This health-care option—old CHAMPUS with some refinements—may be the only one open to those living in some areas.

A Standard for Tricare

By Suzann Chapman, Associate Editor

Tricare Standard is simply CHAMPUS by another name. Even so, some complain that implementation of the Defense Department’s regional managed-care contracts has led to serious problems with the program. They say that physicians who once accepted CHAMPUS decline to accept Tricare Standard. They maintain that the claims process has become more convoluted and, in some cases, much more restrictive.

In Fiscal 1994, Congress instructed the Pentagon to combine the health programs of the three services and come up with a new, nationwide program modeled on health maintenance organization (HMO) plans. The program would have to provide health care at no greater cost to the government and with reduced out-of-pocket costs to beneficiaries who enrolled.

Enter Tricare with its package of three health-care options. Tricare Prime is the option, similar to HMOs, in which beneficiaries must enroll and use network providers, whether military or civilian. Tricare Extra is similar to a preferred-provider organization, in that it offers somewhat reduced cost for beneficiaries who use providers within the Tricare Prime network. Tricare Standard is CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) and provides the most freedom but costs the beneficiary and the government more.

CHAMPUS marked its thirtieth anniversary last year. Congress created the DoD-administered, insurance-like program in 1966 to handle the needs of a growing population of dependents and retirees and their family members, who could not get medical care in a military treatment facility (MTF).

In Fiscal 1967, the CHAMPUS budget was $106 million. CHAMPUS officials estimate that probably no more than a few thousand claims were made that first year. In Fiscal 1997, the budget is $3.6 billion. The program received about 22 million claims in Fiscal 1996.

Essentially, Tricare/CHAMPUS operates as a fee for service health-insurance plan, paying a percentage of medical costs after taking a deductible. It does not require premiums, but beneficiaries do share the cost. It also does not cover all health care. As a result, most beneficiaries obtain supplemental insurance.

Several recent changes to procedures for Tricare/CHAMPUS probably have heightened confusion and problems.
Changing the Rules

A recent, critical change for the Tricare/CHAMPUS program has been the gradual institution of Medicare reimbursement levels. In some cases, Tricare/CHAMPUS payment levels were higher than those established for Medicare. However, that changed for the most part in 1993 with the implementation of the same billing limitation used by Medicare.

According to Pentagon health officials, DoD is making progress in bringing Tricare/CHAMPUS reimbursement rates in line with the Medicare level. However, current Tricare/CHAMPUS rates are less than Medicare for 61 out of 7,000 reimbursable services. Officials state that the Pentagon needs legislative assistance and a rule change to move those rates up so that they are equivalent to the Medicare rate levels.

By law, since November 1, 1993, providers who do not participate in Tricare/CHAMPUS are prohibited from billing more than 15 percent above the CHAMPUS maximum allowable charge. For instance, if the CMAC for a procedure is $100, then the nonparticipating provider may charge no more than $115. Providers who do participate in Tricare/CHAMPUS are those who have agreed to accept the CMAC as their full fee for services.

Military health-care beneficiaries who opt to see a nonparticipating provider, who will not comply with the 115 percent rule, have two choices. They can pay the additional amount, as well as the copayment. Or, they can mail a written complaint to the Tricare/CHAMPUS claims processor, who will

Tricare Contacts and Contract Status

First stop for questions about military health-care benefits is the health-benefits advisor at the nearest military treatment facility or the Tricare Service Center at or near the MTF. You may also call the following numbers within each region to ask general questions or find a number for the nearest TSC.

<table>
<thead>
<tr>
<th>Region</th>
<th>States</th>
<th>Lead Agent</th>
<th>Contractor</th>
<th>Start Date</th>
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<tbody>
<tr>
<td>1</td>
<td>Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, northern Virginia</td>
<td>Rotates annually among Walter Reed Army Medical Center, National Naval Medical Center, and Malcolm Grow Medical Center in the Washington, D.C., metropolitan area</td>
<td>Pending</td>
<td>December 1997</td>
</tr>
<tr>
<td>2</td>
<td>North Carolina, southern Virginia</td>
<td>Navy Medical Center Portsmouth, Portsmouth, Va.</td>
<td>Pending</td>
<td>February 1998</td>
</tr>
<tr>
<td>3</td>
<td>Florida (excluding panhandle), Georgia, South Carolina</td>
<td>Dwight David Eisenhower Army Medical Center, Fort Gordon, Ga.</td>
<td>Humana Military Healthcare Services</td>
<td>July 1996</td>
</tr>
<tr>
<td>4</td>
<td>Alabama, Mississippi, Tennessee, Florida panhandle, eastern Louisiana</td>
<td>Keesler Air Force Medical Center, Keesler AFB, Miss.</td>
<td>Humana Military Healthcare Services</td>
<td>July 1996</td>
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<tr>
<td>5</td>
<td>Indiana, Illinois, Kentucky, Michigan, Ohio, West Virginia, Wisconsin</td>
<td>Wright-Patterson Air Force Medical Center, Wright-Patterson AFB, Ohio</td>
<td>Pending</td>
<td>February 1998</td>
</tr>
<tr>
<td>6</td>
<td>Arkansas, Oklahoma, Texas (except extreme western area), most of Louisiana</td>
<td>Wilford Hall Air Force Medical Center, Lackland AFB, Tex.</td>
<td>Foundation Health Federal Services, Inc.</td>
<td>November 1995</td>
</tr>
<tr>
<td>7</td>
<td>Arizona, New Mexico, Nevada, extreme western Texas</td>
<td>William Beaumont Army Medical Center, Fort Bliss, Tex.</td>
<td>TriWest Healthcare Alliance, Inc.</td>
<td>April 1997</td>
</tr>
<tr>
<td>8</td>
<td>Colorado, southern Idaho, Iowa, Kansas, Minnesota, Missouri, Montana, Nebraska, North Dakota, South Dakota, Utah, Wyoming</td>
<td>Evans US Army Community Hospital, Fort Carson, Colo.</td>
<td>TriWest Healthcare Alliance, Inc.</td>
<td>April 1997</td>
</tr>
<tr>
<td>9</td>
<td>Southern California</td>
<td>San Diego Naval Medical Center, San Diego, Calif.</td>
<td>Foundation Health Federal Services, Inc.</td>
<td>April 1996</td>
</tr>
<tr>
<td>10</td>
<td>Northern California</td>
<td>David Grant Air Force Medical Center, Travis AFB, Calif.</td>
<td>Foundation Health Federal Services, Inc.</td>
<td>April 1996</td>
</tr>
<tr>
<td>11</td>
<td>Washington, Oregon, northern Idaho</td>
<td>Madigan Army Medical Center, Fort Lewis, Wash.</td>
<td>Foundation Health Federal Services, Inc.</td>
<td>March 1995</td>
</tr>
<tr>
<td>12</td>
<td>Hawaii</td>
<td>Tripler Army Medical Center, Honolulu, Hawaii</td>
<td>Foundation Health Federal Services, Inc.</td>
<td>April 1996</td>
</tr>
</tbody>
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tains that although some providers have raised concerns, especially about the new pricing levels, most have accepted the recent changes. According to the Pentagon, providers across the nation accept the new payment levels on 86 percent of Tricare/CHAMPUS services, about the same as five years ago.

Officials also state that participation by civilian providers is highest where Tricare has been implemented and where military presence is great. For example, in California and Hawaii, where military managed-care demonstration programs were established in 1988, provider participation in Tricare Standard/CHAMPUS is at 94 percent and 98 percent, respectively. Other states with large military beneficiary populations also show higher provider participation—Florida at 91 percent, Texas at 88 percent, and Virginia at 92 percent.

On the other hand, states with a smaller military presence have lower provider participation—Connecticut at 64 percent, Minnesota at 63 percent, Iowa at 62 percent, Vermont at 60 percent, and Idaho at 55 percent.

Those Pesky NASs

The Defense Department also instituted two rule changes on September 23, 1996, regarding the infamous non-availability statement (NAS).

First, the easy part. Those beneficiaries who are not enrolled in Tricare Prime and who are using Tricare Extra or Standard do not need an NAS for outpatient care from civilian providers. They will need an NAS for nonemergency inpatient care from a civilian provider if the beneficiary lives within the MTF catchment area, that is, within the ZIP code service area.

Second, the hard part. Although an NAS is not required, the civilian provider must have certain procedures (currently the list includes 17, ranging from cataract removal to tonsillectomy) approved ahead of time by the regional Tricare contractor. Whether or not they participate in Tricare/CHAMPUS, providers must ask for pre-authorization by letter or phone. The beneficiary may check with the regional health-care finder to ensure the procedure will be covered if the provider does not, or will not, make the request.

If the procedure is not pre-approved, it may not be covered, or the government could reduce the amount it pays to the provider by 10 percent. And, since the list of 17 may change over time, there is no guarantee that Tricare/CHAMPUS will honor a second claim just because it covered a procedure once.

Some beneficiaries feel that these kinds of changes and the implementation of Tricare nationwide may have prompted providers who once accepted CHAMPUS payments to refrain from doing so now. However, individual providers have always had the option to participate in CHAMPUS on a case-by-case basis.

Tricare/CHAMPUS Claims Processors

The contractors who currently process claims for Tricare/CHAMPUS are the same four who handled claims processing before the start of Tricare. In two cases, the names have changed, and some areas of coverage have shifted. As of July 1996, they are:

- Foundation Health Federal Services, Inc., which processes claims for part of Idaho, Oregon, and Washington. It is also the current Tricare contractor for Regions 6, 9, 10, 11, and 12.
- Palmetto Government Benefits Administrators, known as Palmetto GBA, which handled CHAMPUS claims processing as Blue Cross/Blue Shield of South Carolina until 1994. It now covers Alabama, Alaska, Arizona, California, Colorado, District of Columbia, Florida, Georgia, Hawaii, Idaho (excluding Benewah, Bonner, Boundary, Kootenai, Latah, and Shoshone counties), Iowa, Kentucky (excluding the Fort Campbell area), Louisiana (New Orleans area), Maryland, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, South Carolina, South Dakota, Tennessee, Utah, Virginia, West Virginia, Wisconsin, and Wyoming.
- Wisconsin Physicians Service, which processes claims for Arkansas, Kansas, Kentucky (Fort Campbell area), Missouri, Oklahoma, and Texas.

send a letter to the provider stating the law and asking for a refund.

The second course would probably lead to the removal of the provider from the list of authorized Tricare/CHAMPUS providers, as well as from the Medicare list. In which case, Tricare/CHAMPUS will not pay any portion of bills from that provider.

There is an exception, however. If the CMAC rates are so low in a given area that providers refuse to participate, DoD can increase the rate for that area. But that would be an unusual exception, since in most areas a number of providers are usually willing to accept CMAC rates.

Another fundamental change also caused some consternation for both providers and beneficiaries. Beginning October 1, 1996, federal law required all institutional or individual providers, except pharmacies, to file claims on behalf of Tricare/CHAMPUS patients.

Previously, only participating providers routinely filed claims for their Tricare/CHAMPUS patients. Since last October, it no longer matters whether or not the provider chooses to participate in the Tricare/CHAMPUS program.

The law prohibits patients from filing the claims themselves, unless they request and receive a waiver from the appropriate regional Tricare contractor. What’s more, the contractors will grant waivers only if they decide that the patients would have reduced access to needed medical care unless they receive care from that provider. In other words, there must be a shortage of providers in that location for a particular service. The beneficiaries must submit the waiver with each claim.

Without a waiver, if a provider refuses to file on behalf of the patient or charges an administrative filing fee, the CMAC will be reduced by 10 percent. The provider may not pass this charge on to the patients. Additionally, repeated failures to file claims for patients may lead to removal of the provider from the list of those authorized to provide care to Tricare/CHAMPUS beneficiaries. At that point, the government will not pay any portion of the bill.

There is an exception to this claims filing law. If a beneficiary has other health insurance that provides primary coverage—that is, it pays before Tricare/CHAMPUS—then the beneficiary may file the claim. They do not need a waiver but must show what the other insurance company paid.

Tricare/CHAMPUS officials main-
Painful Process

Many beneficiaries are unhappy with the new state of military health care, and defense officials agree that there are no easy answers. They emphasize that it’s a tough process to move from what had been essentially an open medical system to a highly structured managed-care arrangement.

In testimony before Congress last March, the senior noncommissioned officers from each service stated that there were problems with the new health-care system and stressed the importance of the health-care benefit to recruiting and retention in the future. However, all of them felt that, given time, the Tricare program will succeed.

CMSAF Eric W. Benken, USAF’s top enlisted man, said that he heard good reviews at Fairchild AFB, Wash., which is in the first region to implement Tricare. At other locations, such as in the Texas-Oklahoma area, “it’s been a little bit tougher, a little bumbier, although it’s getting better,” he said.

“It’s going to have fits and starts—you know, it’s not a small process to undertake.”

Dr. Stephen C. Joseph, who recently retired as the Pentagon’s top health official, told a Congressional committee in March that the shift of military medicine in a few years from three cottage industries into a corporate endeavor has been an evolutionary process that has some problems inherent in it, “But we’re convinced we’re on the right road of balancing the triangle of access, quality, and cost-containment—but it is not without pain and it’s not without difficulties.”

Some of those difficulties arise from the varying desires of beneficiaries. For example, some beneficiaries want to have health care provided within an MTF, but they live in an area where they’re forced to use a civilian provider. Others want to be able to choose any civilian provider rather than choosing a military provider at an MTF or being limited by a network. And some retirees want to continue to use an MTF but don’t want to pay an annual premium because they are accustomed to free health care.

The annual premium for retirees enrolled in Tricare Prime is $230 for singles and $460 for families. By charging retirees an annual premium, the Defense Department expects to keep its costs down and still live up to the Congressional mandate of “reduced out-of-pocket costs.” According to DoD, the average retiree paid $900 per year for health care prior to implementation of Tricare.

Among the many associations that are closely following this military health-care issue is the National Military Family Association, whose officials admit that Tricare Prime is less costly than Tricare/CHAMPUS.

In testimony before Congress March 12, NMFA’s Sylvia Kidd noted, “While copayments in the civilian part of [Tricare] Prime and enrollment fees for retirees are certainly a departure from free health care, [Tricare] Prime still offers a reduction in health-care costs to those who have been forced to use the standard CHAMPUS program.”

In fact, the Defense Department expected military health-care beneficiaries to prefer its HMO option, thus reducing their dependence over time on Tricare/CHAMPUS. However, even when Tricare is fully implemented in early 1998, Tricare Prime will not be available in all areas. Some beneficiaries will have to use Tricare/CHAMPUS.

It is a bureaucratic and often confusing process—both for the beneficiaries and the claim processors. Dr. Joseph stated that the Pentagon is increasingly aware of the complexities of Tricare/CHAMPUS claims processing.

He said that a critical element in the Tricare program is to make sure the contractors process claims quickly, accurately, and fairly. Each of the contractors must process 75 percent of claims submitted within 21 days or face monetary penalties. “We have taken the necessary actions in certain instances,” noted Dr. Joseph. “In one region we’ve cited for deficiencies, we’ve exerted financial penalties—$200,000 in one case.”

With three regions still waiting to implement Tricare, the arduous process is far from over. Probably the best summation of the current state of military health care came from Benken in his recent testimony.

“I think that Tricare is something that has to grow,” he said. “We have to be optimistic, I think, because I don’t think we have too many alternatives. We’re not going to get the 35 percent of the infrastructure that we lost when we did the drawdown. You can stand outside of Austin, Tex., [at] Bergstrom AFB, and rattle the gate all you want. They probably just have tumbleweeds in the hospital. And we’re not going to get that back. So for us, I think Tricare is kind of a do-or-die situation.”

Tricare on the Internet

The Tricare Support Office (formerly Office of CHAMPUS), Aurora, Colo., established an Internet home page as a way to ease problems and frustrations during Tricare’s implementation. Provided on that page (http://www.ochampus.mil) is a discussion site, called “Forum.”

Individuals may post general questions—not specific claims—on the Forum. A public affairs representative responds to queries and, in some cases, starts a process to correct problems. In other instances, the TSO may respond directly via e-mail or ask the e-mailer to send more data to the TSO’s Benefits Services Branch.

The Forum is open; anyone can review any posted question or response. The TSO said that questions and complaints are shared with contract monitors and are available to DoD health officials.

As of April 16, the forum contained a list of 38 topics, including Illogical Rules; Claim Filing, 115 Percent Rules; Claims Service; CHAMPUS Allowables; Resources for Finding CHAMPUS Providers; and Appeals.

Several individuals stated that the new 115 percent rule has left them with larger portions of the bills. Under the old rules, CHAMPUS paid more.

A few individuals complained that, in areas with a limited number of specialists, they are hard-pressed to find ones willing to abide by the 115 percent law. (The TSO said Tricare/CHAMPUS may provide some kind of exemption.)

Many complaints revolved around poorly trained and rude customer-service personnel and inadequate telephone lines.

A few entries maintain that the Tricare/CHAMPUS Maximum Allowable Charge must be wrong for their area. (The TSO stated that the CMAC is calculated annually for each area based on 80 percent of the average for each procedure but must not exceed Medicare rates.)

Several individuals complained about the limited selection of providers and hospitals—they may have the required number but not quality—in the Tricare networks in their areas.

The gripes are often long and sometimes colorful. For instance, “Makes you wonder why you put your life on the line for a bunch of bureaucratic automatons whose only purpose in life is to make things as difficult as possible for you.”

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