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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. However, the Act also established a DOD Task Force to look at the costs of sustaining Defense health care over the long term. The Government Accountability Office (GAO), in cooperation with the Congressional Budget Office (CBO), was also tasked to review of the budgetary implications of DOD health care. For FY2008, the Administration has based its budget submission on the assumption of fee increases. However, the House budget resolution (H.Con.Res. 99) passed on March 29, 2007 reflected opposition to fee increases. This report will be updated as needed.

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 $37 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 12%. 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 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 military health care 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. Some note also that much 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.

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[1] This explanation is generalized; there are many special provisions. For further information, see CRS Report RL33537, *Military Medical Care Services: Questions and Answers*. 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.

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 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. Moreover, some employers and state governments have encouraged employees to take advantage of DOD health care, offering them special supplements to cover any co-payments that might be required. Former Secretary of Defense Donald Rumsfeld noted this phenomenon in testimony to the Senate Armed Services Committee on February 7, 2006: "In effect, the military is increasingly subsidizing the health care costs of private corporations, organizations, and state and local governments. This is a classic example of good intentions leading to unintended, unwelcome, and expensive consequences."

In the FY2007 budget request, DOD 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."

Congressional Responses

The FY2007 defense authorization bill (H.R. 5122) approved by the House on May 11, 2006, included a provision (section 704) precluding increases in premiums, deductibles, and co-payments during the period April 1, 2006, through December 31, 2007. Section 731 would have increased co-payments for prescriptions obtained through retail pharmacies.

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

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

The Senate Armed Service Committee in its version of FY2007 defense authorization legislation (S. 2766) took a slightly different approach from H.R. 5122; section 705 would have prohibited an increase in enrollment fees for coverage under Tricare Prime in FY2007, but did not address Tricare Standard or Extra. In effect, the legislation would have omitted the statutory authority that would be needed for instituting enrollment fees for Tricare Standard. The Senate bill, in section 702, would also have required that beneficiaries obtain prescriptions for maintenance medications from the National Mail Order Pharmacy while it would have removed co-payments from generic and brand named medications that are medically necessary.

The final version of the legislation which was approved by the House on September 29, 2006, and the Senate the following day prohibited DOD from increasing premiums, deductibles, co-payments, and other charges through September 30, 2007[5]. The legislation did not preclude use of retail pharmacies for maintenance medications but the accompanying report (H.Rept. 109-702) indicated an expectation that DOD "will proceed, under current authority, to eliminate co-payments for generic drugs dispensed through the Tricare national mail-order program, as a minimum." It is anticipated that the removal of some co-payments would serve as an inducement to use the mail order pharmacy over retail pharmacies. In the enacted defense authorization act, P.L. 109-364, 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.

Although Congress did not adopt many of DOD's proposals for increasing fees and discouraging access to retail pharmacies, requests for high-level studies of trends in military health care spending indicate that there may be renewed attempts to address the health-care budget issues in the future, perhaps in the context of FY2008 authorization legislation.

A House provision adopted in conference (section 711) requires the establishment of a DOD Task Force, 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." The Task Force will have 12 months to complete the study but an interim report is due on May 31, 2007, with findings and recommendations "particularly with regard to cost sharing under the pharmacy benefits program."

Another provision (section 713) requires 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. A report, with recommendations, is to be submitted to Congress by June 1, 2007.

Congressional opposition to the Administration's proposed FY2008 budget which assumed higher fees is reflected in the House's budget resolution (H.Con.Res. 99) that

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[5] For further information on this legislation, see CRS Report RL33571, *The FY2007 National Defense Authorization Act: Selected Military Personnel Policy Issues*, by Charles A. Henning, David F. Burrelli, Lawrence Kapp, and Richard A. Best Jr.

was passed on March 29, 2007. The accompanying report (H.Rept. 110-69) stated: "High among our priorities is the health care guaranteed our armed forces, not only while they are in harm's way, but when they return home from combat with injuries. For that reason, this resolution opposes Tricare fee increases and call for a substantial increase in the veterans' health care system.[6]" The question of fee increases for military retirees may be addressed during consideration of F2008 defense authorization legislation when reports from the Task Force on the Future of Military Health Care and the GAO are available.

More Ambitious Approaches

The fact that both armed services committees have 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.[7] 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 DOD's outlays by 25% not including the cost of the cash allowance.[8] Secretary Rumsfeld indicated on February 7, 2006, that DOD wants to explore "new, innovative benefit alternatives such as health savings accounts." 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.[9]

Another approach 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. Section 589 of the House version of H.R. 5122 would have required that contributions to the accrual fund be made by the Treasury rather than DOD, but this provision was not accepted by the conference. This provision would have simply shifted spending to other budgetary accounts and would not have affected overall spending totals. Some have argued that this approach would encourage more meaningful analyses of current defense issues by removing the need to consider

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[6] The veterans health care system is not part of defense authorization legislation; see CRS Report RL33409, *Veterans' Medical Care: FY2007 Appropriations*, by Sidath Viranga Panangala.

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

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

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

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. This rejection 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 itself is one part of the federal budget, which is itself under pressure from many directions.[10] 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."[11]

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.[12] Retiree organizations countered 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 are 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 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 miliary medical spending. To some 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 also exist and that funds for medical care should not be seen as unlimited. The issues were present during deliberations on the FY2007 Defense Authorization Act and may well be present during consideration of FY2008 authorization legislation.

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

[11] "'Health Tax' Looms," *Military Officer*, Mar. 2006, p. 27.

[12] 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.