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Testimony

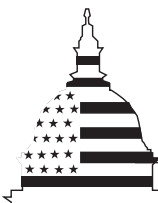
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DEFENSE HEALTH CARE

Lessons Learned From
TRICARE Contracts and
Implications for the Future

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G A O

Accountability * Integrity * Reliability

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss lessons learned from the Department of Defense's (DOD) TRICARE contracts and their implications for the future. TRICARE, implemented in 1994, offers beneficiaries a choice of three options through which they can receive health care from either military treatment facilities (MTF) or civilian providers. Care from civilian providers is arranged and paid for by five TRICARE contractors. Today, over 8 million active duty personnel, their dependents, and retirees are eligible to receive care through TRICARE. The military health system is funded at about \$18 billion for fiscal year 2001. Approximately 30 percent of this amount, \$5 billion, was budgeted for the TRICARE contracts.

Since TRICARE's inception, we have issued numerous products on DOD's progress in implementing it. Over the years, TRICARE has matured in its delivery of health care. For example, 90 percent of beneficiaries surveyed report being satisfied with the overall quality of care; over 80 percent of surveyed beneficiaries reported satisfaction with access to care; and 96 percent of medical claims are processed within 30 days. These successes are due, in large part, to the partnership efforts of DOD and the TRICARE contractors. Notwithstanding these successes, daunting challenges confront DOD and its contractors, including the implementation of major benefit changes recently directed by Congress. Additionally, DOD is in the process of rethinking its own contract approach for the TRICARE contracts. We identified contract management (including TRICARE contracts) as a high-risk and major management challenge facing DOD.¹ My statement today (1) describes shortcomings with the current contracting approach and (2) issues to be considered in developing future TRICARE contracts. It is based on a substantial body of ongoing work and work completed over the past 7 years on the TRICARE program and its contracts. (A list of our products related to TRICARE appears at the end of this statement.)

In summary, TRICARE's successes and maturity reflect the ability of DOD and its contractors to work within the current contract structure. However, it has not been easy, and there are important lessons from current contract shortcomings that need to be addressed in designing

¹*High Risk Series: An Update* (GAO-01-263, January 2001); *Major Management Challenges and Program Risks: Department of Defense* (GAO-01-244, January 2001).

future TRICARE contracts. Most, including DOD, feel that the current contracts are too large, complex, and prescriptive in nature, limiting innovation and competition. Also, numerous adjustments to these contracts have created an unstable program, and program costs have been difficult to predict, contributing to annual funding shortfalls. Additionally, financial incentives, accountability, and data quality need to be strengthened to achieve greater efficiencies. To address these weaknesses, DOD redesigned its solicitation for the next round of TRICARE contracts; however, the initial issuance was withdrawn due to internal concerns and reservations about its costs and specifications. The Assistant Secretary of Defense for Health Affairs (ASD/HA) is now reassessing how to structure the TRICARE contracts and is considering the views and recommendations of the Defense Medical Oversight Committee (DMOC), a group formed by the Deputy Secretary of Defense to provide oversight to TRICARE. Separately, DOD has an ambitious initiative underway to develop an overall medical resource strategy designed to improve fiscal incentives, accountability, and data quality that should provide valuable information to help shape future TRICARE contracts. In developing a viable contract approach, the ASD/HA is considering several other important issues, including the degree of prescriptiveness needed; the frequency of and process for contract adjustments; the size of the contracts and their impact on the level of competition; and whether the current contract structure provides the right incentives and predictability to obtain needed efficiencies.

Background

DOD has the unique dual mission of maintaining adequate medical readiness capability while providing peacetime health care. During the early 1990s, in a time of military downsizing, medical cost escalation, and budgetary constraints, DOD restructured its system into TRICARE to improve beneficiaries' access to health care while maintaining quality and controlling costs. TRICARE gives beneficiaries a choice among a health maintenance organization (TRICARE Prime), a preferred provider network (TRICARE Extra), and a fee-for-service benefit (TRICARE Standard). TRICARE Prime, the option in which care is most actively managed, is the only option requiring beneficiaries to enroll.

Under TRICARE, DOD supplements care provided in its MTFs with civilian providers. To do so, DOD contracts with civilian health care companies to administer its TRICARE program on a regional basis. The primary responsibilities of these TRICARE contractors include: developing civilian provider networks (includes credentialing providers and negotiating reimbursement discounts), ensuring adequate access to health

care, enrolling beneficiaries, referring and authorizing beneficiaries for health care, processing health care claims, conducting utilization management and quality management programs, and educating providers and beneficiaries.

The TRICARE Management Activity (TMA), under the ASD/HA, is responsible for procuring and administering the TRICARE contracts. Since 1994, TMA has sequentially awarded 7 contracts covering 11 geographic TRICARE regions. These contracts were competitively bid and awarded as fixed-price, at-risk contracts.² Nonetheless, DOD designed them to include adjustments for health care cost increases beyond the contractors' control, while other costs, such as administrative, remain fixed. All of the contracts were awarded for a base period and 5 option years.³ (See table 1.) Four of the contracts have used all of the option years and three of these have been extended for an additional 2 years. The negotiation for the fourth contract's extension is expected to be completed in June 2001. TMA anticipates that all of its contracts will be extended; however, the TRICARE contracts will eventually need to be resolicited and awarded because they are only authorized to be extended a maximum of 4 option years.⁴

²At-risk features of the contract provide for the sharing of financial gains and losses between the contractor and the government. For example, contractors are at risk for health care cost overruns up to 1 percent of health care prices. Beyond that, the contractor and the government share in losses until an amount prepledged by the contractor, called contractor equity, is totally depleted, at which time the government assumes full responsibility for further losses.

³The base period, which varies by contract, consists of a transition period, ranging from 6-9 months, and the early months of health care delivery.

⁴Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L. 106-398, § 724).

Table 1: TRICARE Contractors, Regions, Date of Initial Award, and Extensions

TRICARE Contractor	Region name and number	Date of initial award	Extensions
Health Net Federal Services ^a	Northwest/11	September 1994	Yes
Health Net Federal Services	Southwest/6	April 1995	Yes
Health Net Federal Services	Golden Gate, Southern California, and Pacific/9, 10, and 12	August 1995	Under negotiation
Humana Military Healthcare Services	Southeast and Gulf South/3 and 4	November 1995	Yes
TriWest Healthcare Alliance	Central/(formerly 7 and 8)	June 1996	N/A ^b
Anthem Alliance ^c	Mid-Atlantic and Heartland/2 and 5	September 1997	N/A ^b
Sierra Military Healthcare Services	Northeast/1	September 1997	N/A ^b

^aHealth Net Federal Services, formerly Foundation Health Federal Services, changed its name in February 2001.

^bNot applicable.

^cIn April 2001, DOD announced that Humana Military Healthcare Services acquired Anthem Alliance and will assume responsibility for the Mid-Atlantic and Heartland regions.

Source: TMA.

In August 1999, the Deputy Secretary of Defense formed DMOC to provide greater oversight in the operation of the TRICARE program. Its membership consists of the Under Secretary of Defense (Personnel and Readiness), the four service Vice Chiefs, the military department Under Secretaries, the Under Secretary of Defense (Comptroller), the Director for Logistics from the Joint Staff, the Surgeons General, and the Assistant Secretary of Defense (Health Affairs). As part of its responsibilities, DMOC undertook a review of TMA's contract approach for the TRICARE contracts.

Shortcomings With the Current Contracting Approach

DOD's current contracting approach for TRICARE poses several administrative challenges, and has contributed to significant funding shortfalls. To be considered for a contract award, offerors were required, in effect, to submit voluminous, expensive-to-produce proposals, which has limited competition. Offerors have stated that complicating the preparation of proposals was the need to address DOD's overly

prescriptive requirements, restricting its ability to use best practices to achieve the same results with greater cost efficiency. Furthermore, TRICARE contracts were awarded while DOD was realigning and reducing its MTF capability during a time of budgetary concerns. The resulting shift to greater reliance on civilian providers as well as frequent changes to the program resulted in numerous adjustments to the TRICARE contracts, both planned and unplanned. The effect and cost of these numerous adjustments created an unstable program and contributed to annual budget shortfalls.

Large, Complex Proposals Costly To Bid

Under DOD's contract approach, the TRICARE contracts were competitively bid. Because the required proposals were large, complex, lengthy, and preparation involved significant sums of money, offerors incurred substantial expense to participate. In preparing the proposal, offerors were required to address 13 different tasks, including enrollment and beneficiary services, fiscal management and controls, program integrity, and automated data processing. The proposals were also to address seven cost factors including utilization management, provider reimbursement discounts, and coordination of third party liability. To illustrate the size and complexity of the resulting proposals, one complete proposal consisted of 33,000 pages.

In 1995, we reported that several offerors stated that it cost them between \$1 million and \$3 million just to develop their proposals.⁵ More recently, one contractor official told us that it cost the company he worked for about \$5 million to bid. As a result of the large contract size and complexity, competition has been limited to large companies with significant resources. Further, because of the large cost to develop a proposal, losing contractors stated they had everything to gain by protesting the award even at substantial cost to them and DOD. All seven contract awards have been protested; three were sustained.

⁵*Defense Health Care: Despite TRICARE Procurement Improvements, Problems Remain (GAO/HEHS-95-142, August 3, 1995).*

Prescriptive Requirements May Limit Offerors' Use of Best Practices and Increase Costs

The requests for proposal (RFP) DOD used to solicit TRICARE contracts have been very prescriptive. DOD officials stated that highly detailed proposals were needed to ensure a uniform nationwide program under which beneficiaries and providers would be subject to the same requirements and processes regardless of region. For example, utilization management is used to ensure that patients receive all necessary care in the most cost-effective manner. DOD's proposal required the offerors to perform utilization management functions, such as pre-authorization, concurrent and retrospective reviews, and waiver considerations, for all types of health care in all settings. These activities were to be performed using a uniform set of criteria determined by DOD. However, offerors have often cited utilization management as the area in which more relaxed DOD requirements would enable them to implement effective techniques with greater savings. Offerors said that this could be achieved with an RFP that emphasized health care outcomes desired rather than mandate the processes to achieve them. They believe it would allow them more innovation and flexibility in devising approaches to economically achieve such outcomes without adversely affecting the quality of care delivered. Such an approach deserves DOD's careful consideration, but would also require provisions such as appropriate, evidence-based reviews performed by qualified health care professionals to ensure that all desired outcomes are achieved.

In addition, prescriptive requirements for utilization management review have contributed to claims processing inefficiencies. As we reported in June 2000, DOD's contractual requirements for prepayment review of claims are manifested as thousands of edits in the adjudication logic of the claims processing system.⁶ These edits result in claims being "kicked out" of the system for manual review, which extends processing time and increases administrative costs. However, not all of these edits are needed, especially since contractors are at risk for some health care dollars. For example, claims for electrocardiograms—14,000 for one contractor alone—were being manually reviewed, but in every case at the time of our evaluation, the claims were paid after review. As we reported, over half of TRICARE's claims were manually reviewed, a rate significantly higher than the industry average of 25 percent. In its claims improvement initiative, DOD has been partnering with its contractors to review the need for these edits.

⁶ *Defense Health Care: Opportunities to Reduce TRICARE Claims Processing and Other Costs* (GAO/T-HEHS-00-138, June 22, 2000).

Numerous Contract Adjustments Lead To An Unstable Program and Funding Shortfalls

Further complicating the design of the TRICARE contracts is the fact that DOD designed them to have periodic adjustments to the contract price, which are called bid price adjustments (BPA). These adjustments are based on shifts in workload between the MTFs and civilian providers as well as other operating conditions of the contract, such as changes in the number of beneficiaries caused by the frequent geographic rotation of active-duty members and their dependents. To calculate these adjustments, DOD uses a formula that incorporates factors including cost, population shifts, inflation, and utilization. However, these determinations have been a source of contention with contractors. For example, contractors have been concerned with DOD's use of inaccurate and incomplete data, such as that used to determine the MTF workload. In addition, contractors were concerned about some of the factors used in the BPA formula. As a result, in recent negotiations, DOD agreed to modify its inflation index and other adjustment factors. Outside of the regularly scheduled BPA process, TRICARE contractors have also initiated additional adjustments in the contract price called requests for equitable adjustment, which are used to redress unforeseen changes in contract conditions, such as higher than anticipated claim submissions, that subsequently increased their administrative expenses.

In addition, DOD has made a total of over 1,000 unscheduled modifications to these contracts via contract change orders—an average of 156 per contract as of June 30, 2000. Change orders may result from new laws or regulations, or from DOD initiatives. They range in scope from administrative changes, such as changes to home health care billing procedures, to significant benefit expansions, such as the elimination of copayments for active duty dependents that will significantly add to program costs. Until recently, DOD directed its contractors to implement change orders prior to negotiation of the final terms of the modification, including payment. As we recently reported, DOD's management of the change order process resulted in a large backlog of outstanding change orders, which was mostly eliminated under a recent short-term effort by DOD and the contractors to settle all outstanding contract adjustments.⁷ Negotiated settlements for this initiative totaled about \$900 million for

⁷*Defense Health Care: Continued Management Focus Key to Settling TRICARE Change Orders Quickly* (GAO-01-513, April 30, 2001).

current and prior fiscal years.⁸ DOD hopes to avoid future problems with change order backlogs by using a new process to negotiate and settle changes prior to implementation. However, it is premature to evaluate the effectiveness of this process because TMA has not yet issued any change orders under it.

Change orders and other contract adjustments have contributed to program instability and have led, in part, to DOD's having to request additional funding from Congress to address health program budget shortfalls. These requests have called into question DOD's financial management practices for estimating and budgeting costs. In fiscal year 2000, Congress provided a supplemental appropriation of \$1.3 billion—nearly half of which was designated for contract adjustments. Likewise, in fiscal year 2001, TMA estimates a shortfall of \$1.4 billion—over a third of which is due to the recent settlement of contract adjustments. As we have reported in our high-risk series, accurate financial information is crucial to making sound decisions so that DOD's missions and goals are efficiently and effectively accomplished.⁹

Future Design of Tricare Contracts is Uncertain

Based on knowledge gained during the first several years of operation and anticipating contract expirations, TMA undertook an effort to redesign the TRICARE contract approach. A new RFP was developed, but was withdrawn by the Under Secretary of Defense for Personnel and Readiness shortly after issuance because of serious concerns about its design. The ASD/HA is currently reassessing future contract approaches for TMA to employ and is considering DMOC's recommendations. Separately, DOD has initiated an effort to determine overall medical resource needs, which could provide valuable information that will help shape future TRICARE contracts. However, to successfully accomplish this initiative, DOD needs to address pervasive problems with its financial management and workload data.

⁸It is not possible to identify the amounts related specifically to change orders for each of the contracts because the change orders and other contract adjustments were jointly settled.

⁹*High Risk Series: An Update* (GAO-01-263, January 2001).

TRICARE 3.0 Withdrawn

TMA officials spent 3 years developing a new TRICARE contract vehicle, commonly referred to as TRICARE 3.0, for the next round of contracts. They created TRICARE 3.0 using a partnership approach, which included input from numerous military and private industry representatives, including the current TRICARE contractors, as well as health care consultants. The intent behind TRICARE 3.0 was to address shortcomings of the current contracts. For example, as we recommended in 1995, TMA attempted to develop less prescriptive requirements with a shift in focus from process to outcomes.¹⁰ This shift was intended to provide contractors with the incentive to employ their best practice techniques to achieve needed outcomes with improved cost efficiency while maintaining quality of care. TMA also hoped that a less prescriptive approach would result in a more stable contract with fewer unplanned changes and adjustments.

Using TRICARE 3.0, TMA issued an RFP for the Northwest Region in February 2000. However, 6 months later, the Under Secretary of Defense for Personnel and Readiness withdrew it because of (1) the absence of a valid cost estimate and (2) requirements that offerors develop proposals based on DOD business processes that were changing. The contractors felt that the requirements under TRICARE 3.0 were more prescriptive than they had anticipated. They were also concerned about the fairness of the structure for financial penalties and incentives. Financial penalties were to be based on measurable, quantitative standards; however, the financial incentives were to be based on beneficiary satisfaction surveys—which the contractors believe are a less reliable measure of performance.

New Medical Resource Strategy Could Provide Key Data for Future Contracts

DOD is developing an overall medical resource strategy that encompasses the direct health care provided through the MTFs as well as the civilian TRICARE contracts that potentially will provide valuable information in designing future procurement strategy. The medical resources strategy begins with defining the military readiness needs and optimizing care delivery throughout the military health system. DOD has recognized the need for this fundamental strategy to more completely establish how large the military medical infrastructure needs to be, including where resources should be placed and used to best support readiness and provide peacetime care. In essence, DOD would determine what resources are needed to meet readiness requirements, and this determination would

¹⁰ *Defense Health Care: Despite TRICARE Procurement Improvements, Problems Remain* (GAO/HEHS-95-142, August 3, 1995).

drive all decisions for how best to provide peacetime care—whether in the direct care system or from the TRICARE contractors, commonly referred to as make-or-buy decisions.

As we reported in November 1999, DOD established a tri-service team of senior officers to develop a strategy, called Optimization, to clearly define readiness needs and costs in order to make better decisions about peacetime care using make-or-buy analyses.¹¹ The team's goals consisted of devising an approach to determine each military treatment facility's correct size, identifying excesses and shortages of medical personnel by specialty, and determining the right provider mix for each facility. DOD officials agreed with us that until this is done, it is not possible to judge the need for nor relative efficiency of their direct care system—information that is critical to the development of a contract approach.

Optimization is an ambitious undertaking that is dependent upon accurate and reliable information. However, key health care cost and workload data problems have been pervasive, and DOD continues to struggle with its data systems' inaccuracies. As we and others have reported, the root cause has been DOD's and the services' lack of oversight and incentives to ensure the data's accuracy, timeliness, and completeness.¹² These impediments make it critical that the implementation of Optimization is closely monitored.

New TRICARE Contract Approach Considerations

Attaining sufficient competition may be key to obtaining the best quality for the best price for the TRICARE contracts. In determining a contract approach, DOD needs to carefully weigh the impact of its decisions on competition, including whether to carve out elements of TRICARE, such as pharmacy or enrollment, for separate, national contracts. Other considerations, such as smaller contracts covering smaller geographic areas, could also influence competition. Also, it should recognize the effect that the complexity of earlier contracts, with the resulting high contractor proposal costs, had on competition and simplify the contracts as much as feasible. The challenge for DOD, in other words, is to decide

¹¹ *Defense Health Care: Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime Care* (GAO/HEHS-00-10, November 3, 1999).

¹² GAO/HEHS-00-10, November 3, 1999.

whether to continue to use fewer large and complex contracts versus managing smaller and potentially simpler contracts, each of which has unique management challenges.

DOD's continued partnering with private industry to reach agreement on the degree of prescriptiveness needed, by identifying the specific functions in which the use of best practice techniques would be most practical, is a worthwhile endeavor. In determining this, DOD and the contractors recognize that the contract needs to be flexible to maintain a balance between DOD's goal of providing uniform benefits nationwide with the realization that the delivery of health care is local. Conversely, some contract functions may benefit from more specific requirements, such as performance measurement to assess how well contractors are meeting requirements.

In light of the complexity and difficulties with adjustments to the current contracts, such as negotiating and settling almost a thousand contract change orders, a more stable environment for future contracts is needed. For example, modifications to the contract could be made on a regularly scheduled basis, such as annually, rather than on a continual ad hoc basis. However, with recent benefit changes, including Senior Pharmacy, TRICARE for Life, and the elimination of copayments for family members in Prime, the program will be in a state of flux with numerous anticipated contract adjustments that will be needed to implement them. We hope that once the changes have been incorporated, the TRICARE program and contracts will become more stable.

Concluding Observations

Given long-range budget pressures and escalating health care costs, DOD faces a formidable challenge in creating a new contract approach. The current approach is considered to be overly complicated, prescriptive, and given the frequent adjustments, has created an unstable program. This approach may not be the best way to satisfy TRICARE contracting needs or achieve optimal competition. DOD's Optimization effort is an important step in ultimately developing a contract approach and warrants close scrutiny as it is being implemented. The extent to which DOD is contemplating other business process changes for TRICARE could further complicate planning a new contract approach. Moreover, DOD is planning in an environment of substantial ongoing and future changes to the TRICARE program, including the expansion of benefits to Medicare-eligible beneficiaries and the removal of copayments for family members enrolled in Prime. To ensure that progress continues, sustained management and congressional oversight will be necessary.

Mr. Chairman, this concludes my prepared statement. I will be happy to respond to any questions you or other members of the Subcommittee may have.

**GAO Contact and
Staff
Acknowledgments**

For more information regarding this testimony, I can be contacted at (202) 512-7101. Key contributors to this testimony include Michael T. Blair, Bonnie W. Anderson, and Allan C. Richardson.

Related GAO Products

Defense Health Care: Continued Management Focus Key to Settling TRICARE Change Orders Quickly ([GAO-01-513](#), April 30, 2001).

Military Health Care: Factors Affecting Contractors' Ability to Schedule Appointments ([GAO/HEHS-00-137](#), July 14, 2000).

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DOD and VA Health Care: Jointly Buying and Mailing Out Pharmaceuticals Could Save Millions of Dollars ([GAO/HEHS-00-121T](#), May 25, 2000).

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Defense Health Care: Reimbursement Rates Appropriately Set; Other Problems Concern Physicians ([GAO/HEHS-98-80](#), February 26, 1998).

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