comply. Cost sharing, utilization management, and other requirements are different for mental health services in standard CHAMPUS, just as they are in many civilian sector health plans. Given the need to craft a benefit design which is cost-effective for beneficiaries and the Government, we found no alternative but to preserve the distinct treatment of mental health services.

Regarding comments about potentially high costs for durable medical equipment and prostheses, we agree, and have lowered the catastrophic cap to \$3,000 for retirees, their family members and survivors enrolled in TRICARE Prime.

Regarding objections to the provision allowing for annual updates in enrollment fees and copayments, since the uniform HMO Benefit cost sharing was calculated to be constant over a five-year period, we acknowledge this concern, and are committed to maintaining a stable benefit. We have retained the provision allowing updates, however, because of the statutory direction to administer the Uniform HMO Benefit so the DoD costs are no higher than they would be without the program. If the program is not budget neutral, enrollment fees or other cost sharing will need to be increased, or other actions taken, to assure budget neutrality. We recognize that this is a sensitive issue, and we strongly believe that no increases in enrollment fees will be necessary during the first five years of the program, because we performed exhaustive analysis in arriving at the cost sharing structure, and critically reviewed all the assumptions we made about program performance. Considerations leading to retention of the provision permitting updates to fees include, first, that the enrollment fees in the Uniform HMO Benefit are set at the absolute minimum necessary to comply with the budget neutrality dictates; there is no "cushion" built in. Second, the Congressional Budget Office, in reviewing the Uniform HMO Benefit, determined that there is so much uncertainty about the performance of managed care systems that precise predictions are impossible. CBO has formally estimated that the Uniform HMO Benefit will increase DoD's costs of health care delivery, despite the statutory requirement that it be budget neutral, and that total cost will probably increase by about 3 percent. Finally, the implementation of TRICARE over the next several years provides an opportunity to confirm the assumptions we made in establishing the Uniform HMO Benefit.

Regarding objections to application of enrollment fees to retirees, their

survivors, and family members, and not to active duty families, and suggestions that this represents an inapporpriate subsidy, we would point out that our analysis considered the costs of retirees, their family members and survivors separately from the costs of active duty family members. There is no subsidy of active duty family members by other beneficiaries inherent in the benefit design; instead the differences in cost sharing reflect the differences established statutorily when CHAMPUS was created in 1966, and revised numerous times since then.

Regarding the comment that we ignored the statutory requirement that the Uniform HMO Benefit be modeled on private sector HMO plans, because its cost sharing requirements were higher in some, we disagree. The Uniform HMO Benefit does include somewhat higher copayment than are used in most private sector HMO plans, owing to the other statutory requirements we must address; however, we feel that the Uniform HMO Benefit is "modeled" on HMO plans, because it employs the same approach they do, replacing percentage-based cost sharing with fixed dollar copayment to limit beneficiary out-of-pocket expenses and reduce incentives for over-provision of care. The statute imposes several conflicting requirements for the Uniform HMO Benefit, and our design attempts to "harmonize" these requirements to the maximum extent feasible. These include the requirement to model the benefit on private sector plans, the requirement that beneficiary out-of-pocket costs be reduced, and that government costs be no greater than would otherwise be incurred for enrollees. Replicating a typical HMO plan offered in the Federal Employee Health Benefits Program, for example, would violate the out-of-pocket cost provisions, because (although per-visit copayments are very low) annual out-ofpocket costs are much higher than in CHAMPUS owing to much higher premiums. Using the very attractive (low) copayments from one of these plans along with low enrollment fees would violate the requirement for budget neutrality. In a nutshell, the Uniform HMO Benefit design reflects a careful balancing of several statutory requirements; considering any one of them in isolation is inappropriate.

## 3. Provisions of the Final Rule

The final rule is consistent with the proposed rule, except for one important change. We have revised the benefit in response to concerns about the vulnerability of a small number of retirees to high out-of-pocket costs, owing to the percentage cost share for durable medical equipment, coupled with a catastrophic cap of \$7,500 per family. Instead of incorporating the standard CHAMPUS catastrophic cap of \$7,500, the Uniform HMO Benefit will include a catastrophic cap of \$3,000 for retirees, survivors, and their family members. Thus retirees, survivors, and their family members who enroll in TRICARE Prime will have a considerably lower limit on their annual out-of-pocket expenses, in addition to the dramatically lower per-service charges features in the Uniform HMO Benefit.

## D. Applicability of the Uniform HMO Benefit to the Uniformed Service Treatment Facilities Managed Care Program (Section 199.18(q))

## 1. Provisions of Proposed Rule

The section would apply the Uniform HMO Benefit provisions to the Uniformed Services Treatment Facility Managed Care Program, beginning in fiscal year 1996. This program includes civilian contractors providing health care services under rules quite different from CHAMPUS, the CHAMPUS Reform Initiative, or other CHAMPUS-related programs.

The National Defense Authorization Act for Fiscal Year 1991, section 718(c), required implementation of a "managed-care delivery and reimbursement model that will continue to utilize the Uniformed Services Treatment Facilities" in the MHSS. This provision has been amended and supplemented several times since that Act. Most recently, section 718 of the National Defense Authorization Act for Fiscal Year 1994 authorized the establishment of "reasonable charges for inpatient and outpatient care provided to all categories of beneficiaries enrolled in the managed care program." This is a deviation from previous practice. which had tied Uniformed Services Treatment Facilities (USTF) rules to those of MTFs. This new statutory provision also states that the schedule and application of the reasonable charges shall be in accordance with terms and conditions specified in the USTF Managed Care Plan. The USTF Managed Care Plan agreements call for implementation in the USTF Managed Care Program of cost sharing requirements based on the level and range of cost sharing required in DoD managed care initiatives.

The Conference Report accompanying National Defense Authorization Act for Fiscal Year 1994 calls on DoD "to develop and implement a plan to introduce competitive managed care