoid sending some patients out of their hospitals for needed care. This may have the effect of reducing the need to negotiate the more complex resource-sharing agreements while still making the most of contractor support of military facility capabilities. DOD's alternative financing approach is still being developed, however, so its eventual impact on contractor support of military direct care capabilities is still unclear.

Implementation of Utilization Management Delayed

DOD estimated that utilization management in its facilities could save over $480 million nationwide over 5 years. However, DOD and the contractor were not ready to perform this function at the start of health care delivery in the Northwest and Southwest Regions as planned. Therefore, the full extent of TRICARE savings from utilization management may not be realized.

Utilization management is intended to ensure that beneficiaries receive necessary and appropriate care in the most cost-effective manner. For example, utilization management reviews would verify that hospital admissions are medically necessary before patients check in or that lengths of hospital stays are not excessive. Utilization management also includes case management, which involves assigning health care providers to manage care for patients with high-cost, chronic conditions (such as diabetes or asthma) to try to avoid costly and disruptive crises that lead to emergency room visits or unscheduled hospital admissions.

Utilization management can be done internally by the military facilities, or the contract can be written so that the contractor is required to perform this function. In the Southwest Region, where the contractor is responsible for utilization management, regional officials have expressed dissatisfaction with the contractor's performance of utilization management activities and have withheld partial contract payments until the contractor's performance improves. Because the contractor has hired additional utilization management staff, both DOD and the contractor believe the situation will be resolved soon. The Northwest Region's utilization management program, which is handled by the military, was not implemented for over 5 months, but it is now under way.

DOD Is Identifying Performance Measures but Is Not Collecting Certain Needed Data

Because of TRICARE's newness, size, and complexity, appropriate and effective information management has become increasingly important. During early TRICARE implementation, DOD did not define performance measures to evaluate how well it is meeting its goals, but DOD is now defining such measures at the national and regional levels. However, some data needed to evaluate the program are not being captured.

DOD Is Defining Performance Measures

Before TRICARE's implementation, DOD had not defined performance measures needed to monitor and evaluate all major aspects of health care delivery at both the regional and national levels. During implementation, the regional officials quickly recognized the importance of having such measures for evaluating achievement of regional and national TRICARE goals, and for providing a good information base for management decisions. Thus, the regions have begun creating their own sets of measures to assess the efficiency and effectiveness of the delivery of health care services in the region. These measures will be used in an ongoing evaluation of customer services, including patient satisfaction, and clinical services, including inpatient and outpatient care, disease prevention and health screening, disease management, enrollee health, and population health management.

DOD is separately developing a set of performance measures to be used at the headquarters level to monitor various aspects of health care delivery across the regions, such as TRICARE Prime enrollment and preventable admissions. DOD officials said the identification of performance measures will be a continuing effort for all health care stakeholders as DOD's needs change throughout TRICARE implementation. However, the

appropriateness and effectiveness of these performance measures remain to be seen.

Beneficiary Access Data Not Being Captured

Currently, neither DOD nor the contractors are tracking access data to ensure that they are meeting DOD's standards for access to primary care services.[8] However, these data are needed to enable the Congress and DOD to measure TRICARE's performance against this key system goal.

Access to care relates to a patient's ability to get the appropriate level of health care in a timely manner. Timely access to military health care has long been a major source of beneficiary dissatisfaction. To improve performance in this area, DOD established primary care access standards in their 1994 TRICARE Policy Guidelines. These standards apply to both military and civilian providers and address areas such as wait times for appointments and the availability of emergency services. The following are DOD's current access standards for maximum appointment wait times:

- 4 weeks for a well visit, which is nonurgent care for health maintenance and prevention;
- 1 week for a routine visit, which is nonurgent care requiring a health care provider; and
- 1 day for acute illness care, which is urgent care requiring a health care provider.

DOD collects some access data through an annual beneficiary satisfaction survey. The DOD survey contains 25 questions that look at how easily beneficiaries entered the health care system and whether they received the care they believed was necessary. Types of questions include where care was received, types of preventive services received, the number of calls made for an appointment, usual length of time between scheduling the appointment and seeing a provider, usual length of wait in the provider's office, approximate travel time from residence to provider's office, and beneficiaries' general level of satisfaction with access to care.

Although important, these survey data are based on beneficiaries' perceptions generalized over a 12-month period and do not measure DOD's actual performance against its newly established standards. DOD could collect the access data needed to measure its performance at the time beneficiaries schedule their primary care appointments. According to lead

[8]Primary care is the entry point to the military health care system that includes a variety of basic services and may lead to referrals for specialty care.

agent and Health Affairs officials, they are currently not doing so because DOD's patient appointment and scheduling system, as configured, does not capture this information. DOD officials told us that the needed access data could likely be gathered by modifying the DOD appointment and scheduling system to capture precise waiting time information while still complementing these empirical data with the annual survey data.

DOD Is Not Defining and Measuring How Many Former Nonusers Have Enrolled

DOD also is not collecting the enrollment data needed to identify eligible beneficiaries who enroll in TRICARE but have not previously been users of the military health care system. Identifying beneficiaries attracted to military care by the TRICARE program is crucial to DOD's ability to contain health care costs because, as the Congressional Budget Office estimates, this population accounts for about 25 percent of DOD's 8.3 million beneficiaries. Each of these current nonusers who chooses TRICARE Prime adds to the overall cost of military health care.

Although DOD believes that the impact of such enrollment will be lessened because of the annual enrollment fee and through targeted marketing to current system users, DOD officials told us that TRICARE Prime's generous benefits[9] will entice some nonusers to enroll, and that data on such enrollment are needed. However, DOD has not yet developed a definition that will enable it to identify these enrollees. DOD officials at both the national and regional levels told us that defining the various types of former nonusers, though necessary, is difficult because beneficiaries rely on the military health care system in varying degrees. For example, some beneficiaries have other health insurance but continue to use the military pharmacies. Also, some beneficiaries may begin to use military health care for reasons other than the TRICARE reforms, such as the loss of other health insurance.

Once DOD has a working definition of this population of former nonusers, it can seek to ensure that appropriate data are being captured to identify these beneficiaries. DOD officials told us that the collection of such data should be done through a set of questions consistently administered to enrollees across the regions. By gathering this information, DOD could better evaluate the impact of this enrollment on TRICARE's costs. Ultimately, DOD needs these data to reassess TRICARE's cost-sharing

[9]The Joint Chiefs of Staff endorsed this benefits package as the best option for the beneficiaries. Because all estimates related to the savings of any HMO option contain a degree of uncertainty, they recommended that the fee structure be reviewed in the future. They urged that this review be based upon data rather than conjecture.

structure as it works to contain overall health care costs while maintaining fees for beneficiaries that are neither too high nor too low.

Conclusions

Despite initial beneficiary confusion caused by marketing and education problems, as well as problems with computer systems' compatibility, early implementation of TRICARE is progressing consistent with congressional and DOD goals. However, the success of DOD's current efforts to address the implementation of resource-sharing agreements and utilization management is critical to containing health care costs. DOD also needs to gather certain enrollment and performance data so that it and the Congress can assess TRICARE's success in the future.

Recommendations

We recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs to

- collect data on the timeliness of appointments in order to measure TRICARE's performance in improving beneficiary access against DOD's standards and
- assess the impact of new beneficiaries who would not be using military health care if not for TRICARE, by defining these new users, identifying them, and estimating the cost implications of their use of military health care.

Agency Comments and Our Evaluation

In a letter dated May 15, 1996, commenting on a draft of this report, the Director of TRICARE Operations Policy wrote that DOD fully agreed with the report and with both of our recommendations. Regarding our recommendation concerning DOD's need to collect data on the timeliness of appointments, the Director said that DOD already identifies the time between when an appointment is made and the actual appointment. However, in order to gather access data more precisely and completely, DOD plans to make computer system modifications during fiscal year 1997. The Director also wrote that DOD strongly believes that access data should continue to be collected through surveys of beneficiaries. As stated in the report, we agree that both types of access-to-care information are important. We believe that DOD's plans for collecting access data, if implemented properly, should be sufficient to measure TRICARE's success against DOD's standards.

Regarding our recommendation that DOD assess the cost implications of TRICARE enrollment by beneficiaries who would not otherwise be using military health care, the Director commented that DOD has taken several steps to minimize such enrollments, including designing TRICARE's cost-sharing structure and targeting marketing to current military medical system users. While we agree that cost sharing and enrollment targeting will deter some from enrolling in TRICARE, the program is still attractive to beneficiaries who would not otherwise be using military health care. The Director also said that DOD is enhancing a computer information system that will allow it to track the extent that enrollees have other health insurance, which, in concert with the beneficiary survey data, should help DOD assess the impact of beneficiaries who would not be using military health care if not for TRICARE.

DOD officials also suggested several technical changes to the report that we incorporated as appropriate.

We are sending copies of this report to the Secretary of Defense and will make copies available to others upon request.

Please contact me at (202) 512-7111 or Dan Brier, Assistant Director, at (202) 512-6803 if you or your staff have any questions concerning this report. Other major contributors are Allan Richardson, Evaluator-in-Charge, Bonnie Anderson, Sylvia Jones, and David Lewis.

Stephen P. Backhus
Associate Director, Health Care
Delivery and Quality Issues

Background on TRICARE

TRICARE is intended to ensure a high-quality, consistent health care benefit, preserve choice of health care providers for beneficiaries, improve access to care, and contain health care costs. TRICARE features a triple-option benefit. The first option, TRICARE Standard, mirrors the current fee-for-service CHAMPUS program. The second option is TRICARE Extra, a preferred provider option through which beneficiaries receive a 5-percent discount on the Standard option when they choose among a specified network of providers. The third option, TRICARE Prime, represents the greatest change to defense health care delivery. TRICARE Prime is an HMO alternative and is the only option that requires beneficiaries to enroll.

To implement and administer the TRICARE program, DOD has reorganized the military health care system into 12 new, joint-service regions. DOD created the position of lead agent for each region to coordinate among the three services and the contractor and to monitor the delivery of health care. The lead agent is a designated military medical facility commander supported by a joint-service staff. Table I.1 presents information on the 12 TRICARE regions, including the designated lead agents, the states included in the regional boundaries, and the number of military medical facilities in each region.

Table I.1: Profile of the 12 TRICARE Regions

Region	Lead agent	States in region	Military medical facilities[a]
1—Northeast	National Capital (Bethesda, Walter Reed, and Malcolm Grow Medical Centers)	Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Northern Virginia	10
2—Mid-Atlantic	Portsmouth Naval Hospital	North Carolina and Southern Virginia	7
3—Southeast	Eisenhower Army Medical Center	Georgia, South Carolina, and parts of Florida	12
4—Gulf South	Keesler Air Force Medical Center	Alabama, Mississippi, Tennessee, and parts of Louisiana and Florida	9
5—Heartland	Wright-Patterson Air Force Medical Center	Illinois, Indiana, Kentucky, Michigan, Ohio, West Virginia, and Wisconsin	5
6—Southwest	Wilford Hall Air Force Medical Center	Arkansas, Oklahoma, and parts of Louisiana and Texas	13
7—Desert States	William Beaumont Army Medical Center	Arizona, Nevada, New Mexico, and parts of Texas	8
8—North Central	Evans Army Community Hospital	Colorado, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming, and parts of Idaho	13
9—Region Nine	San Diego Naval Hospital	Southern California	6
10—Golden Gate	David Grant Air Force Medical Center	Northern California	3
11—Northwest	Madigan Army Medical Center	Oregon, Washington, and parts of Idaho	4
12—Hawaii-Pacific	Tripler Army Medical Center	Hawaii	1
Total			**91**

[a]These numbers represent military medical centers and community hospitals. Military outpatient clinics and facilities scheduled for closure are not included.

TRICARE uses contracted civilian health care providers to supplement the care provided by the defense health care system on a regional basis—a significant feature maintained from earlier demonstration programs. The managed care support contractors' responsibilities include developing networks of civilian providers, locating providers for beneficiaries, performing utilization management functions, processing claims, and providing beneficiary support functions. Seven contracts will be awarded to civilian health care companies covering the 12 TRICARE health care regions. Table I.2 describes the status of contract awards and start dates for health care delivery.

Table I.2: TRICARE Implementation Status

Regions	Lead agents	Contract status	Health care delivery start date
Northwest	Madigan	Awarded to Foundation Health Federal Services, Inc., September 1994, for $475 million	March 1995
Region Nine, Golden Gate, and Hawaii-Pacific	San Diego, David Grant, Tripler	Awarded to Foundation Health Federal Services, Inc., September 1995, for $2.5 billion	October 1995[a]
Southwest	Wilford Hall	Awarded to Foundation Health Federal Services, Inc., April 1995, for $1.8 billion	November 1995
Southeast and Gulf South	Eisenhower, Keesler	Awarded to Humana Military Healthcare Services, November 1995, for $3.8 billion	July 1996
Desert States and North Central	William Beaumont, Evans	Award date scheduled for third quarter 1996	February 1997
Northeast	National Capital	Award date scheduled for first quarter 1997	September 1997
Mid-Atlantic and Heartland	Portsmouth, Wright-Patterson	Award date scheduled for first quarter 1997	September 1997

[a]Foundation will not begin delivering care until April 1996 as a result of bid protest decisions. In the interim, all care will be delivered by Aetna, the previous managed care support contractor for the demonstration project in the California-Hawaii regions.

Between the contract award date and the health care delivery start date is a 6- to 8-month transition period for both DOD and the contractor. During this time, the contractor performs tasks such as the establishment of provider networks and beneficiary support functions. Both the contractor and DOD begin some early marketing and education of beneficiaries and providers. Enrollment of all eligible non-active duty beneficiaries begins either during the transition phase or at the start of health care delivery.

Ordering Information

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