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CRS Report for Congress

Increases in Tricare Costs: Background and Options for Congress

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Summary

In its FY2007, FY2008, and FY2009 budget submissions, the Department of Defense (DOD) proposed increases in Tricare enrollment fees, deductibles, and pharmacy co-payments for retired beneficiaries not yet eligible for Medicare. These actions were justified by DOD as necessary to constrain the growth of health care spending as an increasing proportion of the overall defense budget in the next decade. Congress has passed legislation each year to prohibit the proposed fee increases. In passing the FY2009 National Defense Authorization Act (P.L. 110-417), however, Congress included measures establishing demonstration projects intended to find ways to contain costs through increased use of preventive care services by TRICARE beneficiaries. The scope of these measures are limited. Defense health care spending will likely remain an issue for the DOD in the next Administration, and Congress can anticipate being asked to consider new proposals to constrain costs. 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 more than doubled since FY2001, growing from about $17 billion to over $42 billion in FY2009. DOD projections for health care indicate that even further growth can be realistically anticipated, perhaps reaching $64 billion in FY2015.[1] In 1990, according to DOD estimates, health-care expenses constituted 4.5% of DOD's budget; by 2015 they could reach over 12%. This growth in health-care costs could have a substantial effect on spending for other defense programs.

[1] Department of Defense, *Defense Health Program Fiscal Year 2009 Budget Estimates, Exhibit PBA-19, Appropriation Highlights*, February 2008, page 4.

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 dependents; (2) a benefit program with annual enrollment fees and co-payments to retired military personnel and their dependents who are not eligible for Medicare; (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); and (4) a premium-based health care benefit for reservists and their families known as Tricare Reserve Select. Military retirees aged 65 and above also remain eligible for treatment in military medical facilities on a space or service-available basis. As of 2007, 36% of Tricare beneficiaries were retirees under age 65 and their dependents, approximately 20% were TFL retirees (generally age 65 and older), and 44% were active duty personnel and their dependents.

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.[2] 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). Special versions of these plans for beneficiaries in overseas and remote areas are also available.

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.[3] Pharmacy costs have seen the fastest rate of growth in DOD health care spending, quadrupling from $1.6 billion in FY2000 to $6.5 billion in FY2007. 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. Third, expanded access to defense health care for non-active duty reservists was provided in the Defense Authorization Act for FY2007 (P.L. 109-364). 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 a generous benefit with limited contributions and co-payments required of beneficiaries. Observers also

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[2] 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.

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

point out that most defense health care is not directly related to treating 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.[4]

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 estimate, in Tricare Prime the outpatient utilization rate was 44% higher than in civilian HMOs; the inpatient utilization rate was 60% higher.[5] Health-care analysts tend to ascribe this to lower out-of-pocket costs for DOD beneficiaries.[6]

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 rather than plans available through their civilian employers. Special supplements by employers for Tricare beneficiaries are illegal (see 10 U.S.C. 1097c).

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 have been required to make somewhat higher co-payments for some prescriptions.

DOD 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 unspecified benefit reforms. For the FY2009 budget submission, 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.

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[4] Defense Health Board, *Task Force on the Future or Military Health Care*, December, 2007, page 13.

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

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

In July, 2008, the presidentially directed 10th Quadrennial Review of Military Compensation (QRMC) issued its report on deferred and noncash compensation for members of the uniformed services.[7] The QRMC recommended that Tricare Prime premiums for single retirees under age 65 be set at 40% of Medicare Part B premiums (which vary by the enrollee's adjusted gross income). Tricare Standard/Extra premiums for single retirees would be set at 15% of Part B premiums. Family rates would be set at twice the single rate regardless of family size. Tricare deductibles would be linked to Medicare rates with copayments waived for preventative care and prescription drug payments limited to no more than two thirds of the average copayment faced by civilians at retail pharmacies. In addition, the QRMC recommended that health care for retirees under age 65 be financed through accrual accounting in order to illuminate how current manning decisions will affect future costs.

Congressional Responses

The FY2007, FY2008, and FY2009 defense authorization acts prohibited DOD from increasing premiums, deductibles, co-payments, and other charges through September 30, 2009 (See section 704 and 708 of P.L. 109-364, sections 701 and 702 of P.L. 110-181, and sections 701 and 702 of P.L. 110-417). Provisions were also enacted in 2006 (see section 707 of P.L. 109-364) 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.

The FY2007 national defense authorization (see section 711 of P.L. 109-364) also required the establishment of a DOD Task Force on the Future of Military Health Care, composed of military and civilian officials with experience in health-care budget 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 of the same act (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 $1,100 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

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[7] Department of Defense, *Report of The Tenth Quadrennial Review of Military Compensation: Volume II - Deferred and Noncash Compensation*, July, 2008, pp 41-64.

from higher cost-shares, however, 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. DOD's budget submission assumed savings of $1.2 billion from the additional fees charged as well as reductions in use of services by military retirees. Although the Congress rejected the proposed fee increases for FY2009, it did address the cost containment issue in another way by enacting a number of preventive health measures[8] intended to reduce usage at some point in the future. The preventive care measures included the following.

- Waiver of copayments for non-Medicare eligible Tricare beneficiaries for preventive services including cancer screening, annual physical examinations, and vaccinations (section 711 of P.L. 110-417).
- A three-year military health risk management demonstration project to evaluate the efficacy of providing incentives to encourage healthy behaviors (section 712).
- A smoking cessation program for non-Medicare eligible Tricare beneficiaries (section 713).
- A preventive health allowance demonstration project running through December 31, 2011, in which not more than 1,500 members each of the Army, Navy, Air Force, and Marine Corps annually would receive $500 if without dependents or $1,000 with dependents in order to increase the use of preventive health services (section 714).
- Additional authority for studies and demonstration projects relating to delivery of health and medical care (section 715).

Reporting requirements were included and the results of these projects may be useful in informing future policy decisions. However, the Congressional Budget Office (CBO) cost estimate does not project any savings and suggests that if DOD were to carry out each of the programs authorized by section 712 alone, the cost would be about $50 million per year over a period of three years, based on costs for other demonstration projects.[9]

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. Different approaches have already been suggested. One option 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.[10] The size of the payment would be adjusted to a level that would be less costly to DOD over the longer term than current programs. The acceptability of this approach to retirees is uncertain; the number of

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[8] Sections 711-715 of P.L. 110-417, October 14, 2008.

[9] CBO, *Cost Estimate S. 3001 National Defense Authorization Act for Fiscal Year 2009*, June 13, 2008, pages 10-11.

[10] See CBO, *Growth in Medical Spending*, pp. 18-19.

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 DOD's outlays by 25% not including the cost of the cash allowance.[11] 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.[12] 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

DOD has maintained since 2006 that there is a need to adjust fees to make up for frozen fee structures over the past decade and that the proposed rates are still much lower than the fee structures of civilian plans including those in the FEHBP.[13] Retiree organizations have continued to argue that proposed raises in enrollment fees and co-payments are unfair, that the requirements of military service are unique and extraordinary and that health-care premiums have been paid in service and sacrifice. Some further argue that fee hikes are especially inappropriate for retiring 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. In the case of retired servicemembers and their dependents, most recognize a special responsibility inasmuch as health care after retirement is viewed as an important incentive to follow a difficult and often dangerous career. Other observers argue that competing requirements for defense funds do exist and that funds for medical care should not be seen as unlimited. These issues have been present ever since DOD proposed fee increases in 2006 and are not expected to disappear in the near future.

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[11] Ibid., pp. 19-20.

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

[13] Department of Defense, *Final Report of the Task Force on the Future of Military Health Care*, December 2007, p. 92.