

**NATIONAL DEFENSE UNIVERSITY
NATIONAL WAR COLLEGE**

**DEFENSE HEALTH CARE COSTS:
STRATEGIC IMPLICATIONS**

**COLONEL STEPHEN MCGUIRE
COURSE NUMBER 5605
US MILITARY STRATEGY AND JOINT OPERATIONS
SEMINAR H**

**PROFESSOR
CAPT DAVID K. BROWN**

**ADVISOR
COL(s) ROBERT KADLEC**

Report Documentation Page				Form Approved OMB No. 0704-0188	
Public reporting burden for the collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to Washington Headquarters Services, Directorate for Information Operations and Reports, 1215 Jefferson Davis Highway, Suite 1204, Arlington VA 22202-4302. Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to a penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.					
1. REPORT DATE 2001		2. REPORT TYPE		3. DATES COVERED 00-00-2001 to 00-00-2001	
4. TITLE AND SUBTITLE Defense Health Care Costs: Strategic Implications				5a. CONTRACT NUMBER	
				5b. GRANT NUMBER	
				5c. PROGRAM ELEMENT NUMBER	
6. AUTHOR(S)				5d. PROJECT NUMBER	
				5e. TASK NUMBER	
				5f. WORK UNIT NUMBER	
7. PERFORMING ORGANIZATION NAME(S) AND ADDRESS(ES) National War College, 300 5th Avenue, Fort Lesley J. McNair, Washington, DC, 20319-6000				8. PERFORMING ORGANIZATION REPORT NUMBER	
9. SPONSORING/MONITORING AGENCY NAME(S) AND ADDRESS(ES)				10. SPONSOR/MONITOR'S ACRONYM(S)	
				11. SPONSOR/MONITOR'S REPORT NUMBER(S)	
12. DISTRIBUTION/AVAILABILITY STATEMENT Approved for public release; distribution unlimited					
13. SUPPLEMENTARY NOTES					
14. ABSTRACT see report					
15. SUBJECT TERMS					
16. SECURITY CLASSIFICATION OF:			17. LIMITATION OF ABSTRACT	18. NUMBER OF PAGES 14	19a. NAME OF RESPONSIBLE PERSON
a. REPORT unclassified	b. ABSTRACT unclassified	c. THIS PAGE unclassified			

Defense Health Care Costs: Strategic Implications

In an ideal world, the National Security Strategy (NSS) drives the National Military Strategy (NMS), the Joint Strategic Capabilities Plan, the Defense and Contingency Planning Guidance, and ultimately the Future Years Defense Program (FYDP) budgetary request to Congress. If resources are unlimited, all aspects of NMS and NSS goals are theoretically achievable. In reality, resource constraints limit the FYDP and hence achievable strategic goals. This forces the US to prioritize national interests, selecting some to pursue and some to abandon. Resource allocation (spending) is strategic.

In our open democratic process, regional or special interest groups can force allocation of resources to goals not necessarily of the highest global priority. Actions by the Defense Department may facilitate action by special interest groups, producing a significant reallocation of defense resources. Ideally, the Defense Department recognizes this possibility when it makes decisions, makes allowances for the possible outcomes, and ultimately makes an informed decision on the wisdom of a particular action and its present and future impact on our NSS.

Unfortunately, the Defense Department is not always sufficiently prescient in its appreciation of the consequences of its actions. This report reviews one such instance, the promise of free medical care for life, and its potential impact on future resource allocation. This case study also demonstrates the intricate interplay of political and legal systems on resource allocation and, by extension, on NMS and NSS.

Background:

Military personnel have long considered medical care to be an important benefit of military service. Military retirees believe the government promised to provide them and their dependents free health care for life.¹ In actuality, despite the overt promises by recruiters and the deliberate actions of the Services, no law entitling free retiree health care ever existed.² In 1956, Congress enacted the first legislation authorizing retirees to obtain free medical care at any military medical facility “subject to the availability of space.” When Congress added military retirees to the Medicare program in 1966, it believed the combination of space available care and Medicare would fulfill the commitment made by the Services. Realizing that military facilities were unable to provide all of the specialty care required by active duty dependents and retirees not yet eligible for Medicare, Congress also enacted the 1966 Civilian Health and Medical Program for the Uniformed Services (CHAMPUS). However, since Medicare-eligible beneficiaries already could receive additional specialty care through Medicare, Congress specifically excluded them from participating in the CHAMPUS program.

A confluence of factors in the 1990s created a health care crisis for both active duty dependents and retirees and their dependents and survivors. The first unforeseen factor was the military downsizing following the end of the Cold War. The military closed 37 hospitals and reduced 23 additional hospitals to clinics.³ Reduced military

¹ Stephen Barr, “Proposal Could Quiet Military Retirees’ Health Care Complaints,” *Washington Post*, 20 June 2000, sec. Metro, p. 2.

² Stephen Barr, “Memorial Day Bittersweet for Vets Who Feel Deprived of Promised Health Benefits,” *Washington Post*, 28 May 2000, sec. Metro, p. 2.

³ Paul Richter, “Military Retirees See Health Care Victory; Benefits: Care After 65, Which Many Say Was Promised To Them, Is Near Reality Pending Senate Action Today. But The New Entitlement Raises Concern,” *Los Angeles Times*, 12 October 2000, sec. A, p. 18.

facility capacity over the decade of the 1990s meant more needs of non-active duty went unfulfilled within the direct care military system. Space available care essentially disappeared at many military treatment facilities. CHAMPUS costs soared as the civilian medical community met dependent and retiree needs for medical care. Congress responded to soaring costs with creation of Tricare as a replacement for CHAMPUS.⁴ Congress mandated that Tricare not add anything to the cost of the overall military medical system. Expected savings, however, did not materialize. A 1995 audit by the Government Accounting Office (GAO) concluded that Congress had given the Defense Department an impossible challenge. Both active duty and retirees began to complain about the lack of access to, and the cost of, medical care.

A second aggravating factor was changing demographics. With force right-sizing, the number of active duty was decreased by a third. Simultaneously the longevity of the US population was increasing. This combination altered the mix of the military medical beneficiary population. In 1952 the retiree population, their dependents, and their survivors comprised only 11% of eligible military medical beneficiaries where in 2000 they represented 52% of beneficiaries.⁵ In addition to comprising a larger percentage of the beneficiary population, retirees also are an older population and thus consume more medical resources per capita. This change in the demographics and per capita resource consumption of the beneficiary population placed increased pressure upon the military medical system at the same time as the American populace was expecting the “peace dividend” to decrease defense spending. Constraints on the Defense Department

⁴ Jeff Nesmith, “Complaints Haunt Pentagon’s Health Care Repair; Where Are The Savings? And Where Is The Service? Doctors, Patients and Politicians Slam Program,” *Atlanta Constitution*, 1 January 1998, sec. National News, p. 7A.

budget accompanied by operational demands meant fewer financial resources were available for military medical facilities, leading to chronic under funding.⁶

A final aggravating factor was technology, accelerating increases in the already escalating costs of medical care. New diagnostic and therapeutic approaches and increased use of established approaches drove two-thirds of the national health care cost increase.⁷ The Health Care Financing Administration (HCFA) reported the 1999 national medical costs at \$1.2 trillion or 13.6 percent of the gross domestic product (GDP) with predictions of a possible increase to 25 percent of GDP by 2030. Costs increased at a 6.5 percent annual rate from 1998 through 2001. The forecast is for costs to accelerate to a 6.8 percent rate through 2008. Pharmaceutical expenditures will increase 14.6 percent in 2001⁸ and continue to increase at a rate of 14-17 percent per year.⁹ Private employers' health premiums increased 10.3 percent in 2001¹⁰ while Federal Employee Health Benefits Plan (FEHBP) premiums increased 9.5 percent.¹¹ Military medicine is not isolated from these societal pressures. It has experienced the same increased demand for new technological advances and pharmaceutical agents as those driving civilian medical services.

A combination of an aging retiree population representing an increasing percentage of the military medical beneficiary population and a global increase in medical costs exceeding inflation translates to an escalating increase in military medical

⁵ F. Allen Boyd, "Congressmen Boyds view on broken medical promises to the military retiree," accessed 28 March 2001; available from <http://rebel.212.net/yet.htm>; Internet.

⁶ "Heal Tricare Funding," *Air Force Times* (Springfield, Va.), 26 March 2001.

⁷ David Blumenthal, "Controlling Health Care Expenditures," *New England Journal of Medicine*, 344, no. 10 (2001): 766-769.

⁸ Michael Prince, "Employers Not Cutting Plans," *Business Insurance* (Chicago), 12 March 2001.

⁹ Blumenthal, "Controlling Health Care Expenditures," 766-769.

¹⁰ Prince, "Employers Not Cutting Plans."

¹¹ Peter Grier, "FEHBP Hit By Rising Costs," *Air Force Magazine*, November 1999, 12.

costs. Despite the expectations of the American public and the hopes of defense budgetary planners, this trend suggests the amount required to finance medical care by the Defense Department will increase significantly over at least the next several decades.

Beneficiary actions:

The availability of quality medical care remains important to both active duty and retirees. The 2000 USAF Careers and New Directions Survey identified the availability of medical care as the number one reason for non-rated career officers and enlisted to remain in uniform.¹² In the 2000 Air Force Follow-Up Quality of Life Survey, approximately 75% of officers and 60% of enlisted were satisfied with their access to care.¹³ In the same survey, approximately 45% of officers and 46% of enlisted were satisfied with access to health care for their families. However, a dichotomy surfaced between pilots that elect to remain versus those that separate when asked to compare military to civilian health care. Although 65 percent of field grade pilots who remain in the military rate military health benefits superior to civilian health benefits, 65 percent of those that separate believe civilian care is superior. These results, while indicating an opportunity for improvement, also highlight the importance of health benefits to our current active force. Improvements in military medicine are required but cannot occur without additional resources. Inadequate funding, with the consequent difficulty in facility maintenance, equipment modernization, and treatment availability, provokes active duty complaints. Secretary of Defense William S. Cohen noted in a 1999 Camp

¹² Air Force Personnel Center, Survey Branch, *Results on Career Decisions in the Air Force: Results of the 2000 USAF Careers and New Directions Surveys* by Charles H. Hamilton and Louis M. Datko (San Antonio, 2000) 7-10.

Pendelton speech that “Tricare is one of the basic complaints that I hear time after time.”¹⁴

Retirees, especially Medicare-eligible, have been very vociferous. While younger retirees could receive benefits under Tricare, Medicare-eligible by statute could not. Medicare-eligible retirees, except for the use of the military pharmacies, found themselves effectively locked out of the military facilities. They could receive benefits under Medicare but this required a monthly enrollment fee for part “B” to cover outpatient care. Additionally Medicare does not have prescription coverage, a significant issue for patients on multiple medications. Since Medicare-eligible retirees were not eligible for Tricare, they also were not eligible for civilian Tricare pharmacy benefits, including the mail order pharmacy, forcing them to rely on a reduced number of military pharmacies. Finally, Medicare has significant deductibles and co-payments. Senior Defense Department leadership began to acknowledge retiree complaints. In a 1999 speech given to the Association of the U.S. Army, Dr. Susan Bailey, Assistant Secretary of Defense for Health Affairs, said “I joined the Navy in the 1970s and I know there was a promise made. We have a moral imperative to meet that promise.”¹⁵ In 1999, Gen. Henry H. Shelton, Chairman of the Joint Chiefs of Staff, acknowledged that promises of lifetime health care to retirees had been broken.¹⁶ He advocated the creation of an oversight panel on military health, the Defense Medical Oversight Committee (DMOC).

Retirees also took their complaints to Congress. Under prompting by the National Association of Uniformed Services, a military advocacy group, Rep. J.C. Watts (R-Okla)

¹³ Air Force Personnel Center, Survey Branch, *2000 Follow-Up Quality of Life Survey* (San Antonio, 2000) 8.

¹⁴ Roberto Suro, “Up In Arms: Department of Defense; Chiefs Plan Assault on Health Care Woes,” *Washington Post*, sec. A, p. 15.

in 1997 introduced legislation offering Medicare-eligible retirees the option of enrolling in the Federal Employee Health Benefit Program (FEHBP).¹⁷ His proposal would also require offering all retirees the option of enrolling in Tricare. The legislation failed when the GAO estimated the cost at \$1.6 billion per year. Other legislation authorized limited demonstration programs of Medicare subvention and Tricare Senior Prime (for Medicare-eligible retirees) in an attempt to fulfill the promise while controlling costs.

The health benefits debate also contributed to another problem for the Defense Department in the late 1990s. Recruiting and retention rates declined. Joint Vision 2020 (JV2020) recognizes the need for individuals of exceptional dedication and ability if the military is to maintain its dominance.¹⁸ Sufficient recruiting and retention of the appropriate personnel is essential to meet this need. JV2020 also recognizes the relationship of members' standard of living and family-oriented community support programs to recruiting and retention. While there were many factors contributing to this recruiting and retention drop, including the operations tempo of the forces and the robust American economy, medical care also was a significant issue. As previously noted, survey results validated the importance of health care for the member and his family as a prominent retention item.

Corrective actions:

As costs and dissatisfaction mounted, the Defense Department turned to the DMOC, composed of the service vice chiefs and service undersecretaries, to propose a

¹⁵ George Coryell, "Military Remiss in Health Care for Veterans," *Tampa Tribune*, sec. Florida/Metro, p. 1.

¹⁶ Tom Philpott, "Tricare For Life," *Air Force Magazine*, December 2000, 52.

¹⁷ Nesmith, "Complaints Haunt Pentagon's Health Care Repair," sec. National News, p. 7A.

¹⁸ Department of Defense, Joint Chiefs of Staff, *Joint Vision 2020* (Washington, DC, 2000) 12-14.

solution.¹⁹ Gen. Shelton pledged major gains in health care benefits for 2001. On January 18, 2000, the DMOC recommended several initiatives to the Joint Chiefs.²⁰ However, the Clinton Administration endorsed only two limited initiatives for active duty families and nothing for retirees.²¹ The day after the 2001 budget went to Congress, Gen. Shelton testified before the Senate Armed Services Committee that America had broken its promise of lifetime care to generations of retirees.

In Congress, a groundswell for action was growing. Despite the cost obstacle, a bold proposal by Reps. Ronnie Shows (D-Miss.) and Charles Norwood (R-Ga.) and Sens. Tim Johnson (D-S.D.) and Paul D. Coverdell (R-Ga.) promised restoration of full access for all retirees.²² Sen. John McCain (R-Ariz.) proposed implementing Tricare Senior Prime nationwide. Sen. Trett Lott (R-Miss.) and Sen. John W. Warner (R-Va.) recommended a more measured and affordable approach. Their proposal enlarged the Administration's modest plan with several recommendations from the Joint Chiefs, including expansion of the pharmacy benefit to retirees, limited expansion of the Tricare Senior Prime demonstration sites, and expansion of the FEHBP test program.

In an extraordinary confluence of political and social forces, Congress went way beyond expectations when it enacted the Fiscal 2001 National Defense Authorization Act in October 2000.²³ This legislation redesignated medical care for retirees as an "entitlement," making future funding mandatory, not discretionary. Effective October 2001, Tricare-for-Life (TFL), was law, eliminating enrollment fees, premiums, co-payments, and deductibles for 1.4 million Medicare-Eligible military retirees and their

¹⁹ Tom Philpott, "It's Showdown Time on Tricare," *Air Force Magazine*, April 2000, 48.

²⁰ Suro, "Up In Arms," sec. A, p. 15.

²¹ Philpott, "It's Showdown Time on Tricare," 48.

²² Philpott, "It's Showdown Time on Tricare," 48.

eligible dependents. Beneficiaries, however, still pay the Medicare Part B premium, currently \$45.50 per month. It created a Treasury Department managed “Department of Defense Medicare-Eligible Retiree Health Care Fund” with an unfunded obligation of at least \$200 billion. Yearly the Treasury will tell the Defense Department how much to pay into the fund, just as it currently does for the military retirement fund. Congress also included an expansion of the pharmacy benefit, enabling all retirees and their eligible dependents to participate in the mail order pharmacy program or to purchase medications through a Tricare network pharmacy beginning April 2001.²⁴

Legal challenges:

Simultaneously with the pursuit of benefit restoration through the Pentagon and the Congress, retiree organizations pursued restitution through the legal system. In *Coalition of Retired Military Veterans v. United States*, the court dismissed the lawsuit since it challenged nonreviewable military decisions involving the allocation of healthcare resources.²⁵ In *Schism v. United States* in 1998, the court found no legal entitlement to “free” medical care. However, a three-judge ruling by the U.S. Court of Appeals for the Federal Circuit on February 8, 2001 reversed the *Schism v. United States* finding.²⁶ The court found military recruiting efforts into the 1990s created an implied-in-fact contract that the government breached in 1956 when Congress passed a law imposing space-available limitations on military medical care. Damage costs for retirees who entered the military before 1956 could reach \$25 billion if the government is not

²³ Philpott, “Tricare For Life,” 52.

²⁴ Richter, “Military Retirees See Health Care Victory,” sec. A, p. 18.

²⁵ Army, Litigation Division, *Military Retiree Medical Care – Broken Promises or Failure to Read the Fine Print* (Washington, DC, 1998) 62.

successful on appeal. A second class action suit, filed in April 2001, seeks restitution for all personnel who entered the military before 1995, the date Tricare was enacted.²⁷ It alleges the government breached its contract with military personnel when it failed to provide free medical care. If this suit is successful, the Defense Department would pay all costs for retirees, including Tricare enrollment premiums and Medicare Part B premiums, with unknown damage costs in the high billions.

Budgetary impact:

The confluence of military and political forces has produced a solution for health care for military retirees. Unfortunately, Congress did not appropriate monies to cover either these expanded programs or deficiencies in military health care funding. For FY2001, the direct care, military medical services are at least \$462 million short of funds.²⁸ The Defense Department also requires at least another \$161 million to cover the expanded pharmacy benefits for FY2001 with estimates of at least \$1 billion per year needed in the future.²⁹ Recently Defense Health officials placed the FY2001 shortfall at least at \$1.4 billion.³⁰ Additionally the Tricare contractors, under the global settlement for prior year services, will receive millions of dollars. The Bush Administration is proposing \$3.9 billion for the TFL program in 2002 but this may be insufficient.³¹ In

²⁶ Marcia Coyle, "Vet Care Case May Cost Feds Billions," *National Law Journal*, 26 February 2001.

²⁷ Deborah Funk, "Second Suit Claims U.S. Broke Promise," *Air Force Times* (Springfield, Va.), 16 April 2001.

²⁸ Deborah Funk, "Services Fear Cost of Tricare Changes," *Air Force Times* (Springfield, Va.), 12 March 2001.

²⁹ Rick Maze, "Retiree Health Programs Called Funding Drain," *Air Force Times* (Springfield, Va.), 26 March 2001.

³⁰ Deborah Funk, "Shortfall Delays New Tricare Cap for Retirees: Officials Advising Families to Hold on to Medical Receipts," *Air Force Times* (Springfield, Va.), 9 April 2001.

³¹ Maze, "Retiree Health Programs Called Funding Drain," 26 March 2001.

recent testimony before the Defense Subcommittee of the House Appropriations Committee, the Air Force Surgeon General reported the Defense Health Programs shortfall for FY02-07 was at least \$20.06 billion.³²

Military medical costs have become a large number for the Defense Department. The GAO Compendium of Budget Accounts for Fiscal Year 2001 lists total Defense Department obligations for 1999 as \$371.427 billion with a projected 2001 amount of \$389.439 billion.³³ Of this, the Defense Health Program amounts were \$11.198 billion and \$12.291 billion. Additionally active duty medical personnel costs are \$5.4 billion.³⁴ Providing for TFL and the pharmacy benefit will add at least \$5 billion to these numbers. Additionally correction of the chronic under funding of military treatment facilities, payment of the global settlement costs, possible payment of Medicare Part B premiums, and possible payment for the recent and future damage judgment will add more. Finally the \$200 billion unfunded liability for the new Treasury managed Retiree Health Care Fund remains.

Congressional intent was to relieve Congress and the Pentagon from having to choose between funding health care and buying tanks and airplanes.³⁵ Rep. Steve Buyer (R-Ind.) noted the topline for defense spending must be increased.³⁶ Currently the US is running a budgetary surplus that might permit an increase in Defense Department spending of the necessary five to ten billion dollars per year needed to fund these medical

³² Congress, House Appropriations Committee, *Air Force Health Care System before the Defense Subcommittee*, 107th Cong., 1st sess., 22 March 2001.

³³ United States General Accounting Office, Staff Study, *Compendium of Budget Accounts; Fiscal Year 2001* (Washington, DC, 2000) 27-29.

³⁴ Office of the Secretary of Defense, *Operation and Maintenance Overview; FY 2001 Budget Estimates* (Washington, 2000) 66.

³⁵ Mike Lazorchak, "Health Care Fund Will Cover Tricare for Life Costs," *Air Force Times* (Springfield, Va.), 12 March 2001.

³⁶ Philpott, "Tricare For Life," 52.

entitlement programs and still raise other overall defense spending. This surplus, however, could disappear in a recession, in a tax cut, or in new social programs. If this happens and if the topline is not increased, the Defense Department must still pay for this health care entitlement before obligating its discretionary funding for personnel, operations, acquisition, or research and development. Historically over the past decade the Defense Department has met budgetary constraints by decreasing procurement activities while maintaining personnel, current operations and readiness, and research and development programs. This choice has produced the current shortage of equipment affecting all Services. Whether procurement can be increased while at the same time increased medical costs more than consume the currently unallocated federal budgetary surplus remains to be seen. Lack of resources will clearly restrict the options open to the Services and Unified Commands as they design solutions to strategic threats facing America.

Conclusion:

This case study demonstrates how a well-intentioned and seemingly innocent decision by the military in the 1940s now restricts our ability to achieve our NMS. The “hollow promise” of medical care for life had an affect on retention and recruitment. Political and legal action led to a commitment of future dollars that now are unavailable for other defense needs, a commitment that may equal ten percent or more of the current defense budget. The Defense Department can no longer choose between tanks or medicines. However, in the zero-sum game of national resources it still must compete for a portion of a discretionary federal budget decreased by this entitlement commitment to

retiree health benefits. Assuming defense priorities remain the same with manpower current operations funds, and research and development continuing to receive priority, acquisition funds and funds for transformation are problematic. This lack of funds restricts the options of our senior leaders in meeting our NSS and NMS.

Other actions of the Defense Department can potential have a similar constraining affect, limiting future flexibility in dealing with the challenges facing America. Not performing the demographic calculations prior to offering changes in personnel programs, ignoring future pollution restitution expenses for current expediency, or failing to identify correctly the potential impact of rapid technological advances can lead to similar problems in the future. Strategic futurists must not confine themselves to only considering future doctrinal, organizational, and technological changes but their vision must also include consideration of the affects of personnel, social, and environmental actions. Selecting a politically expedient course today may indeed have significant future strategic costs just as an innocent promise of lifetime health care in the 1940s today consumes significant resources and restricts strategic options.