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Briefing Report to the Chairman and Ranking Minority Member, Subcommittee on National Security, Committee on Appropriations, House of Representatives

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DEFENSE HEALTH PROGRAM

Future Costs Are Likely to Be Greater Than Estimated

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International Affairs Division

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The Honorable C.W. Bill Young
Chairman
The Honorable John P. Murtha
Ranking Minority Member
Subcommittee on National Security
Committee on Appropriations
House of Representatives

We recently briefed your subcommittee staff on our analysis of budgetary trends of the Defense Health Program. This report summarizes the content of that briefing. Because the Department of Defense (DOD) wants to reduce spending for infrastructure activities to pay for modern weapon systems, we have been reviewing how DOD categorizes and budgets for infrastructure functions. Last year we reported that DOD will realize no significant net infrastructure savings in its budget estimates between fiscal year 1996 and 2001.[1] DOD defines infrastructure as activities that provide support services to mission programs and primarily operate from fixed locations. It assigns infrastructure activities among eight categories, one of which is central medical. Central medical is the third largest infrastructure category, and nearly all the funds within that category are used for the Defense Health Program.

Background

The $15-billion Defense Health Program accounts for about 6 percent of DOD's total budget. The Defense Health 1998 Program Objective Memorandum (POM) shows that total obligational authority is projected to increase by about $2.7 billion, or 18 percent, from $15.1 billion in 1997 to $17.8 billion in 2003, in current dollars.[2] The POM reflects no program growth when expressed in constant dollars. In addition to meeting wartime patient care requirements, the program provides health care benefits for active duty personnel and their dependents as well as for retirees and their dependents. Beneficiaries may receive health care through DOD's new managed health care system called TRICARE. They may use DOD facilities and/or one of three options under DOD contract: a

[1]Defense Infrastructure: Budget Estimates for 1996-2001 Offer Little Savings for Modernization (GAO/NSIAD-96-131, Apr. 4, 1996) and Defense Infrastructure: Costs Projected to Increase Between 1997 and 2001 (GAO/NSIAD-96-174, May 31, 1996).

[2]We based our analysis on the Fiscal Year 1998 POM, the most current data available at the time of our review. During the course of our review, DOD revised the POM estimates as it developed the President's Budget and the 1998 Future Years Defense Program. We provide information on these revised estimates in our report.

health maintenance organization, a preferred provider, and a fee-for-service option, formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Retirees and dependents over age 65 are not eligible for TRICARE because they receive Medicare benefits. However, they may receive health care in DOD medical facilities on a space-available basis. DOD has managed care initiatives in place that it hopes will result in efficiencies and savings.

Results in Brief

Future Defense Health Program costs are likely to be greater than DOD has estimated. Our analysis showed that one key assumption DOD used to estimate future program costs appeared to be unrealistic and another was questionable. First, DOD assumed that no cost growth would be attributable to advances in medical technology and the intensity of treatment, an important and valid health care cost growth factor.[3] Second, DOD assumed that a certain level of savings would be achieved from its new emphasis on utilization management techniques to reduce unnecessary treatment and testing, although it did not use a formal methodology or analysis to derive the savings. DOD's projection that health program budgets will not increase in constant dollars during fiscal years 1998-2003 also appears to be unrealistic, given that during fiscal years 1985-96, the operation and maintenance funds in DOD's health program increased by 73 percent in real terms (operation and maintenance funds take about two-thirds of the Defense Health Program budget).

In developing its budget estimates, DOD applied a factor of zero for technology and intensity. According to health care financing experts, DOD's Defense Health Program is subject to some level of cost growth because of the addition of new technology and increased intensity of treatment. These experts agreed that a factor of between 1 and 2 percent would be appropriate to apply to DOD's program. Also, DOD assumed in its POM estimate that it would save 5 percent from utilization management techniques, even though it did not have a formal methodology for estimating this level of savings. For example, DOD could have derived utilization management savings estimates from analogous private sector health care programs with an adjustment for DOD-unique aspects. Instead, DOD officials discussed and agreed on the target number from a range of savings (2 to 14 percent) reported by private sector managed health care organizations. Later, in a revised health program budget estimate, DOD projected a 7-percent savings during fiscal years 1998-2003 from utilization

[3]Technological advances such as CAT scans, magnetic resonance imaging, organ transplants, and new drug treatments increase costs. Costs are often compounded when new procedures increase the intensity of treatment.

management techniques and its prime vendor program that uses best management practices to buy medical supplies and pharmaceuticals. The revised projected savings, along with other measures, effectively reduced health program budget projections below POM estimates.

Although DOD's budget assumptions appear to be optimistic, the extent to which future costs might exceed the budget estimates is unknown. We analyzed the effects of using different assumptions on the budget estimates for fiscal years 1998-2003. If DOD had accounted for technology and intensity of treatment at a rate of 1.5 percent, for example, in constructing its initial estimates, the projections would have been $3.2 billion higher cumulatively. And if DOD is unable to achieve the level of estimated savings it anticipates from utilization management techniques, program costs would exceed the budget estimate by an additional amount. For example, if DOD achieves a 3-percent savings from utilization management over fiscal years 1998-2003 (instead of the 5-percent assumption it used in initial estimates) and accounts for technology and intensity of treatment at the 1.5 percent rate, program costs would be $4.5 billion greater than estimated. We also compared the 1998 POM—with the 1.5 percent technology factor and the reduced 3-percent savings from utilization management—to revised budget estimates from the post-program and budget decision cycle. This comparison showed that health program costs for fiscal years 1998-2003 could be $8.4 billion greater than estimated. However, the extent to which future costs exceed the Defense Health Program budget estimates depends on the specific assumptions applied.

Agency Comments

We discussed our draft report with DOD officials, who partially concurred with the findings. We incorporated their suggestions into this report as appropriate. DOD commented that it is not appropriate to include an additional cost growth factor for technology and intensity at this time because the matter is still under study. However, our analysis of the literature and discussions with experts show that technology and intensity is widely recognized as a health care cost growth factor that is by definition beyond medical inflation in the private and public sectors. Health care financing experts and Defense Health Affairs officials agree that cost growth from technology and intensity of treatment affects the Defense Health Program. While DOD has not yet determined the specific rate to apply to its program, experts told us a factor of about 1 or 2 percent would be appropriate to apply to the capitation model. As a result, we believe that while the study has not yet been completed, it is reasonable

for DOD to include a factor for cost growth from technology and intensity in the budget estimates.

DOD also commented that the 73-percent real growth in operation and maintenance spending in the health program between 1985 and 1996 reflects the consolidation in 1991 of the various medical programs in the military services into the Defense Health Program and that earlier data on costs were compiled from inconsistent historical data. While DOD correctly points out that its health and medical program spending was spread among the military services until the Defense Health Program was created, our analysis of this cost growth was taken from various DOD Future Years Defense Programs using defense mission categories that cut across military service-specific programs.

DOD agreed that it had no formal methodology or analysis to support its assumptions of 5 percent and 7 percent utilization management savings through fiscal year 2003. DOD also commented that while the DOD Comptroller supports the capitation model concept for budgeting purposes, that office does not necessarily agree with the data or assumptions currently being used to generate the estimate.

Scope and Methodology

We extracted and analyzed estimated total obligational authority data for the Defense Health Program from the 1998 POM. As DOD revised its estimates to prepare the President's budget and the 1998 Future Years Defense Program, we obtained updated information and compared it to the original POM. We also obtained information on the capitation model concept that DOD Health Affairs uses to make program budget projections and discussed the factors and assumptions used in the model with DOD Health Affairs and DOD Program Analysis and Evaluation officials. At our request, DOD Health Affairs applied the model using a technology and intensity of treatment cost growth factor and a lower rate of utilization management savings in order for us to estimate the health program budgets under different assumptions. We also discussed the model with knowledgeable experts outside DOD and reviewed reports on health care costs available from federal agencies and private organizations. However, we did not validate the accuracy or completeness of DOD's capitation model.

We performed our review between September 1996 and January 1997 in accordance with generally accepted government auditing standards.

We are providing copies of this report to the Chairmen and Ranking Minority Members of the House Committee on National Security, the Senate Committee on Armed Services, and the Senate Committee on Appropriations; the Secretaries of Defense, the Army, the Navy, and the Air Force; and the Director, Office of Management and Budget. Copies will also be made available to others upon request.

If you have any questions about this report, please contact me at (202) 512-3504. The major contributors to this report were Davi M. D'Agostino and Richard A. McGeary.

Richard Davis
Director, National Security
Analysis

Contents

Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DOD	Department of Defense
PA&E	Program Analysis and Evaluation
POM	Program Objective Memorandum
PBD	program budget decision
TOA	total obligational authority

Background

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Defense Health Program in the Defense Budget

- Central medical is DOD's third largest infrastructure category.
- Defense Health Program captures 98 percent of central medical infrastructure for fiscal year 1997 and consumes about 6 percent of the DOD budget.
- DOD Health Affairs, Program Analysis and Evaluation, and Defense Comptroller have key roles in Defense Health Program budget estimates.

Central medical is the third largest of eight infrastructure categories, after installation support and central training, and is expected to remain the third largest for the foreseeable future. Most of the central medical infrastructure category consists of the Defense Health Program. The Department of Defense (DOD) projects that the program will represent about 6 percent of DOD's total budget through at least fiscal year 2003.

DOD Health Affairs develops the Defense Health Program budget consistent with guidance and direction from the DOD Program Analysis and Evaluation (PA&E) directorate and the DOD Comptroller.

GAO Most Defense Health Spending Is for Patient Care

- About 73 percent of Defense Health Program costs are for patient care.
- Patient care is medical benefits for active duty and retired military and their dependents through military hospitals and clinics and DOD-contracted care.
- Some patient care is required for wartime readiness; the rest is for peacetime medical benefits.
- The program is regarded as an entitlement program within the discretionary DOD budget.

The majority of the Defense Health Program budget is dedicated to patient care. In addition to providing patient care to meet wartime readiness requirements, the program also serves the peacetime health care needs of its beneficiaries. Active duty and retired military personnel under age 65 and dependents are eligible for care in DOD medical facilities under title 10, U.S.C., or they may choose DOD-contracted care in the private sector. Military retirees over age 65 are eligible for treatment in DOD medical facilities on a space-available basis.

Although the DOD budget is discretionary, active duty and retired military personnel and their dependents consider the Defense Health Program to be an integral part of their employment and retirement benefits. For this reason, the Defense Health Program is regarded somewhat like an entitlement program.

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Defense Health Care Benefits and TRICARE Program Components

- Direct care is medical care provided by DOD personnel in DOD military medical facilities.
- DOD's new TRICARE program includes
  - a health maintenance organization,
  - a preferred provider organization, and
  - CHAMPUS fee-for-service coverage.

Direct care (patient care provided in DOD medical facilities) is very inexpensive to the beneficiary. For example, outpatient care provided in DOD medical facilities is free. Inpatient care for retired enlisted personnel is also free. Retired officers pay $4.75 per day, and dependents pay $9.50 per day for inpatient care.

Beneficiaries may also choose one of the three options in DOD's new TRICARE system. TRICARE Prime is a health maintenance organization type of plan. Retirees pay $230 per year ($460 for families), $12 per outpatient visit, and the greater of $25 per hospital admission or $11 per day. Members can also enroll in Prime with a military treatment facility and avoid the per visit charges. TRICARE Extra is a preferred provider organization plan. It has a $300 deductible per family and a $150 deductible per person, along with a 15-percent co-payment for active duty families and a 20-percent co-payment for retirees for outpatient care. Inpatient care costs $250 per day or 25 percent of the charge. Lastly, TRICARE Standard is the former Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). It has a maximum $300 deductible and a 20-percent co-payment for active duty family members' outpatient care, and a 25-percent co-payment for retirees and their dependents. Inpatient care costs $323 per day or 25 percent of the charge.

Budget Trends

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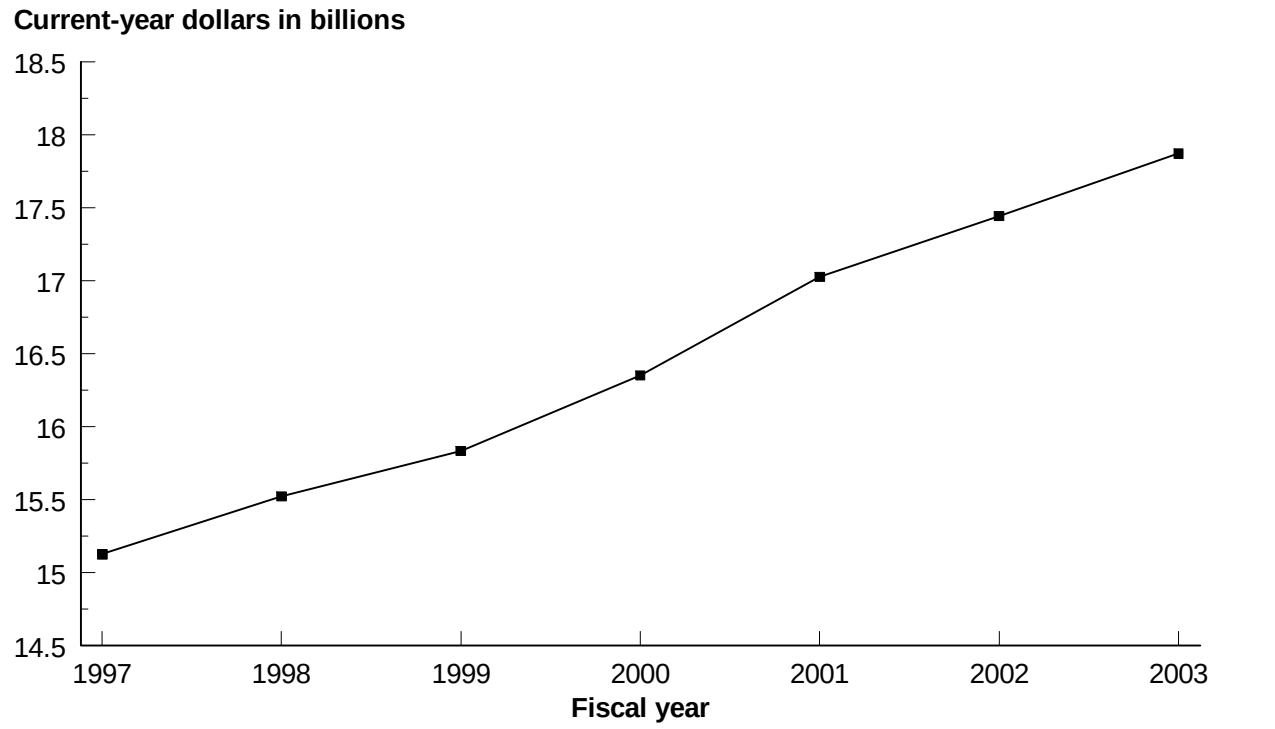
Projected Total Obligational Authority for Defense Health Program



Note: Total Obligational Authority (TOA).

Source: 1998 Program Objective Memorandum (POM).

The 1998 POM shows that DOD projects the Defense Health Program to increase by about $2.7 billion, or 18 percent, from fiscal year 1998 to fiscal year 2003, in current-year dollars. When viewed in constant dollars, DOD projects no program growth. However, between fiscal year 1985 and 1996, the operation and maintenance funds in DOD's health program increased by 73 percent in real terms. Operation and maintenance funds account for about two-thirds of the Defense Health Program budget.

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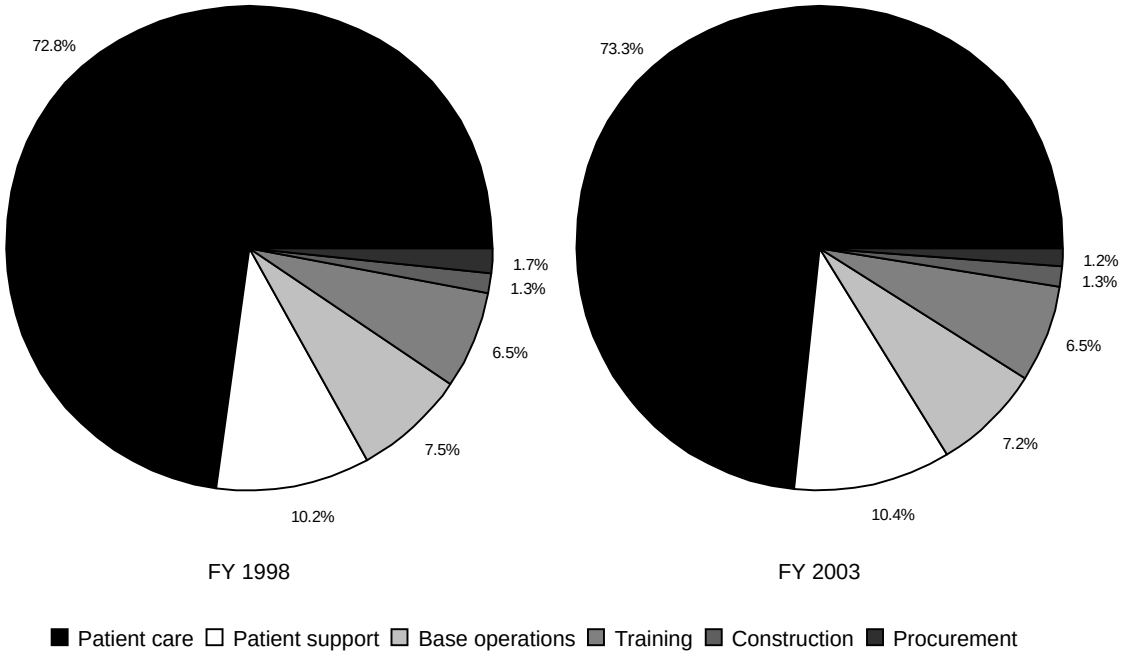
Distribution of Defense Health Program Funds by Major Cost Categories



Source: 1998 POM.

The majority of the Defense Health Program budget is for total patient care. In the fiscal year 1998 estimate, patient care accounts for $11.2 billion of the $15.5 billion budget. This portion of the budget is projected to remain at about 73 percent. Consequently, the driving force behind the Defense Health Program budget is patient care, both medical care for active duty personnel and their dependents and health care benefits received by military retirees and their dependents.

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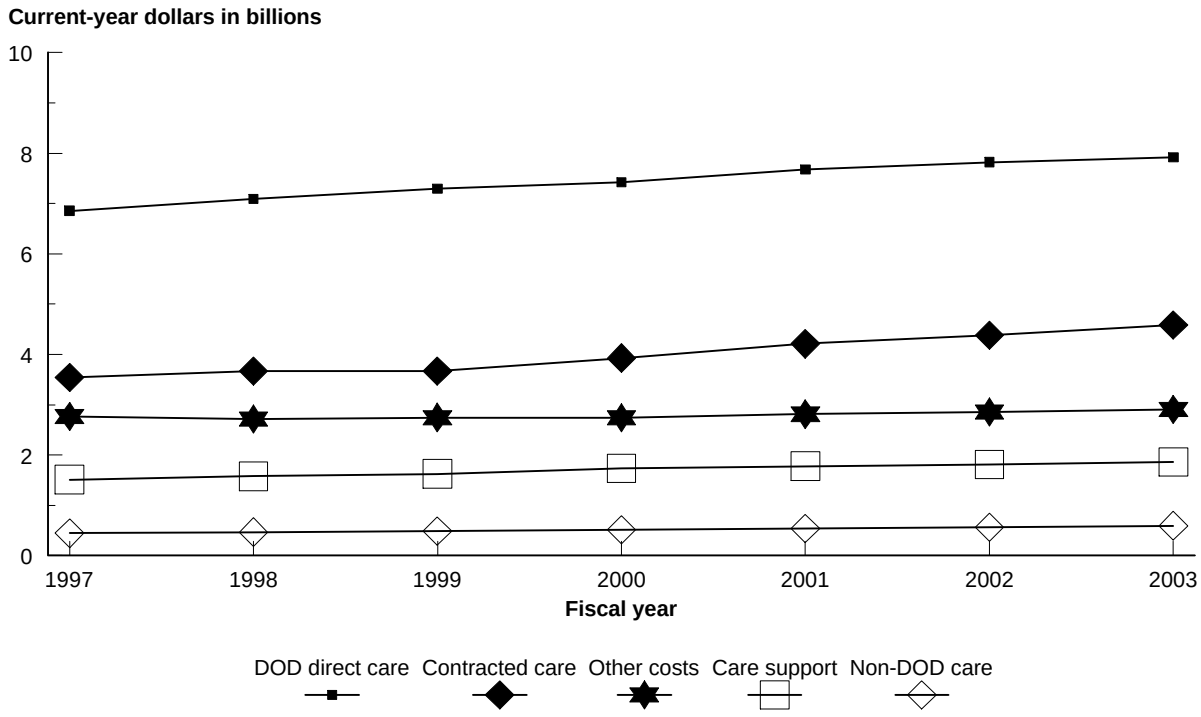
Trends in Defense Health Program TOA by Category



Source: 1998 POM.

Direct patient care, which DOD provides in its medical facilities, is the largest portion of the Defense Health Program budget. The estimated TOA for direct care is projected to increase by about 16 percent, from $6.9 billion in fiscal year 1997 to $7.9 billion in fiscal year 2003. Patient care that is purchased or provided under contract is projected to increase by 31 percent, from $3.5 billion to $4.6 billion. Other budget categories within the Defense Health Program are also projected to increase, but to less extent. For example, patient care support is projected to increase by 23 percent. Patient care support includes a number of functions such as management headquarters, military public and occupational health, veterinary services, examining activities, the aeromedical evacuation system, and the Armed Forces Institute of Pathology.

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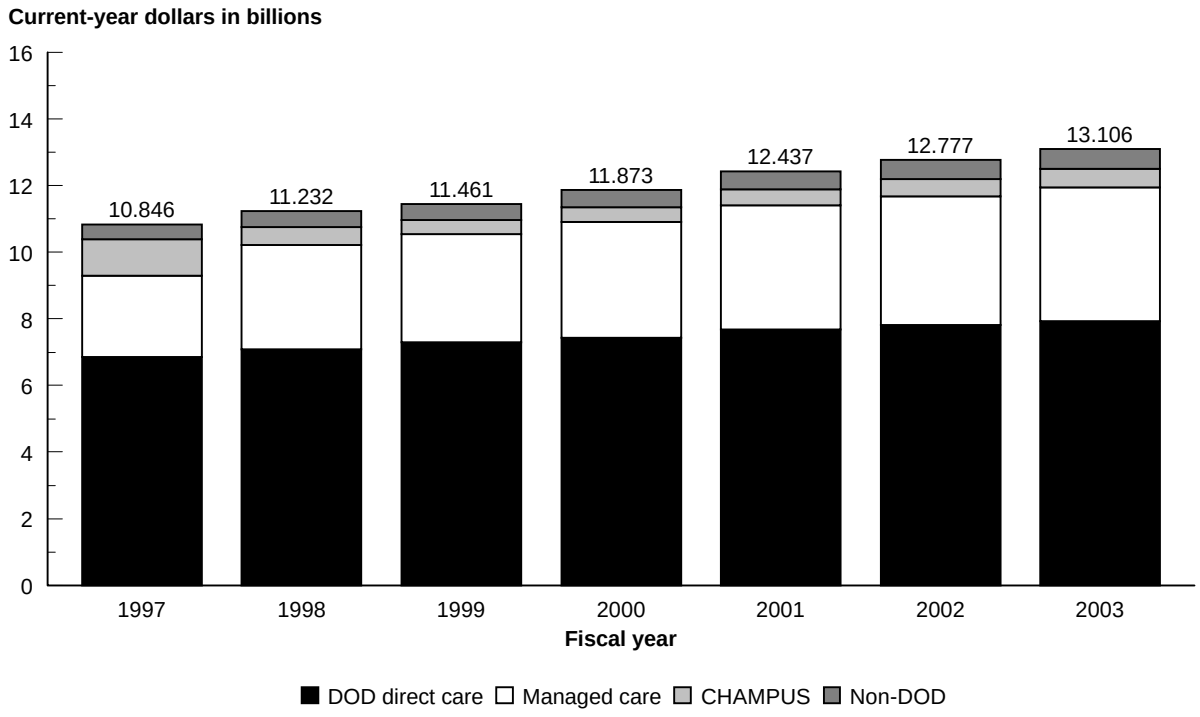
Trends in Patient Care by Source



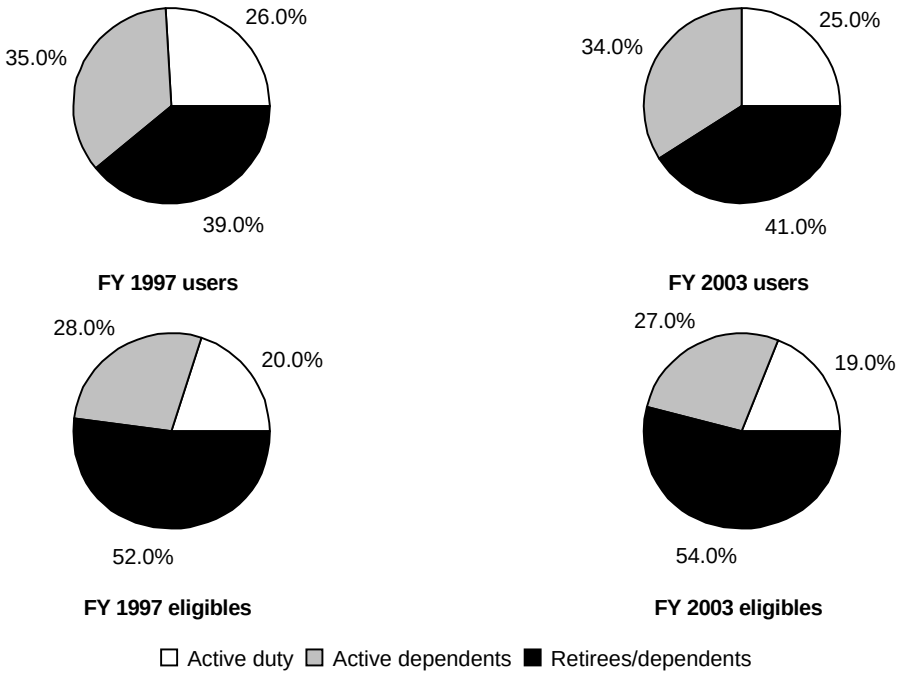
Source: 1998 POM.

We further analyzed the patient care portion of the Defense Health Program POM. DOD projects in the 1998 POM that TOA for all patient care—both care in military treatment facilities and government-funded care from civilian providers—will increase 21 percent, from $10.8 billion in fiscal year 1997 to $13.1 billion in fiscal year 2003. Patient care consists of care provided directly in DOD facilities, managed care provided through contracts, the former CHAMPUS fee-for-service health care plan, and care provided in non-DOD facilities such as emergency rooms or Uniformed Services Treatment Facilities.[1]

DOD direct care is the largest portion of the patient care budget category and is projected to continue as the dominant category through fiscal year 2003. However, managed care support spending is projected to expand. Health care support contracts under the new TRICARE system are projected to increase by 67 percent, from $2.4 billion to $4 billion, while the CHAMPUS portion is projected to decrease, from $1 billion to about $514 million.

[1]Uniformed Services Treatment Facilities 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.

GAO Distribution of Defense Health Program Beneficiaries



Source: 1998 POM.

Among all users of the DOD health system, DOD projects a slight decrease in the share of active duty personnel and their dependents and a slight increase in the share of retirees and their dependents between fiscal year 1997 and 2003. Of user beneficiaries, 61 percent are projected to be active duty personnel and their dependents in fiscal year 1997 compared to 59 percent in fiscal year 2003. However, retired beneficiaries and their dependents who use the system are projected to increase as a percentage of the user population, from 39 percent in fiscal year 1997 to 41 percent in fiscal year 2003.

More people are eligible to obtain health care benefits under the Defense Health Program than the number who actually use the benefits. For example, some retirees and their dependents may be eligible for non-DOD health care benefits through their current private sector employer. Among the total of those eligible for DOD health care benefits, the percentage of active duty personnel and their dependents is projected to decrease by 2 percent between fiscal year 1997 and 2003, from 48 percent to 46 percent, while the percentage of retirees and their dependents is expected to increase by 2 percent, from 52 percent to 54 percent, over the same period.[2]

[2]DOD Health Affairs officials expect the number of military retirees over age 65 to increase through 2014. Although the elderly may tend to require more health care than some other segments of the population—which could affect health care costs—military retirees receive care in DOD medical facilities on a space-available basis. Medicare-eligible dependents and retirees are not eligible for DOD-contracted care under the TRICARE system.

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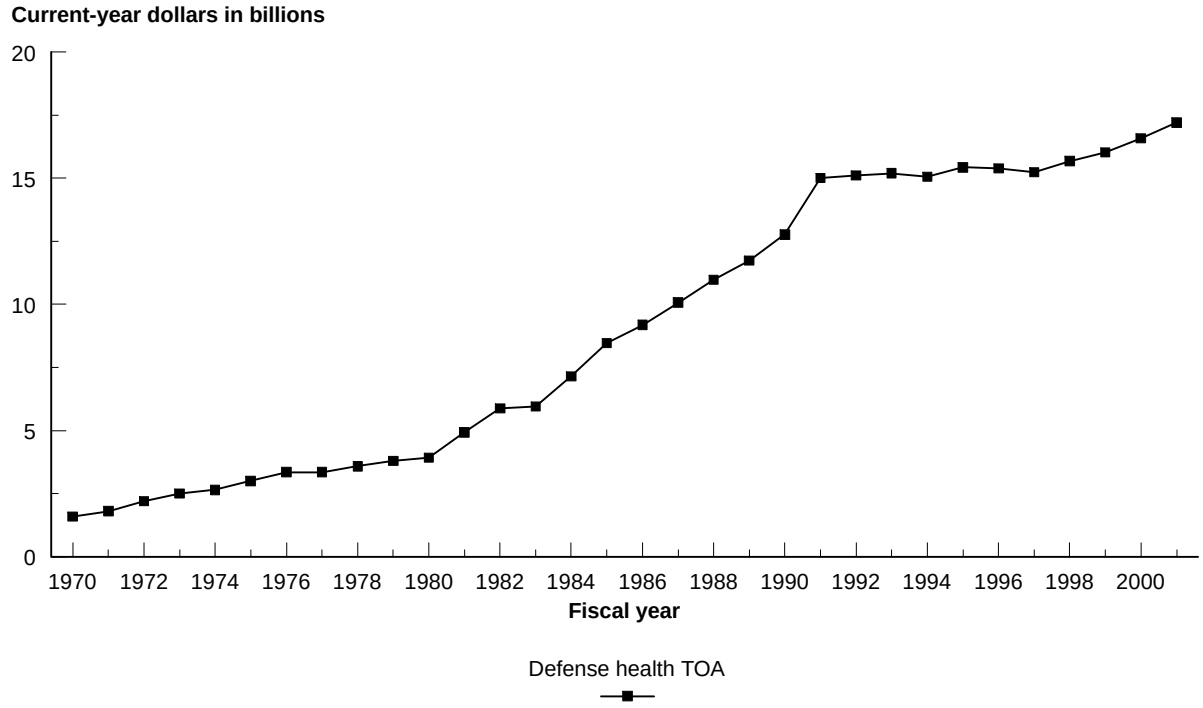
Historical Defense Health TOA Trends



Source: DOD Health Affairs historical data and 1998 POM.

The TOA for the medical program has increased from about $2 billion in fiscal year 1970 to $17 billion projected for fiscal year 2001.[3] (Both fiscal years' amounts are expressed in current dollars.) DOD Health Affairs attributes the flattening of the curve since fiscal year 1990 to the reduced force structure and initiatives to better manage patient care. For example, DOD has reduced the average length of hospital stays in DOD medical facilities.

[3]Because an appropriate DOD deflator is unavailable, we present TOA in current dollars. It should be noted that some of the increase since 1970 is due to general price level inflation.

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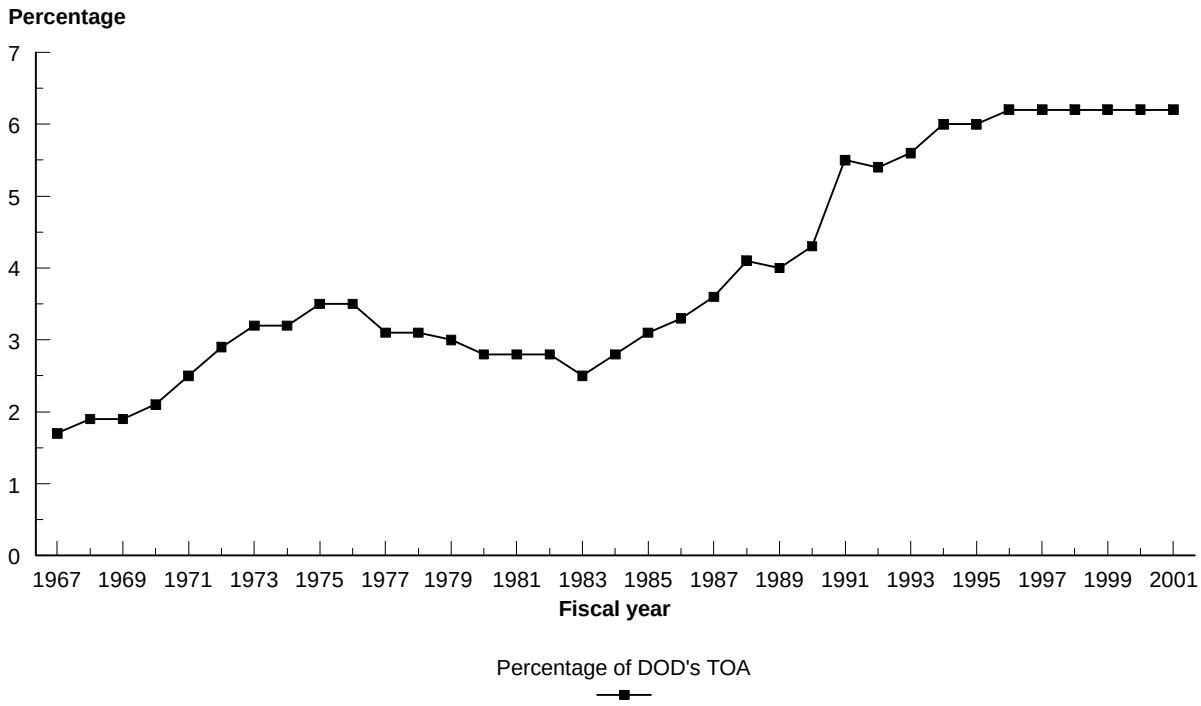
Historical and Projected Defense Health Share of DOD's TOA



Source: DOD Health Affairs.

The medical share of DOD's TOA has increased from 1.7 percent 30 years ago to 6.2 percent in recent years. Although the historical data show an upward trend in the Defense Health portion of the total DOD budget, DOD projects a flat 6.2-percent share of TOA from fiscal year 1996 to fiscal year 2001.

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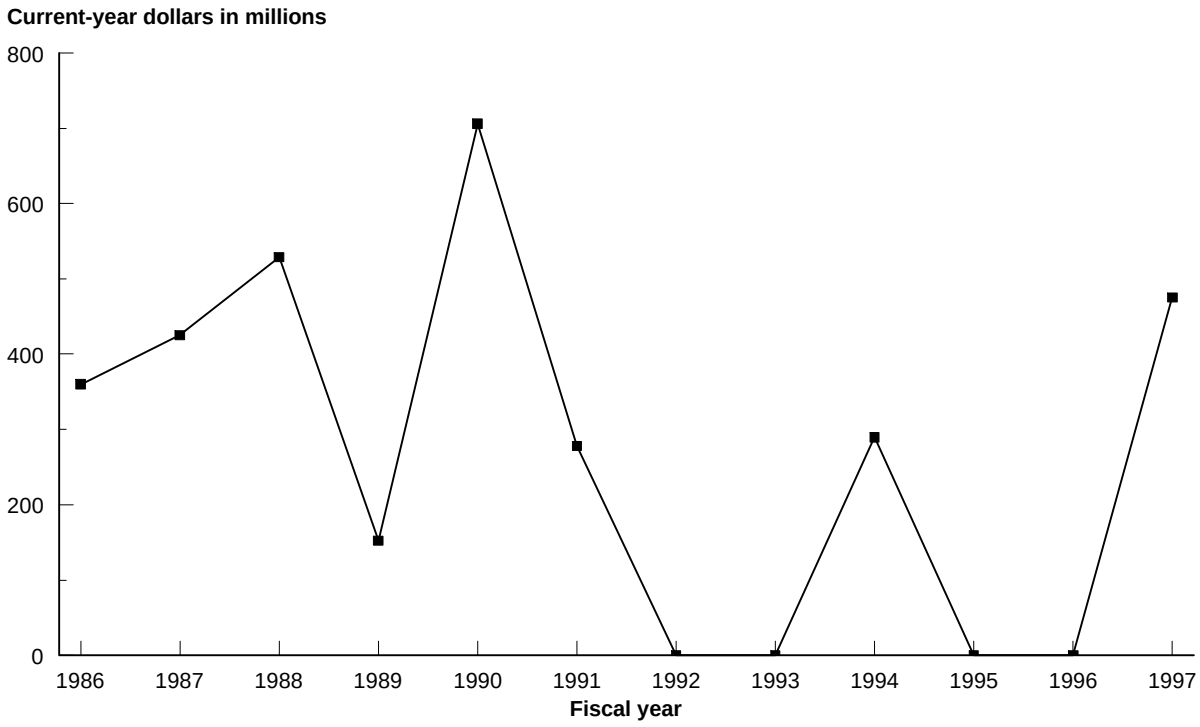
History of DOD's Underestimated Defense Medical Program TOA



Source: DOD Health Affairs.

DOD has a history of underestimating its medical program budget authority. DOD officials attributed this problem to the difficulty in estimating CHAMPUS costs. For 8 of the 12 fiscal years since 1986, DOD's health program has received additional funds above those budgeted. The understated budgets were addressed by either reprogramming funds or supplemental funding in 6 years. There were appropriation adjustments in 2 years. In 4 of the past 6 years additional funding was not required.

Model and Assumptions

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DOD's Methodology and Assumptions in Constructing the Estimate

- Health Affairs uses a capitation financing model to estimate patient care costs.
- DOD considers the capitation financing model to reasonably estimate Defense Health Program costs.

To construct the Defense Health Program budget, DOD Health Affairs uses a capitation financing model that estimates per capita health care costs on the basis of the user population, adjusted for gender and age and other factors such as inflation. The budget is constructed under the guidance and direction of the Defense Comptroller and PA&E.

PA&E and the Defense Comptroller accept the model as a reasonable approach for estimating patient care costs. An Institute for Defense Analysis analyst who is familiar with the model agrees. Health Care Financing Administration officials noted that DOD's current approach is an improvement over previous DOD budgeting methods, which were based on historical workload.

GAO DOD's Methodology and Assumptions in Constructing the Estimate

- DOD assumed 5 percent savings from utilization management for the 1998 Defense Health Program POM and raised this to 7 percent for revised estimates.
- Utilization management savings are not derived from program performance data or formal methodology.
- Congressional Budget Office and Health Care Financing Administration suggest anticipated savings may be optimistic.

Managed health care allows for the application of utilization management techniques, such as gatekeepers, to reduce unnecessary treatment and testing. The introduction of such techniques within the Defense Health Program may result in lower costs. DOD initially estimated cumulative savings of 5 percent from utilization management in the Defense Health Program POM, but during the course of our review it increased the projection to 7 percent in revised budget projections.

PA&E and DOD Health Affairs did not have managed care program performance data to permit a more reliable estimate and, in the absence of such data, did not derive the utilization management savings assumption from a formal methodology or analysis. For example, DOD might have derived estimated utilization management savings from an analysis of analogous programs in the private sector, or from a blend of specific savings from specific types of health care programs that apply utilization management techniques similar to those being employed in DOD's program. DOD could have then adjusted these estimates for DOD-unique conditions. Instead, DOD officials who constructed the estimates explained that they discussed and agreed on savings estimates from a range of 2 to 14 percent experienced in the private sector without a formal methodology or analysis as a basis.

In a July 1995 study, the Congressional Budget Office stated that depending on the assumptions, the broad application of managed care techniques—including utilization management—under DOD's new TRICARE system in fiscal year 1996 could generate a savings of no more than 1 percent under optimistic assumptions and increased costs of up to 6 percent under pessimistic assumptions. Health Care Financing Administration officials stated that although the introduction of utilization management generally can be expected to generate one-time savings, they could not offer an estimate as to the extent of savings that DOD might achieve.

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DOD's Methodology and Assumptions in Constructing the Estimate

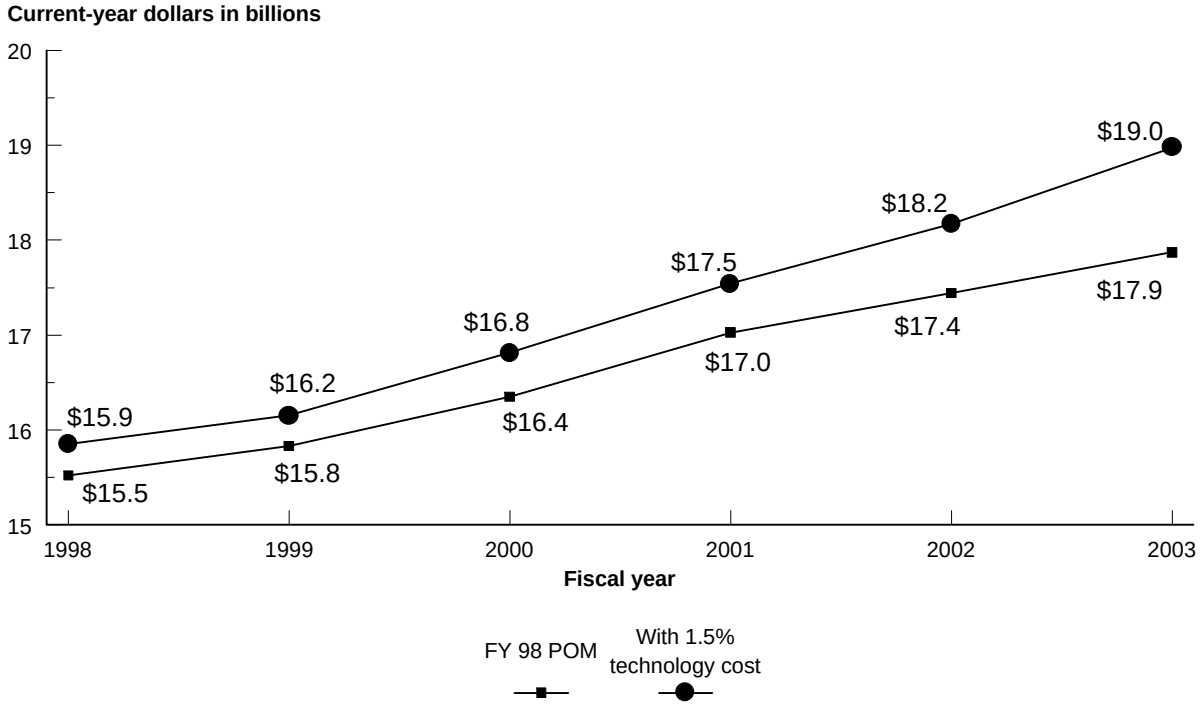
- DOD's model allows for a cost growth factor for technology and intensity of treatment, but the 1998 POM estimate assumes a factor of zero.
- A contractor is studying the extent to which technology and intensity affect the Defense Health Program budget.
- Outside experts believe that a reasonable estimate for cost growth from technology and intensity of treatment is about 1 or 2 percent.

As health care providers adopt new and expensive medical technologies and offer more intensive patient treatment, medical cost growth occurs above the rate of medical inflation. Under a DOD contract, the Institute for Defense Analysis has been studying for over a year the extent to which new technology and increased intensity of treatment affect the Defense Health Program budget. DOD Health Affairs has allowed for a technology and intensity of treatment factor within its cost-estimating model. However, because the contractor had not yet issued its report, DOD Health Affairs applied zero for this cost growth factor.

A PA&E official stated that it is appropriate to apply a zero factor for technology because DOD has a number of small, low-technology facilities and performs fewer complex and expensive procedures compared to some private sector hospitals. Further, the official stated that medical inflation rates already account for technology cost growth.

We reviewed information on specialized units, medical procedures, and services available at some of DOD's larger medical facilities and found, for example, that neonatal intensive care, oncology, HIV-AIDS, and open heart surgery were common. All officials with whom we spoke within DOD and outside of DOD agreed that precisely measuring the technology cost growth factor is very complex and difficult. Nevertheless, analysts from the Health Care Financing Administration and the Institute for Defense Analysis estimated that a cost growth factor of about 1 or 2 percent for technology and intensity of treatment is a reasonable factor for DOD to apply in estimating the Defense Health Program budget. It is widely recognized in health care financing literature that technology and intensity cost growth occurs beyond medical inflation.

Defense Health POM Estimate, Adding 1.5 Percent for Technology and Intensity



Source: 1998 POM.

Because DOD does not account for the technology and intensity of treatment cost growth factor in its budget estimate, its Defense Health Program budget is likely to be understated. To illustrate the effect of accounting for this factor, we asked DOD Health Affairs to apply the model using a technology cost growth factor of 1.5 percent instead of zero.[1] The addition of this technology factor to the model increased the POM estimate by a cumulative $3.4 billion between fiscal year 1998 and 2003.

[1]A 1.5 percent factor is the approximate midpoint of the range of estimates that health care financing experts thought was reasonable. Although DOD has not yet determined the appropriate factor for the Defense Health Program, we believe that adding 1.5 percent illustrates the potential effect of applying a factor within this range.

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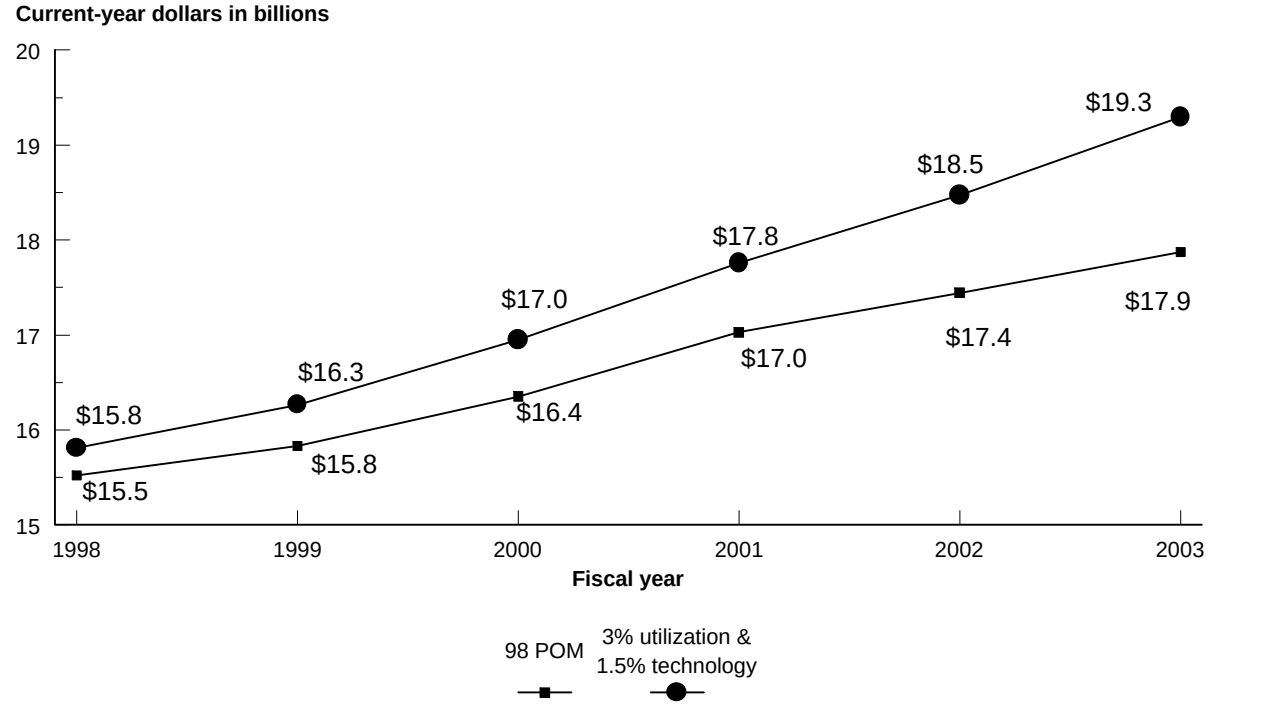
Defense Health POM With 3 Percent Utilization Savings and 1.5 Percent Technology Cost



Source: 1998 POM.

The extent of savings expected from utilization management techniques is speculative. DOD applied a 5-percent savings rate to the 1998 POM estimate. This estimate was not based on a study or other methodology, but rather was a percentage DOD selected because it fell within the 2- to 14-percent range experienced by private sector managed health care providers. We asked DOD Health Affairs to apply the model using both a 1.5-percent technology cost growth factor and a reduced utilization management savings rate of 3 percent. Although the savings rate, if any, is unknown at this time, applying a 3-percent rate illustrates the effect of a lower rate of savings than DOD has included in its estimates. Using these two adjusted factors, the combined cumulative underbudgeting of the Defense Health Program between fiscal year 1998 and 2003 would be $4.5 billion.

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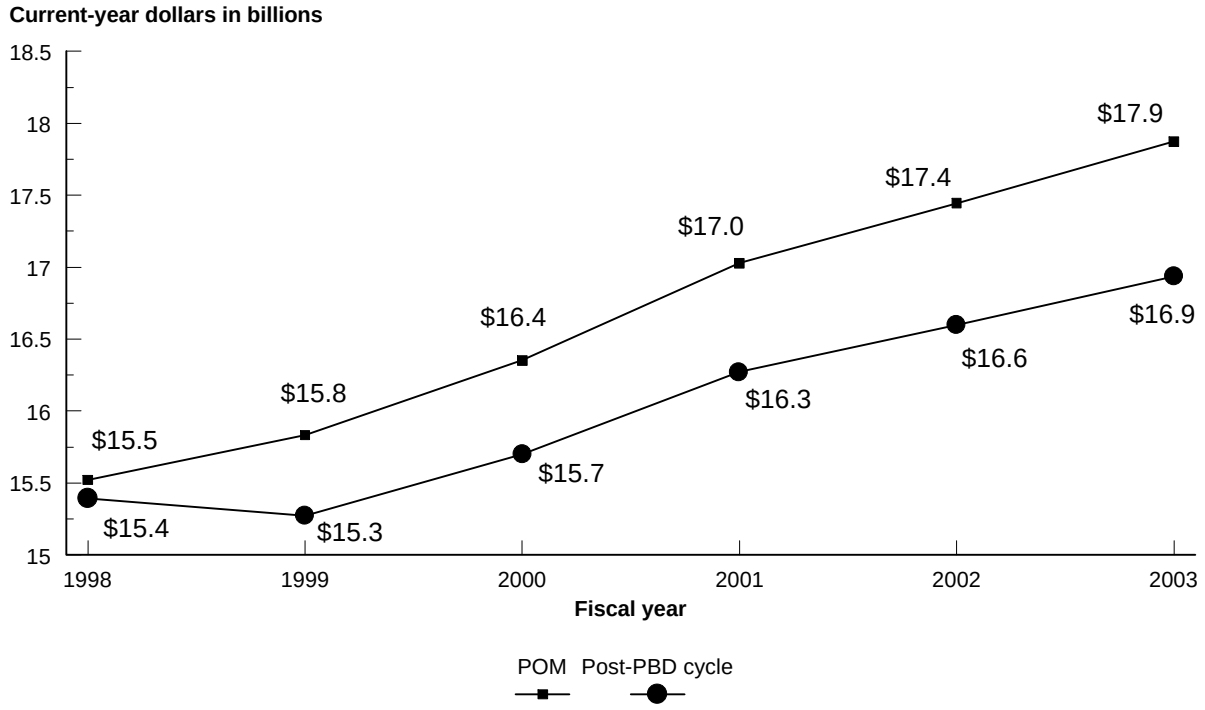
1998 POM and 1998 Post-Program Budget Decision Cycle Data



Note: Program Budget Decision—PBD.

Source: 1998 POM and post-PBD cycle data.

As the programming and budgeting process continued after the Defense Health Program POM was issued, DOD reduced its estimate of TOA for fiscal years 1998-2003. The 1998 POM estimate for fiscal year 2003 was $17.9 billion, for example, whereas the post-program budget decision (PBD) estimate was $16.9 billion. DOD increased its estimated savings from utilization management from 5 percent to 7 percent, lowered the cost of living assumption in the base year because 1996 inflation was lower than expected, and reduced operation and maintenance funding among other measures.

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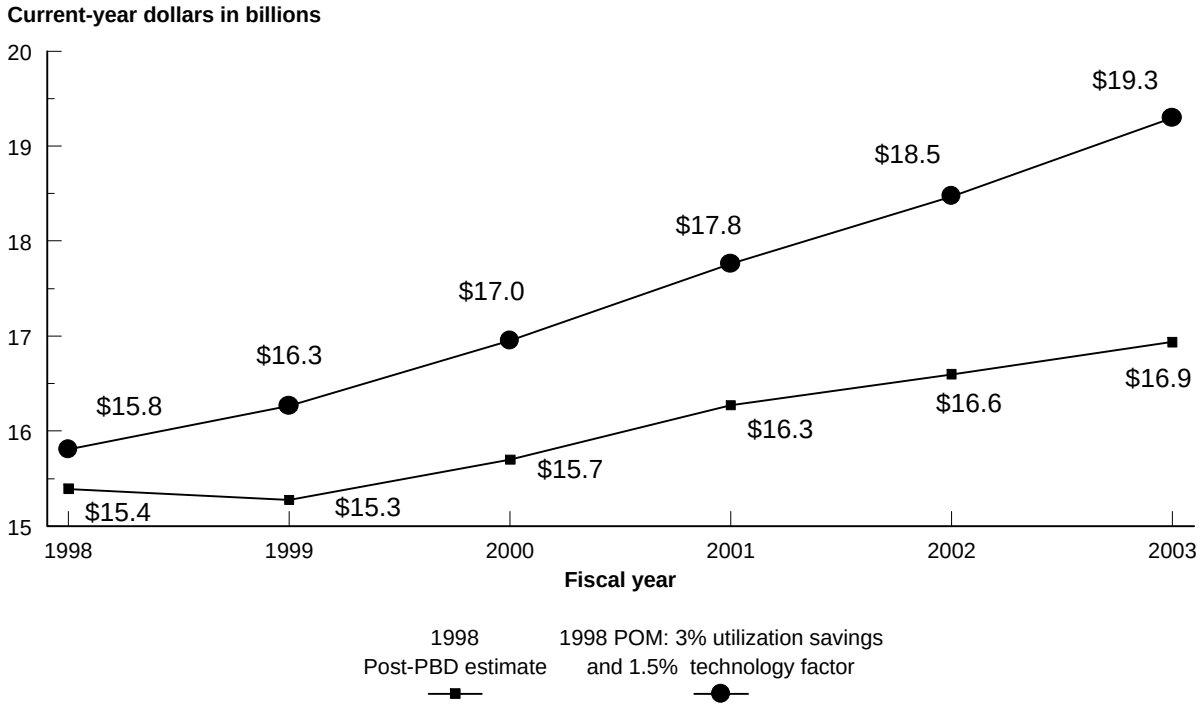
Updated Budget Estimate and 1998 POM With 3 Percent Utilization Management Savings and 1.5 Percent Technology Cost



Source: 1998 post-PBD cycle data and 1998 POM.

To illustrate the effect of DOD's lower estimate of Defense Health Program TOA, we compared the post-PBD cycle estimate to the POM estimate that incorporated a 1.5-percent technology factor and a lower utilization management savings of 3 percent. TOA using the post-PBD cycle data was $16.9 billion in 2003, for example, while the estimated program requirement using the revised assumptions for technology and utilization management savings was $19.3 billion. Using these assumptions, the post-PBD estimates could be understated by a cumulative $8.4 billion from fiscal year 1998 to fiscal year 2003.

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