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Effects of Mandated Cost Sharing on Uniformed Services Treatment Facilities Likely to Be Minor

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

The Honorable Robert K. Dornan
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Subcommittee on Military Personnel
Committee on National Security
House of Representatives

As required by the National Defense Authorization Act for Fiscal Year 1996 (P.L. 104-106), this report describes the financial and other effects that the Department of Defense's (DOD) new health care benefit and cost-sharing package will likely have on the Uniformed Services Treatment Facilities (USTF).[1] USTFs are former Public Health Service hospitals now under civilian ownership and designated by the Congress in the Military Construction Authorization Act of 1982 (42 U.S.C. 248c) to be part of the Military Health Services System (MHSS). The Congress has periodically renewed this legislative authority, which is now set to expire September 30, 1997. Under the USTF program, the Congress has appropriated nearly $1 billion since fiscal year 1994 for the USTFs to deliver health care to what now totals 124,000 beneficiaries.

DOD's health care benefit and cost-sharing package is an integral part of TRICARE, DOD's nationwide managed health care initiative. Section 726(a) of P.L. 104-106 requires that DOD extend TRICARE cost shares to the USTFs after either October 1, 1996, or the start of TRICARE in the USTF service area, whichever is later. Currently, USTF members pay no enrollment fees and low or no copayments for health services. Appendix I shows the TRICARE cost-sharing provisions and the current USTF cost-sharing requirements. The USTFs contend that the new cost shares will harm them financially. This is because a substantial number of healthy USTF members

[1]"Cost sharing" refers to the requirement that enrollees pay copayments for the care they receive and/or enrollment fees for joining a health plan.

may disenroll to seek less costly coverage, leaving the USTFs at risk from their less healthy members' higher care costs—an outcome known as adverse selection. Accordingly, P.L. 104-106 provides that the USTFs could submit to us, within 30 days of its enactment, evidence on the likely financial effects of the new cost shares. The act further requires that if the USTFs submitted such evidence, we review whether the cost shares will (1) cause adverse selection of USTF members; (2) be inappropriate for a fully at-risk managed care facility; and (3) result in a USTF member population different from DOD's general population. In March 1996, the USTFs submitted a report to us detailing their position.[2]

To do our work, we contracted with the Hay Group for actuarial assistance. In reviewing the USTFs' actuarial estimates, we examined various supporting documents, including adverse selection literature; records from a telephone survey of USTF members asking whether members would disenroll because of the new cost shares and instead use TRICARE Standard;[3] and the health care costs of surveyed members. We also interviewed the USTFs' actuary (Milliman & Robertson, Inc.), the USTF market research firm (Market Street Research, Inc.), and USTF and DOD representatives in Washington, D.C. We did our work from February 17 through May 9, 1996, in accordance with generally accepted government auditing standards.

Results in Brief

While the new cost-sharing arrangement mandated under TRICARE may cause some adverse selection, it will have no lasting negative financial effects on the USTFs. We estimate that less than 10 percent of the USTFs' current members will disenroll and USTF costs will increase by less than 2 percent of their current reimbursement levels. DOD's reimbursement approach, however, automatically adjusts USTFs' capitation payments for higher USTF costs due to enrollee age and gender. It also allows for negotiated adjustments in reimbursement rates for the effects of benefit and cost-sharing revisions, which may result in adverse selection.

In contrast, the USTFs estimated in their March 1996 report to us that the cost shares will cause about a 40-percent USTF disenrollment rate and cost increases of about 11 percent over current reimbursement levels. We found weaknesses in the USTFs' data gathering and health claims analysis,

[2]Stanley A. Roberts and Robert G. Cosway, Impact on Uniformed Services Treatment Facilities of the Implementation of the TRICARE Uniform HMO Benefit Cost Shares Provisions (Seattle, Wash.: Milliman & Robertson, Inc., 1996).

[3]Under TRICARE, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is renamed TRICARE Standard.

however, that tend to overstate the disenrollment estimate and reduce the results' reliability. Also, according to actuarial research, a major disenrollment incentive is a high out-of-pocket cost difference between an individual's current health plan and competing plans. But such differences between the USTFs' new cost shares and TRICARE Standard's out-of-pocket costs (a maximum of $460 per year less under TRICARE Standard) are not likely to be great enough to cause disenrollment in excess of 10 percent. Further, in estimating an 11-percent cost increase, the USTFs included all large claims incurred in the prior year. Actuarial research shows, however, that individuals who incur a large claim in one year will not necessarily do so the following year because large claims may be for one-time high-cost events. Moreover, our analysis showed that these estimates are greatly influenced by just a few large claims.

Contrary to the USTFs' contention, the new cost shares are appropriate for the risks to be borne by the USTFs. Although the cost shares could create some problems for a managed care plan not able to adjust its capitation, any USTF loss attributable to age and gender would be covered through automatic capitation adjustments. Any costs attributable to revisions of the benefit and cost-sharing provisions are negotiable between DOD and the USTFs. DOD has recently reiterated this position in its discussions with us and the USTFs. As a result, the new cost shares are not expected to create a financial burden on the USTFs. Furthermore, the new cost-sharing structure is similar to that of health maintenance organization (HMO) plans in the Federal Employees Health Benefits Program (FEHBP), although with lower out-of-pocket costs. Compared with the 1996 FEHBP HMO plan costs in USTF regions, for example, the TRICARE enrollment fee for family coverage is from $614 to $6,975 less per year than FEHBP's HMO plan premiums.

Finally, the USTFs believe that adoption of the new cost shares will result in their enrolling an older, perhaps less healthy beneficiary population than is enrolled under TRICARE. This, in their opinion, will increase USTF costs. The USTF and DOD beneficiary populations, however, are already different in that the USTFs serve proportionately more retirees and their dependents than exist in the DOD populations in their regions. At issue, therefore, is to what degree this difference is expected to change as a result of the USTFs' new cost shares. Adopting the cost shares may make the USTF population more like DOD's general population by reducing the number of USTF retirees and their dependents under age 65.

Background

DOD offers medical services to 8.3 million eligible people through the MHSS—1.7 million active duty members[4] and another 6.6 million non-active duty members, such as dependents of active duty personnel and military retirees and their dependents. The bulk of the health care is provided at more than 600 military hospitals and clinics worldwide; through CHAMPUS; and, to a comparatively minor extent, at USTFs.[5]

The USTF managed care program involves the formation of provider networks to deliver a full spectrum of inpatient and outpatient care and preventive services; beneficiary enrollment; and a monthly capitated reimbursement system. DOD's capitation payment rates cover all the medical care a member would need in a year. Subject to annual appropriations, USTFs are permitted to enroll any person eligible for MHSS benefits except for active duty members, who receive their care at military hospitals and clinics. But unlike those under CHAMPUS, USTF members do not lose their participation rights when they reach age 65 and become eligible for Medicare. At the beginning of fiscal year 1996, the USTFs had 124,012 members, including about 27,000 Medicare-eligibles, and an appropriated funding level of $339 million (see table 1).

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

[5]DOD administers CHAMPUS, an insurance-like program that pays for a portion of the care military families and retirees receive from private sector health care providers. Military retirees and their dependents who are covered under Medicare are also eligible for care at military medical facilities on a space-available basis but are not eligible for CHAMPUS.

Table 1: USTF Enrollment and Program Budget, FY 1996

Dollars in Millions

Facility name	Location	Members enrolled	Share of program
Bayley Seton Hospital	Staten Island, N.Y	15,772	$53.2
Brighton Marine Public Health Care Center	Boston, Mass.	11,892	40.0
Johns Hopkins Medical Services Corporation	Baltimore, Md.	23,881	57.0
Lutheran Medical Center	Cleveland, Ohio	6,570	13.9
Martin's Point Health Care Center	Portland, Me.	18,795	41.3
Pacific Medical Center and Clinics	Seattle, Wash.	20,048	58.8
Sisters of Charity Hospitals[a]	Texas	27,054	75.0
Total		**124,012**	**$339.3**[b]

Note: See app. II for annual USTF funding and enrollment since fiscal year 1994.

[a]Sisters of Charity Hospitals operates three USTF facilities in Texas (St. John's Hospital, Nassau Bay; St. Joseph's Hospital, Houston; and St. Mary's Hospital, Port Arthur). Sisters of Charity recently sold its fourth USTF facility, St. Mary's Hospital, Galveston, to the University of Texas Medical Branch, which is no longer a USTF.

[b]In addition to DOD's covered beneficiaries, this appropriation includes $24.3 million for the Department of Transportation's Coast Guard beneficiaries and the Department of Health and Human Services' Commissioned Corps beneficiaries of the Public Health Service and the National Oceanic and Atmospheric Administration.

By September 1997, DOD plans to complete its implementation of TRICARE—a nationwide managed care program. TRICARE is aimed at improving access to high-quality care while containing costs. TRICARE involves coordinating and managing beneficiary care on a regional basis using all available military hospitals and clinics supplemented by competitively contracted civilian services. TRICARE offers beneficiaries three plans: (1) TRICARE Standard, a fee-for-service arrangement to replace the present CHAMPUS program; (2) TRICARE Extra, a preferred provider plan; and (3) TRICARE Prime, an HMO that provides comprehensive medical care to beneficiaries through an integrated network of military and contracted civilian providers. (App. I compares the cost-sharing provisions of the three TRICARE plans.)

As required by P.L. 104-106, DOD is to develop a plan to integrate the USTFs into TRICARE. We will soon report on several issues regarding the USTFs' integration into TRICARE, including whether the USTFs should retain their special, noncompetitive relationship with DOD. The managed care support

contractors under TRICARE compete on a cost-effectiveness basis rather than through a noncompetitive negotiation of rates as is done with the USTFs.

Potential Adverse Selection Effects Will Likely Be Minor and Offset by Capitation Adjustments

Our analysis of the potential effects on the USTFs of adopting the TRICARE cost shares showed that less than 10 percent of the members will disenroll, causing less than a 2-percent increase in operating costs. But DOD's reimbursement approach takes into account and otherwise adjusts the USTFs' capitation payments for higher costs that may result from changes in the population's age and gender. It also allows for negotiated adjustments in reimbursement rates for the effects of benefit and cost-sharing revisions, which may result in adverse selection.

In contrast, the USTFs estimated that the new cost shares will cause about a 40-percent USTF disenrollment rate and cost increases of about 11 percent. However, the USTFs' estimates are overstated because of weaknesses in their survey and health claims data, and the absence of out-of-pocket cost differences among the key plans that are significant enough to cause disenrollment of more than 10 percent.

Survey and Claims Data Weaknesses Reduce Reliability of USTFs' Estimates

The USTFs' estimates of the effects of the new cost shares were based largely on the results of a telephone survey of USTF households and an analysis of health claims data. In February 1996, the USTFs conducted a survey of 2,100 member households (300 from each USTF) to determine whether, with the new cost shares, members would disenroll and choose TRICARE Standard.[6] Retirees under age 65 and their households were surveyed because only this group—not the Medicare-eligible or active duty dependent members—will be subject to the new enrollment fee.[7] Also, USTF health claims data for the surveyed households covering the 12 months ending September 30, 1995, were analyzed to determine the costs for members who said they would remain and those who would disenroll.

Our review of the USTFs' survey approach and data analysis raised several concerns about the reliability of their estimates. First, the survey questions focused solely on the households' out-of-pocket cost increases and did not

[6]Because TRICARE is currently available at the Pacific Medical USTF in Seattle, members there were asked whether they would leave the USTF and choose TRICARE Prime, TRICARE Extra, or TRICARE Standard.

[7]DOD has exempted active duty families and eligible USTF members who are paying Medicare part B premiums from paying TRICARE's annual enrollment fee.

probe respondents' views about the quality of or access to care at the USTF versus other options available to them. (See app. III for the questionnaires used in the USTF survey.) Since households may base their health plan decisions on factors other than out-of-pocket costs, such as access and quality, questions on these other factors would have added needed perspective to the survey responses. Second, the wording of several questions could have misled respondents and produced incorrect responses. For example, one question asked: "If you have to choose between CHAMPUS [or TRICARE Standard, TRICARE Extra, or TRICARE Prime at the Pacific Medical USTF] and the [subject] USTF with higher copays and enrollment fees for your household in the future, which would you select?" The question's phrasing could have led respondents to believe that with the new cost shares the USTFs will have higher copayments than the other choices. This is not the case.

Furthermore, survey choices were categorized as "would stay," "would leave and choose TRICARE Standard," "neither, or would choose different plan," and "don't know." To reduce the number of "don't know" responses, interviewers were instructed to probe respondents and try to force them to make a decision. One probe was "We're not asking you to make a firm commitment right now, but we are interested in knowing which one you would be most likely to choose on the basis of the information I just read to you." Because interviewers tried to force respondents to change "don't know" answers, the responses in these cases may not reliably predict the respondent's answer. Finally, the average length of time individuals took to respond to the survey was about 4 minutes. This short period probably did not allow most individuals to weigh and respond thoughtfully about the medical plan they would choose.

When analyzing cost differences among respondents, the USTF actuaries combined the "don't know" responses with the group who responded they would disenroll. This caused an overstatement of the number of respondents the USTFs estimated will leave. Also, in analyzing potential cost differences, the USTF actuaries did not verify the claims data the USTFs reported. In addition, four of the USTFs provided incomplete data for the surveyed households. They provided less than 12 months of claims data and/or omitted such services as outpatient prescription drugs and care provided under subcontract with non-USTF providers. For Bayley Seton and Johns Hopkins, 172 and 106, respectively, of the 300 surveyed households for each facility were dropped because no claims data were available for these households. Furthermore, the USTF report stated that the USTFs had to perform some adjustments to produce theoretical billed charges. In

effect, a percentage of the claims costs the USTFs provided is incomplete, or estimated; thus, such data cannot be validated and are of questionable use for estimating the potential cost effects of adverse selection.

USTFs Overestimated Disenrollment Resulting From Adverse Selection

According to actuarial research, any time a health plan increases a member's out-of-pocket costs relative to competing plan choices, some adverse selection can occur. But for the USTFs to experience the 40-percent disenrollment rate they estimated, the cost differences would have to be significantly higher than what would exist between the USTFs' new cost shares and TRICARE Standard. As table 2 shows, the USTF households that face the greatest out-of-pocket increase—$460—relative to TRICARE Standard are those incurring no medical expenditures. Most USTF households, or those incurring some medical expenditures, will have even lower relative cost differences. According to actuarial experience, such relative cost difference levels will not result in major enrollment shifts. Moreover, a Congressional Research Service study of the 1987 FEHBP open season found that out-of-pocket cost differences among plans had to be at least $1,000—$2,000 in 1996 dollars—to result in more than a 10-percent plan disenrollment rate.[8] But as table 2 shows, no USTF household will reach an out-of-pocket cost difference that high when compared with TRICARE Standard.

[8]Congressional Research Service, Federal Employees Health Benefits Team, The Federal Employees Health Benefits Program and Possible Strategies for Reform, House Committee Print 101-5 (Washington, D.C.: House Committee on Post Office and Civil Service, Subcommittee on Compensation and Employee Benefits, 1989).

Table 2: Comparison of Household Out-Of-Pocket Costs Under the USTFs' New Cost Shares and TRICARE Standard

	Out-of-pocket costs		
Annual medical costs	USTFs' new cost shares	TRICARE Standard	Difference
0	$460[a]	0	$460
$400	520	$325	195
600	550	375	175
800	580	425	155
1,000	610	475	135
5,000	890	1,475	(585)
10,000	1,140	2,725	(1,585)
15,000	1,390	3,975	(2,585)
25,000	1,890	6,475	(4,585)
30,000	2,140	7,500[b]	(5,360)
50,000	3,000[b]	7,500	(4,500)

[a]The annual enrollment fee.

[b]The catastrophic limit to out-of-pocket costs.

The disenrollment rate that will likely result from the USTFs' adopting the new cost shares will be less than 10 percent. But to be actuarially conservative, we allowed for a 20-percent outcome and reestimated the USTFs' disenrollment and cost increases. Table 3 shows the comparative results of these adjustments.

Table 3: Estimated Cost Increases With 20- and 40-Percent Disenrollment Rates

	Staying		Disenrolling		Total respondents
	At 40%	At 20%	At 40%	At 20%	
Number of respondents	1,095	1,456	721	360	1,816
Monthly claims cost	$206.51	$193.51	$155.31	$155.31	$185.78
Estimated cost increase[a]	11%	4%			

[a]Derived by subtracting the total respondents' monthly claims cost from the claims cost of those respondents who would remain in USTF, and dividing this increase by the total respondents' cost.

As shown, the 20-percent disenrollment estimate reduces the USTFs' estimated 11-percent cost increase to 4 percent. Reductions in the USTFs' estimated cost increases are greater for the USTFs that may experience the most adverse selection, such as Pacific Medical. (App. IV provides a breakdown on the effects for each USTF.)

Also, although active duty and Medicare-eligible family members are not subject to the new enrollment fee, the USTFs estimated that some of these family members will also disenroll. The USTFs estimated up to 5-percent cost increases for each group as a result of adverse selection. We found, however, that there would be negligible or no adverse selection of such members and thus no cost increase would occur with the new cost shares. Family members of active duty personnel would incur the same out-of-pocket costs at the USTFs as elsewhere in the TRICARE system and thus would not have a relative cost difference incentive to disenroll.[9] Medicare-eligible family members would incur the same costs but have better benefits and better access to care at the USTFs than in TRICARE. We believe, moreover, that individuals from these two categories would replace those retirees under age 65 and their dependents who disenroll because of adverse selection.

Estimating the USTFs' Next-Year Costs With Last Year's Claims Distorts Results

In estimating an 11-percent cost increase resulting from the new cost shares, the USTFs assumed that each affected member would have the same claims costs in the year after adverse selection occurred as they had in the year before. Also, they concluded that members with the most costly claims would be most likely to stay with the USTF, and new enrollees would have the same claims costs as those respondents who said they would stay. According to actuarial research, however, individuals that incur a large claim in one year will not necessarily do so the following year. This is because large claims may be for one-time high-cost events. A recent study of year-to-year health care expenditures for a large manufacturing firm showed that most large claims incurred in a given year are from individuals incurring much lower claims the prior year.[10] Conversely, most of the future large claims will come from individuals with low claims in the current year. According to the USTFs' estimates of adverse selection, members with the least costly claims will be most likely to disenroll.

Also, in any given year, a small number of enrollees will have large claims. If enrollees could predict such claims—and some can—when faced with choosing between competing plans, they would join the plan most cost-beneficial to them (the USTFs, in this case). According to actuarial research, however, many such claims cannot be predicted, so many of the USTF members with high claims in the year after adverse selection would

[9]Any care provided in a military hospital or clinic does not require a copayment.

[10]Matthew Eichner, Mark McClellan, and David Wise, Insurance or Self-Insurance?: Variation, Persistence, and Individual Health Accounts (Cambridge, Mass.: National Bureau of Economic Research, 1995).

have had no reason to have selected the USTF plan before adverse selection occurred.

To illustrate the sensitivity of the USTF analysis to the inclusion of all high-cost claims, we recomputed the USTFs' cost estimates by removing the two largest claimants from each facility. The largest claimants' costs ranged from about $49,000 to $337,000. The comparative results are shown in table 4.

Table 4: Estimated Cost Increases With and Without the Two Largest Claimants

	Estimated cost increase[a]	Respondents staying		Total respondents	
		Number	Monthly claims cost	Number	Monthly claims cost
Including all claimants	11%	1,095	$206.51	1,816	$185.78
Excluding two largest claimants at each facility	4%	1,084	$157.31	1,802	$151.75

[a]Derived by subtracting the total respondents' monthly claims cost from that of the respondents who stay, and dividing this increase by the total respondents' cost.

As shown, removing such high claims costs from the USTFs' estimating base reduces their 11-percent cost increase estimate to 4 percent.[11] Coincidentally, this is the same effect produced by reducing their estimated disenrollment rate from 40 percent to our conservatively applied 20 percent rate. Because less than 1 percent of the surveyed households had high claims that accounted for almost 20 percent of the total claims costs, including or removing such claimants from the estimating base significantly affects the estimating outcome. Moreover, on the basis of the actuarial assumption that individuals who have large cost claims in one year are likely to have lower claims the following year, the USTFs' 11-percent cost increase estimate appears to be unnecessarily high.

Finally, actuarial studies focusing on adverse selection and ways to predict the effects of beneficiary choice have concluded that future-year costs resulting from adverse selection cannot be accurately predicted by any set of known characteristics and circumstances from past years.[12] According to actuarial research, the most reliable way to gauge the effects of adverse

[11]Another approach would be to assume such large claims were randomly distributed between respondents saying they would stay and those who would disenroll, but the cost-increase effect also would approximate 4 percent.

[12]Daniel Dunn and others, A Comparative Analysis of Methods of Health Risk Assessment—Final Report (Schaumburg, Ill.: Society of Actuaries, 1995).

selection is to examine actual experience under the benefit change in question.

Capitation Adjustments Will Likely Offset USTF Cost Increases

Our adjustments to the USTFs' estimated 11-percent cost increase covering the adverse selection for retirees and their dependents under 65 years old resulted in a reduced estimate of 4 percent. Using the 4-percent cost increase, we estimated that the weighted average cost effect of adverse selection for the USTFs in 1996 would be less than 2 percent of their 1996 reimbursement level, or about $5.5 million dollars.

This estimated increase, however, will likely have no lasting negative financial impact on USTFs because DOD's current reimbursement approach automatically adjusts USTF payments to account for changes in members' age and gender. For example, our analysis of the survey data available for Johns Hopkins beneficiaries[13] who had a claims history shows that the facility may gain financially from adverse selction. The Johns Hopkins data indicate that respondents who said they would stay there are, on average, 1.7 years older than all respondents. Because USTF capitation rates generally increase as the members age, some of the older remaining members would cause substantial payment increases as they move to higher capitation bands. For example, DOD pays the Johns Hopkins USTF $885 more per year for a 55-year-old male than a 54-year-old male. For females, the difference between 55- and 54-year-olds is $483 per year (see DOD's capitation bands by age and gender category in app. V). Thus, if its remaining members' average age increases by 1.7 years, we estimate that capitation payments would automatically rise by 4.9 percent. The higher revenue would exceed the USTFs' 4-percent estimate of Johns Hopkins' cost increase resulting from adverse selection.[14]

DOD's current reimbursement approach also allows for negotiated adjustments in reimbursement rates for the effects of benefit and cost-sharing revisions, which may result in adverse selection. DOD's current USTF capitation rates were set through intensive negotiations with each

[13]Other than limiting its study to households with members aged 45 to 64, Milliman did not request age data or include an analysis of the claims by age. However, we received such data on files provided to us by Market Street Research, which conducted the telephone survey.

[14]The average age of USTF respondents with a claims history electing to stay at Johns Hopkins is 54.53 years compared with 52.82 years for the entire Johns Hopkins population surveyed. The average increase in capitation between the 25-to-34 age group ($1,047, the mid-point at age 30) and the 55-to-64 age group ($2,495, the mid-point at age 60) is 2.9 percent. The total increase over the 30-year period (age 30 to age 60) is 138 percent (the annual rate of 2.9 percent compounded: $1.029^{30} = 2.38$). As a result, the capitation increase resulting from a 1.7-year age increase would be 4.9 percent (1.7 years x 2.9 percent per year).

USTF, and the process for periodically adjusting them is set forth in their participation agreements with DOD.[15]

TRICARE Cost Shares Are Appropriate for the USTFs

The TRICARE cost shares are appropriate for the risks to be borne by the USTFs. The cost shares would create some problems for a managed care plan unable to adjust its capitation. But any initial USTF loss would be covered through automatic capitation adjustments based on members' age and gender, and later losses could be offset by future negotiated capitation adjustments. As a result, the TRICARE cost shares will not create a financial burden on the USTFs.

Furthermore, the TRICARE cost sharing is similar to HMO plans in the FEHBP. However, the new $230 to $460 USTF enrollment fees are lower than the employee shares of the typical private sector HMO and signficantly less than those in the FEHBP (see table 5).

[15]We did not evaluate DOD's current capitation rates to determine their actuarial soundness.

Table 5: Comparison of USTFs' New Enrollment Fee With Enrollee Premiums for FEHBP and Other Private Sector HMOs

Plan type	Enrollee cost	Cost difference with USTF
USTF enrollment fee		
Single	$230	
Family	460	
Typical private sector HMO premium in 1995[a]		
Single	237	$7
Family	804	344
1996 premiums for FEHBP HMOs with largest enrollment in a USTF location[b]		
GHI Health Plan (Bayley Seton USTF)		
Single	722	492
Family	1,917	1,457
Harvard CHP (Brighton Marine USTF)		
Single	812	582
Family	2,958	2,498
Kaiser (Johns Hopkins USTF)		
Single	451	221
Family	1,136	676
HMP/Ohio (Lutheran Medical USTF)		
Single	640	410
Family	1,941	1,481
HMO Maine (Martin's Point USTF)		
Single	2,875	2,645
Family	7,435	6,975
Group Health (Pacific Medical USTF)		
Single	464	234
Family	1,074	614
Humana (Sisters of Charity USTF)		
Single	440	210
Family	1,131	671

[a]Source: The Hay Group, Hay/Huggins Benefits Report: Prevalence of Benefits Practices and Executive Summary, Vol. 1 (Philadelphia: Hay/Huggins Company, 1995).

[b]The FEHBP HMOs with the largest enrollments in 1994.

Cost Sharing Could Make USTF and DOD Populations More Alike

The USTFs believe that adoption of the new cost shares will result in their enrolling an older, perhaps less healthy beneficiary population than is enrolled under TRICARE. This in their opinion will increase USTF costs. The USTF and DOD beneficiary populations are already dissimilar. The USTFs serve proportionately more retirees and their dependents. At issue, therefore, is to what degree this dissimilarity is likely to change as a result of the USTFs' new cost shares. In 1994, the USTF population consisted of a larger proportion of retirees and dependents under age 65 than the DOD populations in the USTF regions. This disparity grew during the 1996 USTF enrollment period, as shown in table 6.

Table 6: Comparison of USTF and DOD Beneficiary Populations Within a 60-Mile Radius of the USTF, FY 1994 and 1996

Numbers in percent

	FY 1994		FY 1996	
Enrollee group	USTF enrollees	DOD population in USTF regions	USTF enrollees	DOD population in USTF regions
Active duty dependents	20	37	18	36
Retirees and non-active duty dependents under age 65	55	47	59	47
Retirees and non-active duty dependents aged 65 and over	25	16	22	18

Note: The percentages for each beneficiary group may not add to 100 because of rounding.

Thus, the USTF population, already dissimilar to the DOD population, is becoming more so. But with the new USTF cost shares, the USTF population will actually move closer to the general DOD population as the healthy retirees under age 65 seek less costly medical coverage. Further, those who disenroll will likely be replaced by new enrollees who are dependents of active duty personnel or Medicare-eligible retirees and their families over age 64. But no matter how dissimilar the populations are, DOD's reimbursement approach will account for USTF population changes and offset any resulting negative financial effect.

Conclusions

The establishment of uniform benefits and cost sharing for DOD beneficiaries is a key component of the TRICARE program and something that we and others have long advocated. Such uniformity would, in our view, eliminate inequities and confusion that now exist among beneficiaries of military health plans. While adopting the TRICARE cost shares may cause some minor adverse selection for the USTFs, our analysis

indicates that there will be no lasting negative financial effect on USTF operations. Further, the new cost shares, which are similar to HMOs, are appropriate for the risks to be borne by the USTFs and will likely make the USTF population more similar to DOD's general beneficiary population. More importantly, should there be a financial impact, DOD's current USTF capitation methodology takes into account and allows for adjusted reimbursement levels for such higher costs that result from changes in the enrollee cost shares and population characteristics.

Comments From DOD and the USTFs and Our Evaluation

We received comments on a draft of the report from DOD's Principal Deputy Assistant Secretary for Health Affairs and other DOD officials, and on the USTFs' behalf from officials of the Seattle and Texas facilities.

DOD officials stated that they agreed with the report's analysis and findings. They pointed out, however, that the draft report's language discussing DOD's reimbursement approach should clearly set forth that the capitation rates make automatic age and gender adjustments and also allow for negotiated rate adjustments to cover the possible adverse selection effects of benefit/cost-sharing revisions. We clarified the report's language on this matter and incorporated the officials' other suggested technical report changes as appropriate.

USTF officials also took issue with the report's discussion of factors for which the capitation rates automatically adjust. They stated that there is no provision in their participation agreements with DOD that allows for negotiated capitation rate adjustments for possible adverse selection due to cost-sharing changes. The officials stated that, while the agreements allow for negotiated rate changes due to benefit revisions, the USTFs do not consider the new cost shares to be benefit changes—although they stated they have not consulted DOD on the matter. We believe that because the new cost shares represent a change in the health care package offered to USTF beneficiaries and materially affect the actuarial value or cost of the package, the new cost shares constitute a benefit change. Also, as pointed out, DOD considers the effects of such changes to be subject to negotiated capitation rate adjustments.

USTF officials stated that, contrary to our assertion that the USTFs' survey should have included questions on quality and access along with the questions on higher cost shares, such additional questions were not relevant. They stated that their annual member surveys repeatedly show high member satisfaction with the USTFs, tending to affirm their historic

2-percent disenrollment rate. Adding questions on quality and access would have, in our view, added perspective for more fully understanding why survey respondents gave the answers they did. Moreover, the high levels of member satisfaction referred to by the USTF officials tend to raise further questions as to whether members would disenroll at the USTFs' estimated 40 percent rate.

The USTF officials stated that our removing the two highest claimants per USTF from their database and reestimating the potential cost increase is incorrect. They stated that there will be high claims in each year—or new enrollees with high claims—so that removing the two highest claimants would not reflect the USTFs' actual costs. Also, the officials stated that while it is true that a member with high claims in one year will not necessarily have such claims the next year because the member may have died, the costs should be included in the estimating base to have a true picture of the total costs.

We disagree. The USTFs' cost-effect estimates assume that all claims, including the high claims, for all members whether they said they would stay or leave will be the same in the year after the choice as before the choice. According to actuarial research, however, many of the high claims in one year will not be for the same individuals as in the prior year, which, for example, as the USTFs point out, would occur if the member died.

To illustrate the major impact that a few respondents with high claims costs had on the USTFs' estimated cost increases, we removed the two largest claimants in each USTF. We agree that the USTFs will have some high claims each year. But the level of cost increase the USTFs estimated as a result of adverse selection will depend on the same members (with the highest claims in the year before the choice) staying and having the same high claims in the year after the choice. The USTFs' assumption is actuarially questionable and greatly overstates the adverse selection effect. Even if we had included the two highest claimants per USTF in our illustration, but distributed them randomly among those who stay and those who leave, the net adverse selection effect would have only been approximately 4 percent.

USTF officials also said we were incorrect in basing the estimated cost increase due to adverse selection on their total reimbursement. They said it should be based only on reimbursement for the segment of the USTF members most affected by adverse selection—the retirees and their dependents under age 65.

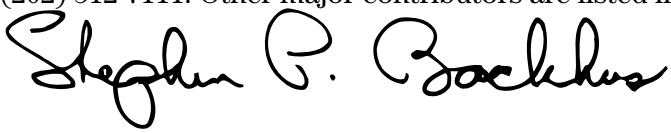
We disagree. One purpose of our evaluation was to determine if the new cost shares would be inappropriate for fully at-risk managed care facilities. To do so, it is necessary to consider the financial impact of adverse selection on the facilities' total income—in this case, DOD's total capitation payments for all USTF members. Also, since the active duty dependents and retirees and their dependents aged 65 and over will not pay any enrollment fee, the impact of adverse selection on these two groups would be negligible. Thus, in our view it is appropriate to compare the potential adverse selection cost increase for the retirees and dependents under age 65 ($5.5 million) to the total income of the USTF facilities ($323.5 million) in determining the 1.7-percent increase in financial risk to the facilities.

Finally, the USTF officials stated that their members cannot be compared to FEHBP or private plan enrollees; that their members are used to and believe they are entitled to free care such that the enrollment fees would be strongly resisted; and that our use of a 20-percent disenrollment rate is not substantiated nor valid.

We disagree. Fewer than 10 percent of the USTFs' members would disenroll, but to be actuarially conservative, we used a 20-percent rate to estimate the cost shares' effects. We based our approach on actuarial research and experience with a wide range of private and public health plans. As the report states, there is very little disenrollment as a result of relative increases in out-of-pocket differences of $460 or less per family. While plans do vary widely in structure and demographics, the relative effect of changes in out-of-pocket costs on choice is similar, and one set of plans can safely be used to predict the results in another set. Also, neither the USTF officials nor their report cited any evidence or studies that showed that disenrollment had been higher than 10 percent for similar out-of-pocket changes in any other plan.

We will send copies of this report to the Secretaries of Defense, Health and Human Services, Transportation, and Commerce; and the USTFs. We will make copies available to others upon request.

If you have any questions about this report, please call me on (202) 512-7111. Other major contributors are listed in appendix VI.



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

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Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
HMO	health maintenance organization
MHSS	Military Health Services System
USTF	Uniformed Services Treatment Facility

Cost-Sharing Provisions in TRICARE and USTF Plans

Table I.1: TRICARE Prime, Extra, and Standard Benefits

	TRICARE Prime		
Benefits	**Active duty family members, ranks E1-E4**	**Active duty family members, ranks E5 and above**	**Retirees and retiree family members[a]**
Enrollment fee	$0	$0	$230(S), $460(F)
Deductible	$0	$0	$0
Inpatient hospitalization	$11/day, $25 min.	$11/day, $25 min.	$11/day, $25 min.
Inpatient physician	$0	$0	$0
Outpatient surgery—hospital	$25	$25	$25
Emergency room	$10	$30	$30
Ambulance	$10	$15	$20
Physician office	$6	$12	$12
Outpatient surgery—office	$6	$12	$12
Inpatient psychiatric	$20/day, $25 min.	$20/day, $25 min.	$40/day
Outpatient psychiatric	$10 individual, $6 group	$20 individual, $12 group	$25 individual, $17 group
Prescription drugs	$5	$5	$9
Vision exams	$6	$12	$12
Durable medical equipment	10%	15%	20%
Catastrophic limits (single or family)	$1,000	$1,000	$3,000

TRICARE Extra			TRICARE Standard		
Active duty family members, ranks E1-E4	Active duty family members, ranks E5 and above	Retirees and retiree family members[a]	Active duty family members, ranks E1-E4	Active duty family members, ranks E5 and above	Retirees and retiree family members[a]
$0	$0	$0	$0	$0	$0
$50(S), $100(F)	$150(S), $300(F)	$150(S), $300(F)	$50(S), $100(F)	$150(S), $300(F)	$150(S), $300(F)
$10.50/day, $25 min.	$10.50/day, $25 min.	The lesser of $250/day or 25% institution charges	$10.50/day, $25 min.	$10.50/day, $25 min.	The lesser of $330/day or 25% institution charges
$0	$0	20%	$0	$0	25%
$25	$25	20%	$25	$25	25%
15%	15%	20%	20%	20%	25%
15%	15%	20%	20%	20%	25%
15%	15%	20%	20%	20%	25%
15%	15%	20%	20%	20%	25%
The greater of $25/admission or $20/day	The greater of $25/admission or $20/day	20% institution charges + 20% prof. fees	The greater of $25/admission or $20/day	The greater of $25/admission or $20/day	25% institution charges + 25% prof. fees
15%	15%	20%	20%	20%	25%
15%, no deductible	15%, no deductible	20%, no deductible	20% after deductible	20% after deductible	25% after deductible
15%	15%	20%	20%	20%	25%
15%	15%	20%	20%	20%	25%
$1,000	$1,000	$7,500	$1,000	$1,000	$7,500

Notes: For TRICARE Prime, any care provided in a military hospital or clinic does not require a copayment. Some beneficiaries are required to pay a subsistance allowance.

(S) = single; (F) = family.

[a]Retirees must be under 65 years old to be eligible for TRICARE.

Source: DOD.

Table I.2: Comparison of USTFs' Current and New Cost-Sharing Provisions

	Current cost shares				New cost shares			
Category	Active duty family members, ranks E1-E4	Active duty family members, ranks E5 and above	Retirees	Retiree family members	Active duty family members, ranks E1-E4	Active duty family members, ranks E5 and above	Retirees[a]	Retiree family members[a]
Enrollment fee	$0	$0	$0	$0	$0	$0	$230(S), $460(F)	$230(S), $460(F)
Deductible	$0	$0	$0	$0	$0	$0	$0	$0
Inpatient hospitalization (includes physicians)	$0	$25/ admission	$25/ admission	$25/ admission	$11/day, $25 min.	$11/day, $25 min.	$11/day, $25 min.	$11/day, $25 min.
Outpatient surgery—hospital	$0	$25	$0	$25	$25	$25	$25	$25
Emergency room	$0	$25	$0	$25	$10	$30	$30	$30
Ambulance	$0	$0	$0	$0	$10	$15	$20	$20
Physician office	$0	$5	$0	$5	$6	$12	$12	$12
Outpatient surgery—office	$0	$25	$0	$25	$6	$12	$12	$12
Inpatient psychiatric	$0	$50/ admission	$50/ admission	$50/ admission	$20/day, $25 min.	$20/day, $25 min.	$40/day	$40/day
Outpatient psychiatric	$0	$10	$0	$10	$10/$6 group	$20/$12 group	$25/$17 group	$25/$17 group
Prescription drugs	$0	$5	$0	$5	$5	$5	$9	$9
Vision exams	$0	$10	$0	$10	$6	$12	$12	$12
Durable medical equipment	$0	10%	$0	10%	10%	15%	20%	20%
Catastrophic limit (single or family)	Not applicable	Not applicable	Not applicable	Not applicable	$1,000	$1,000	$3,000	$3,000

Note: (S) = single; (F) = family.

[a]Retirees aged 65 and older who are paying Medicare part B premiums do not have to pay an enrollment fee.

USTF Funding and Enrollment, FY 1994-96

Table II.1: Allocation of USTF Managed Care Program Budget

USTF	FY 1994	FY 1995	FY 1996
Bayley Seton	$29,695,800	$45,600,000	$53,236,085
Brighton Marine	36,776,800	38,700,000	40,010,161
Johns Hopkins	45,290,300	52,000,000	57,020,329
Lutheran Medical	15,641,000	14,400,000	13,915,480
Martin's Point	42,300,500	39,200,000	41,340,896
Pacific Medical	49,539,600	59,000,000	58,802,354
Sisters of Charity	75,756,000	72,100,000	75,022,395
Total	**$295,000,000**	**$321,000,000**	**$339,347,700**

Note: Data include appropriations for the Army, Navy, Marine Corps, Air Force, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration. This table lists the budget ceiling DOD has established for each USTF program on the basis of the total USTF appropriation.

Source: DOD.

Table II.2: USTF Managed Care Program Enrollment, FY 1994-96

USTF	FY 1994	FY 1995	FY 1996
Bayley Seton	8,574	13,858	15,772
Brighton Marine	10,290	11,411	11,892
Johns Hopkins	16,832	21,847	23,881
Lutheran Medical	3,878	6,001	6,570
Martin's Point	14,334	18,047	18,795
Pacific Medical	16,064	20,439	20,048
Sisters of Charity	24,720	26,903	27,054
Total	**94,692**	**118,506**	**124,012**

Source: DOD.

Questionnaires Used to Survey Member Reactions to Proposed Cost Shares

APPENDIX A: QUESTIONNAIRE FOR SIX USTFS

Hello, my name is ____ and I'm with Market Street Research in Northampton, Massachusetts. We are conducting a short survey of people who are enrolled in the Uniformed Services Family Health Plan through SITE$. The survey takes less than five minutes.

For the purposes of this survey, I need to speak with the SITE$ USFHP member in your household who is most responsible for making decisions about health care coverage for your household. Would that be you?

Currently you belong to USFHP. With this plan, you use SITE$'s USFHP doctors, hospitals, and specialists. There is no enrollment fee and if you are retired from the military, no copayments except for $25 per in-patient hospital or emergency care visit. If you are an eligible family member, you pay $5 per office visit, $5 for each prescription, and $25 per in-patient hospital or emergency care visit.

7. Overall, does this health plan meet your household's needs?
   1--Yes
   2--No
   3--Don't know

As you may know, the Department of Defense is considering making some changes in the costs of health plans it offers to retirees and their family members. At some point in the future, you may need to decide between CHAMPUS and an USFHP with higher copays and enrollment fees.

For CHAMPUS you can use any doctor that accepts CHAMPUS. You have annual deductibles of $150 per person or $300 per family for medical care outside of the hospital. After the deductible is paid you also pay 25 percent of your medical costs up to $5,000 and nothing additional after $7,500. For hospital care you pay $330 per day. CHAMPUS has no enrollment fee.

8. Overall, does the CHAMPUS plan meet your household's needs?
   1--Yes
   2--No
   3--Don't know

If the DOD were to increase USFHP copays and add enrollment fees, you would use the USFHP network of doctors and hospitals. You would have an annual enrollment fee of $230 per person or $460 per household. Both retirees and their family members would pay $12 per office visit, $9 for prescriptions, and $11 per day for in-patient hospital care.

9. Overall, would the USFHP with higher copays and enrollment fees meet your household's needs?
   1--Yes
   2--No
   3--Don't know

Market Street Research, Inc. USFHP Member Survey

10. **If you have to choose between CHAMPUS and the USFHP with higher copays and enrollment fees for your household in the future, which would you select [DO NOT** READ RESPONSES]?
1--CHAMPUS--go to Q. 12
2--USFHP--go to Q. 12
3--Don't know--TRY TO FORCE CHOICE--go to Q. 12
4--Neither or would choose different plan--go to Q. 11

11. **Do you think you would select:**
1--Commercial insurance through you or your spouse's employer
2--Commercial HMO through your or your spouse's employer
3--Some other option
4--No health insurance
5--Don't know

12. **In general, how would you rate your health?**
1--Excellent
2--Very good
3--Good
4--Fair
5--Poor
6--Don't know

13. **How many people other than yourself are enrolled in USFHP under your military sponsor?**
1--One
2--Two
3--Three
4--Four
5--Five
6--Six
7--More than six
8--None--go to Q. 20

I would like you to rate the health of the other people in your household who are enrolled in USFHP, starting with the oldest (UP TO SIX HOUSEHOLD MEMBERS RATED).

14 to 19. How would you rate the health of the oldest USFHP member in the household other than yourself?
1--Excellent
2--Very good
3--Good
4--Fair
5--Poor
6--Don't know

APPENDIX B: QUESTIONNAIRE FOR PACIFIC MEDICAL CENTER

Hello, my name is ____ and I'm with Market Street Research in Northampton, Massachusetts. We are conducting a short survey of people who are enrolled in the Uniformed Services Family Health Plan through SITE$. The survey takes less than five minutes.

For the purposes of this survey, I need to speak with the SITE$ USFHP member in your household who is most responsible for making decisions about health care coverage for your household. Would that be you?

Currently you belong to USFHP. With this plan, you use SITE$'s USFHP doctors, hospitals, and specialists. There is no enrollment fee and if you are retired from the military, no copayments except for $25 per in-patient hospital or emergency care visit. If you are an eligible family member, you pay $5 per office visit, $5 for each prescription, and $25 per in-patient hospital or emergency care visit.

7. Overall, does this health plan meet your household's needs?
   1--Yes
   2--No
   3--Don't know

As you may know, the Department of Defense is considering making some changes in the costs of health plans it offers to retirees and their family members. At some point in the future, you may need to decide between Tricare Standard, Tricare Extra, Tricare Prime and USFHP with higher copays and enrollment fees than you have now.

The first option you have is Tricare Standard, in which you can use any doctor who is Tricare certified. You have annual deductibles of $150 per person or $300 per family for medical care outside of the hospital. After the deductible is paid you also pay 25 percent of your medical costs up to $7,500 and nothing additional after $7,500. For hospital
care you pay $330 per day. There is no enrollment fee.

8. Overall, does the Tricare Standard plan meet your household's needs?
   1--Yes
   2--No
   3--Don't know

Next, you can choose Tricare Extra. Instead of using the standard Tricare network, you choose from a selective network of civilian providers. The benefits and coverage are the same as Tricare Standard, but your cost share is 20% instead of 25% after the deductible has been paid.

9. Overall, does the Tricare Extra plan meet your household's needs?
   1--Yes
   2--No
   3--Don't know

Market Street Research, Inc. USFHP Member Survey

Third, you can choose Tricare Prime. Benefits are extended to include preventative care. You pay an enrollment fee of $230 per individual or $460 per family, and both retirees and family members pay a $12 copayment for office visits, $9 for prescriptions and $11 per day for hospital care. You must choose a Primary Care Provider at a Military Treatment Facility or with Group Health of Puget Sound, and you must receive all care within the Prime network.

10. **Overall, does the Tricare Prime plan meet your household's needs?**
1--Yes
2--No
3--Don't know

If the DOD were to increase USFHP copays and add enrollment fees, you would choose a Primary Care Provider at Pacific Medical Center and use the USFHP network of doctors and hospitals through Pacific Medical Center. You would have an annual enrollment fee of $230 per person or $460 per household. Both retirees and their family members would pay $12 per office visit, $9 for prescriptions, and $11 per day for in-patient hospital care.

11. **Overall, would the USFHP with higher copays and enrollment fees meet your household's needs?**
1--Yes
2--No
3--Don't know

12. **If you have to choose between Tricare Standard, Tricare Extra, Tricare Prime, and the USFHP with higher copays and enrollment fees for your household in the future, which would you select [DO NOT READ RESPONSES]?**
1--Tricare Standard--go to Q. 14
2--Tricare Extra--go to Q. 14
3--Tricare Prime--go to Q. 14
4--USFHP--go to Q. 14
5--Don't know--TRY TO FORCE CHOICE--go to Q. 14
6--Neither or would choose different plan--go to Q. 13

13. **Do you think you would select:**
1--Commercial insurance through you or your spouse's employer
2--Commercial HMO through your or your spouse's employer
3--Some other option
4--No health insurance
5--Don't know

14. **In general, how would you rate your health?**
1--Excellent
2--Very good
3--Good
4--Fair
5--Poor
6--Don't know

Market Street Research, Inc. USFHP Member Survey

15. **How many people other than yourself are enrolled in USFHP under your military sponsor?**
1--One
2--Two
3--Three
4--Four
5--Five
6--Six
7--More than six
8--None--go to Q. 22

I would like you to rate the health of the other people in your household who are enrolled in USFHP, starting with the oldest.

16 to 21. **How would you rate the health of the oldest USFHP member in the household other than yourself (UP TO SIX HOUSEHOLD MEMBERS RATED)?**
1--Excellent
2--Very good
3--Good
4--Fair
5--Poor
6--Don't know

22. **If the copayments are increased and your family remains with USFHP, would you:**
1--Seek more care than you've been receiving now
2--Seek the same level
3--Seek less care than you've been receiving now
4--Don't know

Adjustments to USTF Estimated Cost Increases Due to Adverse Selection

This appendix contains estimates of the cost impact on each USTF resulting from adverse selection (1) with and without the two largest claimants of each facility in the computation and (2) using disenrollment rates of 20 percent and 40 percent.

The cost impact with and without the two largest claimants is derived by subtracting the cost for total respondents' monthly claims from the monthly claims cost of the respondents who stay and dividing this increase by the total respondents' monthly claims costs. For example, as shown in table IV.1, the cost for total respondents' monthly claims (including all claimants) is $257. The monthly claims cost of the respondents who stay is $279. Subtracting $257 from $279 yields a cost increase of $22, which is about 8 percent of $257.

The cost impact of using different disenrollment rates is derived by subtracting the total respondents' monthly claims costs from those of the respondents who stay and dividing this increase by the total respondents' costs. For example, as shown in table IV.2, the cost for the total respondents' monthly claims is $257. For a 20-percent disenrollment rate, the monthly claims cost of the respondents who stay is $265. Subtracting $257 from $265 yields a cost increase of $8, which is about 3 percent of $257.

Table IV.1: Estimated Bayley Seton Cost Increases With and Without the Two Largest Claimants

	Estimated cost increase	Respondents staying		Total respondents	
		Number	Monthly claims cost	Number	Monthly claims cost
Including all claimants	8%	75	$279	128	$257
Excluding two largest claimants	8%	74	$215	126	$198

Table IV.2: Estimated Bayley Seton Cost Increases With 20- and 40-Percent Disenrollment Rates

	Staying		Disenrolling		Total respondents
	At 40%	At 20%	At 40%	At 20%	
Number of respondents	75	102	53	26	128
Monthly claims cost	$279	$265	$225	$225	$257
Estimated cost increase	8%	3%			

Table IV.3 Estimated Brighton Marine Cost Increases With and Without the Two Largest Claimants

	Estimated cost increase	Respondents staying		Total respondents	
		Number	Monthly claims cost	Number	Monthly claims cost
Including all claimants	24%	192	$230	300	$186
Excluding two largest claimants	6%	190	$132	298	$124

Table IV.4: Estimated Brighton Marine Cost Increases With 20- and 40-Percent Disenrollment Rates

	Staying		Disenrolling		Total respondents
	At 40%	At 20%	At 40%	At 20%	
Respondents	192	246	108	54	300
Monthly claims cost	$230	$203	$112	$112	$186
Estimated cost increase	24%	9%			

Table IV.5: Estimated Johns Hopkins Cost Increases With and Without the Two Largest Claimants

	Estimated cost increase	Respondents staying		Total respondents	
		Number	Monthly claims cost	Number	Monthly claims cost
Including all claimants	4%	111	$193	194	$185
Excluding two largest claimants	–9%	109	$143	192	$157

Table IV.6: Estimated Johns Hopkins Cost Increases With 20- and 40-Percent Disenrollment Rates

	Staying		Disenrolling		Total respondents
	At 40%	At 20%	At 40%	At 20%	
Respondents	111	153	83	41	194
Monthly claims cost	$193	$188	$176	$176	$185
Estimated cost increase	4%	1%			

Table IV.7: Estimated Lutheran Medical Cost Increases With and Without the Two Largest Claimants

	Estimated cost increase	Respondents staying		Total respondents	
		Number	Monthly claims cost	Number	Monthly claims cost
Including all claimants	20%	188	$159	294	$133
Excluding two largest claimants	11%	186	$122	292	$110

Table IV.8: Estimated Lutheran Medical Cost Increases With 20- and 40-Percent Disenrollment Rates

	Staying		Disenrolling		Total respondents
	At 40%	At 20%	At 40%	At 20%	
Respondents	188	241	106	53	294
Monthly claims cost	$159	$143	$90	$90	$133
Estimated cost increase	20%	8%			

Table IV.9: Estimated Martin's Point Cost Increases With and Without the Two Largest Claimants

	Estimated cost increase	Respondents staying		Total respondents	
		Number	Monthly claims cost	Number	Monthly claims cost
Including all claimants	–16%	200	$98	300	$116
Excluding two largest claimants	–1%	200	$98	298	$99

Table IV.10: Estimated Martin's Point Cost Increases With 20- and 40-Percent Disenrollment Rates

	Staying		Disenrolling		Total respondents
	At 40%	At 20%	At 40%	At 20%	
Respondents	200	250	100	50	300
Monthly claims cost	$98	$109	$152	$152	$116
Estimated cost increase	–16%	–6%			

Table IV.11: Estimated Pacific Medical Cost Increases With and Without the Two Largest Claimants

	Estimated cost increase	Respondents staying		Total respondents	
		Number	Monthly claims cost	Number	Monthly claims cost
Including all claimants	53%	142	$293	300	$192
Excluding two largest claimants	30%	140	$179	298	$137

Table IV.12: Estimated Pacific Medical Cost Increases With 20- and 40-Percent Disenrollment Rates

	Staying		Disenrolling		Total respondents
	At 40%	At 20%	At 40%	At 20%	
Respondents	142	221	158	79	300
Monthly claims cost	$293	$224	$101	$101	$192
Estimated cost increase	53%	17%			

Table IV.13: Estimated Sisters of Charity Cost Increases With and Without the Two Largest Claimants

	Estimated cost increase	Respondents staying		Total respondents	
		Number	Monthly claims cost	Number	Monthly claims cost
Including all claimants	2%	187	$280	300	$275
Excluding two largest claimants	–4%	185	$241	298	$251

Table IV.14: Estimated Sisters of Charity Cost Increases With 20- and 40-Percent Disenrollment Rates

	Staying		Disenrolling		Total respondents
	At 40%	At 20%	At 40%	At 20%	
Respondents	187	244	113	56	300
Monthly claims cost	$280	$277	$267	$267	$275
Estimated cost increase	2%	1%			

USTF Capitation Rates, FY 1996

Gender/age	Bayley Seton	Brighton Marine	Johns Hopkins	Lutheran Medical	Martin's Point	Pacific Medical	Sisters of Charity
Male							
<2	$3,706	$3,828	$3,059	$3,381	$3,447	$3,505	$3,346
2-14	1,073	1,108	886	978	998	1,014	969
15-24	1,170	1,209	966	1,067	1,088	1,107	1,057
25-34	1,263	1,310	1,047	1,157	1,180	1,199	1,141
35-44	1,554	1,612	1,287	1,424	1,452	1,475	1,403
45-54	1,949	2,015	1,610	1,780	1,814	1,845	1,760
55-64	3,023	3,123	2,495	2,758	2,812	2,859	2,730
65-69	7,252	6,089	5,975	5,377	4,123	4,538	5,482
70-74	8,631	7,202	7,117	6,365	4,821	5,330	6,497
75-79	10,372	8,574	8,512	7,539	5,648	6,243	7,694
80-84	11,092	9,143	9,092	8,029	5,994	6,626	8,194
85+	11,692	9,610	9,563	8,418	6,267	6,922	8,587
Female							
<2	3,706	3,828	3,059	3,381	3,447	3,505	3,346
2-14	1,073	1,108	886	978	998	1,014	969
15-24	1,656	1,814	1,448	1,601	1,632	1,660	1,497
25-34	2,330	2,519	2,012	2,224	2,268	2,306	2,103
35-44	2,161	2,317	1,851	2,046	2,086	2,121	1,952
45-54	2,438	2,519	2,012	2,224	2,268	2,306	2,201
55-64	3,023	3,123	2,495	2,758	2,812	2,859	2,730
65-69	6,112	5,183	5,051	4,592	3,568	3,920	4,679
70-74	7,372	6,193	6,084	5,478	4,195	4,625	5,588
75-79	8,511	7,098	7,008	6,264	4,749	5,243	6,391
80-84	9,713	8,031	7,951	7,041	5,296	5,834	7,178
85+	10,433	8,601	8,531	7,531	5,641	6,217	7,678

Source: DOD.

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