



CRS Report for Congress

Increases in Tricare Costs: Background and Options for Congress

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Summary

In its FY2007 budget submission, the Department of Defense (DOD) proposed increases in Tricare enrollment fees, deductibles, and pharmacy co-payments for retired beneficiaries not yet eligible for Medicare. The raises were justified by DOD as necessary to constrain the growth of health care spending as a proportion of the overall defense budget in the next decade. Many beneficiaries argued that the proposed hikes were unfair and unnecessary. The proposed increases found favor in neither chamber and ultimately the FY2007 Defense Authorization Act (P.L. 109-364) prohibited increases in premiums, deductibles and co-payments prior to September 30, 2007. For FY2008, the Administration based its budget submission on the assumption of fee increases but the FY2008 National Defense Authorization Act (P.L. 110-181) extended the prohibition of increases in co-payments and enrollment fee until October 2008 and Congress may move to extend them further. This report will be updated as necessary.

Background

The dollar amounts allocated to health care in the budget of the Department of Defense (DOD) have almost doubled during the past five years, from \$19 billion in FY2001 to over \$38 billion in FY2006, even as the size of the active duty force has remained relatively steady. DOD projections for health care indicate that even further growth can be realistically anticipated, perhaps reaching \$64 billion in FY2015. In 1990, according to DOD estimates, health-care expenses constituted 4.5% of DOD's budget; by 2015 they could reach over 11%. This growth in health-care costs could have a substantial effect on spending for other defense programs and/or the overall size of defense spending within the federal budget.

The Defense health system, which is open to some 9.2 million potential beneficiaries, is large and complicated, but, in brief, DOD provides varying kinds of care to different elements of the eligible population: (1) a complete medical-care benefit to active duty personnel and to their dependents; (2) a benefit program with annual enrollment fees and co-payments to retired military personnel and their dependents who

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are not eligible for Medicare; and (3) a program for those retirees who are eligible for Medicare (and enrolled in Medicare Part B), known as Tricare for Life (TFL), that covers almost all costs that Medicare does not cover (and is funded with an accrual fund that is considered part of the defense budget). Military retirees aged 65 and above also remain eligible for treatment in military medical facilities on a space or service-available basis.

Care is delivered through one of four plans. The first is Tricare Prime, a health maintenance organization (HMO), which is required for active duty personnel and open to dependents and many retirees. Two other plans are Tricare Extra, a preferred provider option in which beneficiaries seek care from providers who have agreed to an established fee structure, and Tricare Standard (formerly CHAMPUS) in which beneficiaries can seek care from any licensed provider and obtain partial reimbursement.¹ A fourth plan, TFL, serves as a supplemental payer to Medicare for care by licensed providers. Prescriptions are available from military pharmacies at no cost; they can also be obtained from civilian pharmacies linked to DOD or by mail order with relatively low co-payments (e.g., \$3 for a generic prescription; \$9 for a brand; \$22 for a non-formulary prescription).

Several factors associated with these plans have led to current and projected cost growth. First, increases in costs of delivering medical services and of prescriptions reflect trends in medical care delivery throughout the civilian economy.² Second, the establishment of TFL in the FY2001 Defense Authorization Act (P.L. 106-398) greatly increased costs by extending a significant medical benefit to millions of Medicare-eligible retirees and their dependents whose previous access to Defense health care had been limited to a diminishing number of military medical facilities. Third, access to defense health care for some non-active duty reservists was provided in the Defense Authorization Acts for FY2005 and FY2006 (P.L. 108-375 and P.L. 109-163). In addition, co-payments in Tricare Prime have been eliminated and the catastrophic cap for retirees has been lowered from \$7,500 to \$3,000, increasing costs to DOD.

Several additional factors have contributed to concerns about the costs of defense health care. In comparison to other plans, including those available to civil servants under the Federal Employees Health Benefit Plan (FEHBP), DOD provides an especially generous benefit with limited contributions and co-payments required of beneficiaries. Observers also point out that most defense health care is not directly related to tending to combat injuries. In recent decades, the multi-billion dollar system has been directed towards care of dependents, especially in the areas of obstetrics and pediatrics, and to the care of retirees at stages of their lives when medical needs tend to increase. Even with the need to care for injuries resulting from the U.S. commitment to Operation Iraqi Freedom, the bulk of DOD medical care is currently provided to dependents and retirees — not to the operating forces.

Furthermore, Tricare beneficiaries, both active duty and retired, tend to make greater use of professional care than other sectors of the population. In FY2004, according to one

¹ This explanation is generalized; there are many special provisions. For further information, see CRS Report RL33537, *Military Medical Care: Questions and Answers*, by Richard A. Best Jr. For specific provisions, see the Tricare website [<http://www.tricare.osd.mil>]; relevant regulations are at 32 C.F.R. 199.

² See CRS Report RL32545, *Health Care Spending: Context and Policy*, by Jennifer Jenson.

estimate, in Tricare Prime the outpatient utilization rate was 44% higher than in civilian HMOs; the inpatient utilization rate was 60% higher.³ Health-care analysts tend to ascribe this to lower out-of-pocket costs for DOD beneficiaries.⁴

Low cost to beneficiaries and increases in the quality and efficiency of Defense health care in recent years have reportedly led many retirees with civilian jobs to choose Tricare even when they have access to other plans through their civilian employers. Special supplements by employers for Tricare beneficiaries are now illegal.

In the FY2007 budget request, DOD first proposed changes to constrain the costs of health care by focusing on care for retirees and their dependents who are not Medicare-eligible. For these beneficiaries, DOD proposed charging, for the first time, annual enrollment fees for Tricare Standard, and also significantly increased annual enrollment fees for Tricare Prime. Annual deductibles would have also been increased. No initiatives were proposed that would affect active duty military and their dependents, nor were changes proposed for health-care benefits available to retirees eligible for Medicare (those aged 65 and over along with a much smaller number of disabled retirees) who are covered by TFL. The TFL-eligible beneficiaries would, however, have been required to make somewhat higher co-payments for some prescriptions.

DOD also strongly urged that, in the future, cost shares be adjusted annually for inflation. The fact that enrollment fees for Tricare Prime were set at \$230 (for individuals) and \$460 (for individuals and their dependents) in 1995 and not subsequently adjusted has been viewed as an important contributing factor to the current budgetary situation.

The Administration's FY2008 budget submission was based on the assumption of \$1.8 billion in proposed assumed savings to be derived from "benefit reform."

For FY2009 the Administration endorsed the recommendations of the Task Force on the Future of Military Health Care mandated by the Defense Authorization Act for FY2007 (P.L. 109-364) (see below) and assumed \$1.2 billion in savings from the increased Tricare premiums and co-payments.

Congressional Responses

The final version of FY2007 defense authorization legislation (P.L. 109-364) that was approved by the House and the Senate in September 2006 prohibited DOD from increasing premiums, deductibles, co-payments, and other charges through September 30, 2007. Congress also adopted provisions (in Section 707) to prohibit most civilian employers (including state and local governments) from actively encouraging or offering incentives to employees who are retired servicemembers to rely on Tricare.

Another House provision (section 711) required the establishment of a DOD Task Force, composed of military and civilian officials with experience in health-care budget

³ Department of Defense, *Evaluation of the Tricare Program: FY2005 Report to Congress*, March 1, 2005, pp. 63, 57.

⁴ Congressional Budget Office, *Growth in Medical Spending by the Department of Defense*, September 2003, p. 27.

issues, to examine and report on efforts to improve and sustain Defense health care over the long term including the “beneficiary and Government cost sharing structure required to sustain military health benefits.” Another provision (section 713) required the Government Accountability Office (GAO) in cooperation with the Congressional Budget Office (CBO) to prepare an audit of the costs of health care to both DOD and beneficiaries between 1995 and 2005.

The Task Force on the Future of Military Health Care submitted its final report in December 2007 (available at [http://www.dodfuturehealthcare.net/images/103-06-2-Home-Task_Force_FINAL_REPORT_122007.pdf]). It found existing cost-sharing provisions anachronistic and recommended phased-in changes in enrollment fees and deductibles that would restore cost-sharing relationships that existed when Tricare was created. For instance, this would mean that average enrollment fees for the average under-65 retiree family would gradually rise from \$460 per year to \$1100 per year.

GAO released its report, *Military Health Care: TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings are Likely Overestimated* (GAO-07-647, available at [<http://www.gao.gov/new.items/d07647.pdf>]) in May 2007. GAO concluded that DOD had overestimated savings that would result from higher cost-shares. GAO judged that DOD estimated more retirees would elect non-DOD medical care than is likely to be the case. GAO concluded, however, that DOD’s proposed fee and deductible increases would save at least \$2.3 billion over five years.

As part of the FY2009 budget request DOD asked for authority to implement the recommendations of the Task Force on the Future of Military Health Care for retirees and DOD’s budget submission assumed savings of \$1.2 billion. Reportedly, neither the House nor Senate Armed Services Committee has supported this request.

More Ambitious Approaches

The fact that both armed services committees called for extensive outside reviews of military health-care financing indicates that Congress may revisit proposals for fee increases at some point as part of more comprehensive changes in defense health-care budgeting. A number of different approaches have already been suggested. One option that has been mentioned by CBO would provide an opportunity for retirees to forego defense health care until they turn 65 in exchange for a lump-sum payment.⁵ The size of the payment would be adjusted to a level that would be less costly to DOD over the longer term than the current programs. The acceptability of this approach to retirees is uncertain; the number of retirees who would take such a payout is unknown and might be very limited given the attractiveness of Tricare.

Another approach would be to offer beneficiaries a “cafeteria plan” under which they would receive an annual cash allowance for health care. Using this allowance they could then select a Tricare plan, a new option involving lower enrollment fees and higher co-payments and deductibles, or apply some of the funds against premiums for civilian health insurance. This could in effect allow retirees to establish health savings accounts (HSAs) for themselves and their dependents. CBO estimates that such an approach could reduce

⁵ See CBO, *Growth in Medical Spending*, pp. 18-19.

DOD's outlays by 25% not including the cost of the cash allowance.⁶ However, HSAs are controversial and making them available to military retirees could raise concerns among both beneficiaries and others with an interest in government health programs.⁷

Still another option would be to readjust budgetary categories to remove health-care spending for retirees — both for those not yet eligible for Medicare and the accrual fund for TFL — from defense appropriation acts. Some have argued that this approach would encourage more meaningful analyses of current defense issues by removing the need to consider trade-offs with retiree health care. Others have countered that such a maneuver would undermine analysis by obscuring the true costs of decisions affecting military manpower.

Conclusion

The DOD proposals set forth in early 2006 proved very controversial and they were not accepted by Congress; similar proposals were turned down in 2007 and support for any increases in enrollment fees and co-payments for military beneficiaries appears limited in 2008. This rejection has occurred despite a widespread awareness of the challenges posed by the growth in military medical spending. Most observers note that there are pressures on many parts of the defense budget — new procurement, research and development, and the need to compensate and retain well-qualified and highly motivated servicemembers. Defense spending is but one part of the federal budget, which is itself under pressure from many directions.⁸ These pressures lead some to suggest that medical spending may face some constraints. On the other hand, the Military Officers Association of America (MOAA), a large organization of retired and active duty personnel, argues that instead of seeking to raise fees for retirees health care, DOD “should be asking Congress for a bigger defense budget to pay for the needed benefit improvements Congress has enacted.”⁹

DOD maintained in 2006 that there is a need to adjust fees to make up for their having been frozen for a decade and that the proposed rates are still much lower than the fee structures of civilian plans including those in the FEHBP.¹⁰ Retiree organizations have continued to argue that proposed raises in enrollment fees and co-payments were unfair, that the requirements of military service are unique and extraordinary and that health-care premiums have been paid in service and sacrifice. They also claim that DOD's health-care benefit has significant influence on recruiting and retaining an all-volunteer force. Some further argue that fee hikes are especially inappropriate for retiring

⁶ Ibid., pp. 19-20.

⁷ For additional background on HSAs, see CRS Report RL32467, *Health Savings Accounts*, by Bob Lyke, Chris L. Peterson, and Neela K. Ranade.

⁸ See CRS Report RL32877, *Defense Budget: Long-Term Challenges for FY2006 and Beyond*, by Stephen Daggett.

⁹ “‘Health Tax’ Looms,” *Military Officer*, March 2006, p. 27.

¹⁰ There remain some retired servicemembers who claim they are entitled to free medical care for the rest of their lives on the basis of alleged earlier promises. Congress has never, however, accepted the principle of completely free medical care. See CRS Report 98-1006, *Military Health Care: the Issue of ‘Promised’ Benefits*, by David F. Burrelli.

servicemembers who have borne the costs of the war on terror during the past several years.

There are complex considerations with regard to any of the various approaches to dealing with the growth of military medical spending. To a considerable extent, the issues involving Defense health care reflect larger health-care issues that affect the entire country. In the case of retired servicemembers and their dependents, most recognize a special responsibility inasmuch as health care after retirement is undoubtedly an important incentive to follow a difficult and often dangerous career. Nevertheless, many observers also appear to believe that competing requirements for defense funds exist and that funds for medical care should not be seen as unlimited. The issues have been present ever since DOD proposed fee increases in 2006 and are not expected to disappear in the near future.