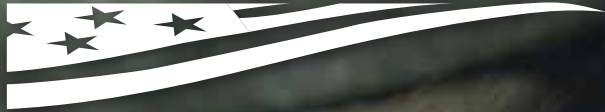


Center for American Progress



doing
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Restoring Tricare

Ensuring the Long Term Viability of the Military Health Care System

Lawrence J. Korb, Laura Conley, and Alex Rothman March 2011



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doing what works

CAP's Doing What Works project promotes government reform to efficiently allocate scarce resources and achieve greater results for the American people. This project specifically has three key objectives:

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- Building a foundation for smarter decision-making by enhancing transparency and performance measurement and evaluation

This paper is one in a series of reports examining government accountability and efficiency.

Contents

- 1 Introduction and summary**

- 3 Background: The challenge of sustaining military health insurance coverage**

- 11 Recommendations for reform**

- 19 Conclusion**

- 21 Endnotes**

- 23 About the authors and acknowledgements**

Introduction and summary

Military health care costs “are eating the Department of Defense alive,” according to Defense Secretary Robert Gates.¹

The Defense Department’s fiscal year 2012 budget request includes \$52.5 billion for the Tricare military medical insurance program, a 300 percent increase over its fiscal year 2001 budget.² As a result of this unprecedented cost growth in the Tricare system, nearly 10 percent of the baseline defense budget now goes to providing medical care for active duty, reserve, and National Guard troops and their dependents, as well as military retirees of all ages and their dependents.

These skyrocketing health care costs will consume an increasingly large portion of the defense budget as the federal deficit forces the country to slow down projected increases in defense spending. The cost of military health care could eventually begin to divert funding away from other crucial national security initiatives.

Congressional inaction over the past 15 years is largely to blame for the sorry state of the military health care budget today. If lawmakers and policymakers want to support Tricare over the long term, they need to understand how and why the current crisis developed. And they need to deal with it in a way that honors commitments to those who have served their country in the armed forces—while also being fair to the American taxpayer.

This paper will challenge policymakers to “do what works,” to rethink the status quo in the military health care system, embrace innovation and experimentation, and be ready to execute changes fairly and efficiently.³ This approach has the potential to reduce spending on military health care by up to \$15 billion a year.

To that end, this report recommends policymakers adopt a menu of cost-saving solutions that reflect the work of government analysts and the best practices available. Specifically, we argue that Congress should work with the Defense Department to make changes according to the following principles:

- Reinstitute a fair cost-sharing balance between military retirees and taxpayers
- Limit double coverage for working-age retirees above a certain income level
- Create incentives to reduce overuse of services
- Establish fair procedures to regulate future cost sharing

Congress and the American public are rightly wary of asking veterans, servicemen and women, and their families to shoulder increasing health care costs when so many service members are or have recently been engaged in operations in Iraq and Afghanistan.

It is important to note, however, that our recommendations would in no way affect active-duty service members, who would continue to receive health care at no cost. Nor would they impact lower-income or seriously injured veterans, who receive health coverage through the Department of Veterans Affairs rather than through the Defense Department's Tricare program.

Rather, this paper recommends restoring the cost-sharing balance between military retirees and the American taxpayer, a balance which was established in 1995 and has since been allowed to deteriorate for no good reason.

In order to address this growing imbalance, we recommend the following steps:

- Gradually phase in increased fees for military retirees, including a tiered fee structure for working-age retirees
- Increase cost sharing to encourage responsible use of Tricare for Life benefits
- Limit double coverage for high-income retirees and peg Tricare premiums to Medicare Part B costs

Once fully implemented, we estimate that these steps could save the Pentagon up to \$15 billion per year.

Background: The challenge of sustaining military health insurance coverage

The cost of military health care has grown in the last decade by almost 300 percent, rising from approximately \$17 billion in 2001 to a projected \$52.5 billion in 2012. Tricare, the military health insurance program, today consumes almost 10 percent of the base defense budget.

To put that number in perspective, the Pentagon projects that in fiscal year 2011 it will spend about as much on health care as on the war in Iraq.⁴ Military health care costs will continue growing, rising by another 28 percent to \$64 billion by 2015, according to Congressional Research Service estimates.⁵

Reasons for rising health care costs

Defense officials in their 2011 budget request identified a number of reasons for the growing military health care budget, among them:

- The Defense Department hasn't raised enrollment fees for Tricare Prime, an HMO-like coverage plan, since its creation in 1995, despite skyrocketing nationwide health care costs. Enrollment fees for the program remain at \$38 a month or \$460 a year for family coverage for military retirees, and \$19 a month or \$230 a year for an individual retiree.
- Congress in 2001 expanded Tricare eligibility to military retirees over 65 and provided more benefits for members of the reserve component. These expansions, supported by both the Bush and Clinton administrations, also lowered fees for active duty military families.⁶
- Retired service members frequently choose military health insurance over civilian plans for which they or their dependents are eligible. "Over 85 percent of retirees 45-49 years of age and 50 percent of retirees between 60-64 years of age had access to other group health insurance, but many choose Tricare instead," according to the Department of Defense.⁷

The Pentagon projects that in fiscal year 2011 it will spend about as much on health care as on the war in Iraq.

- Tricare beneficiaries are using the program's services at an increased rate.
- The cost of prescription drugs is rising nationwide. And prescription drug costs are among the most sharply rising elements of military health spending, according to the Congressional Research Service.⁸

The Defense Department has in the last decade sporadically attempted to control costs, primarily by recommending increases in Tricare fees. In President George W. Bush's budget for fiscal year 2009, for example, the Pentagon asked Congress to raise the fees for Tricare services slightly and save \$1.2 billion in that year alone.⁹

These measures have not been aimed at active duty troops, who do not incur enrollment fees or co-pays for their use of the military health system. Rather, they have been directed at controlling costs for dependents and retirees, who account for the majority of military health care spending.¹⁰ Congress has so far blocked such proposals.

Defense Secretary Robert Gates's fiscal year 2012 proposal

In the Obama administration's fiscal year 2012 budget, Defense Secretary Gates lays out a modest proposal to control Tricare costs by increasing fees on working-age retirees. Most controversially, Gates recommends comparatively small increases in Tricare Prime enrollment fees of \$2.50 per month for individuals and \$5.00 per month for families, beginning in 2012.

While Gates's proposal falls far short of what is necessary to control skyrocketing health care costs, he is right to focus attention on the expense of providing health care to military retirees under the age of 65, many of whom have second careers but choose to remain enrolled in Tricare rather than depend on the plan offered by their civilian employers.

Tricare is designed to be supplementary insurance for retirees with other coverage, but there's no law preventing working-age retirees from declining civilian coverage entirely in favor of Tricare (It is, however, illegal for employers to give military retirees incentives to choose Tricare rather than the company plan). Three-quarters of the nation's 4.5 million military retirees and their dependents have access to civilian plans. Two million of these retirees, or about 45 percent, choose to accept military coverage, saving themselves and their companies thousands of dollars per year per person.⁴³

A brief history of military health care

The military health care system traces its origins to 1775, when Congress established a hospital in Massachusetts to care for active duty military personnel. A permanent medical department was created in 1818. Military dependents, however, did not gain formal access to the military health care system until 1884, when Congress authorized Army medical personnel to care for dependents free of charge “whenever possible.”

The pillars of the modern military health care system—which provides comprehensive care for active duty troops, their dependents, and high-quality care options for military retirees—were not established until the second half of the 20th century, when Congress passed the 1956 Dependents Medical Care Act. This law formed the basis for the 1966 Civilian Health and Medical Program for the Uniformed Services, or CHAMPUS. It established an umbrella care organization for most of the remainder of the century.¹¹

1966: CHAMPUS

The Civilian Health and Medical Program of the Uniformed Services was a federally funded health system established in 1966 for active duty dependents and retirees unable to get care from military treatment facilities. Before CHAMPUS, dependents and retirees had to rely on private sector plans or their own resources to pay for civilian care. The CHAMPUS program provided medical care at civilian facilities under a cost-sharing arrangement for active duty dependents, and retirees and their dependents under age 65. The plan had an annual deductible and required patient co-pays to civilian doctors, but there were no premiums.

Retired service members over 65 and their dependents were excluded from CHAMPUS. Like all Americans, they had access to health care through the Medicare program, also created in 1966.

CHAMPUS did allow retirees to get free care at military treatment facilities when space was available, but the law did not guarantee this benefit. Service members eligible for retired pay were offered care in medical facilities, “subject to the availability of space and facilities and the capabilities of the medical and dental staff,” according to the Congressional Research Service.¹² Although many service members, military retirees, and their lobbying organizations have claimed they were

“promised free health care for life at military facilities,” there is no basis in U.S. law for this assumption and “efforts to locate written authoritative documentation of such ‘promises’ have not been successful,” CRS said.¹³

1995: Tricare

A CHAMPUS reform initiative in the late 1980s began a pilot program in California and Hawaii that gave military dependents a wider range of health benefit options. A revised and broadened version of this pilot became known in 1995 as Tricare, the current military health system. The CHAMPUS program became the current Tricare Standard plan, in which “coverage, deductibles, cost shares, and claim-filing rules stayed the same” as they were under CHAMPUS.¹⁴ The Pentagon also created two new Tricare plans: Prime and Extra. The three plans are detailed below.

It’s important to note that even after the creation of Tricare, active duty troops continue to receive free health care through military facilities, as they did under CHAMPUS. Active duty personnel are automatically enrolled at no cost in the Tricare Prime program. In 2001, co-pays were eliminated for active duty dependents using Tricare Prime at civilian facilities.¹⁵ Retirees and their dependents also received a range of options under the new Tricare coverage and continued to have access to care in military facilities on a space-available basis.

2001: Tricare for Life

The most significant recent change to the Tricare system came in 2001 when Congress, with the support of the Clinton administration, created Tricare for Life, health insurance for retired service members 65 and older and their dependents. This population had previously been excluded from Tricare coverage but could receive free care at military facilities, subject to availability.

Tricare for Life is a supplement, not replacement, for Medicare. Beneficiaries are required to purchase Medicare Part B, a supplementary government insurance product, in order to receive benefits under Tricare, although Tricare is a second payer.¹⁶ For services eligible for reimbursement by both programs Tricare will pay any costs outstanding after Medicare reimbursement. The Tricare for Life beneficiary therefore incurs no significant out-of-pocket costs, making it unnecessary to purchase Medigap coverage, which is private insurance that supplements Medicare.¹⁷

Retirees over 65 still retain their access to military facilities if those facilities can accommodate them.

The current military health care insurance system

The Department of Defense provides high-quality coverage to 9.6 million service members, retirees, and their dependents through the Tricare system. The costs and benefits of coverage vary depending on a beneficiary's career stage (active duty, working-age retiree, or retiree over 65) and his or her Tricare plan (Prime, Extra, Standard, or Tricare for Life).

This section details the health care options currently available to military personnel and dependents at each stage in their careers.

Health insurance for active duty personnel and their dependents

Active duty service members and their families are automatically enrolled in Tricare Prime, an HMO-type option under which enrollees receive treatment primarily at military facilities. These Defense Department-operated facilities are generally located on or near a military base, making them convenient for active duty personnel. Tricare Prime enrollees are also eligible to receive care from a large network of participating civilian facilities.

For active duty personnel and families covered by Tricare Prime, health care is essentially free. Since 2001, dependents of active duty enrollees don't pay enrollment fees, deductibles, or monthly premiums for health care under this plan. (see Table 1 on page 8) These dependents are not even required to pay co-pays for visits to civilian facilities within their plans.

While active duty service members are required to use Tricare Prime, their dependents can enroll in either of other two Tricare plans: Extra and Standard. Both offer greater flexibility in choosing doctors in exchange for slightly higher costs in the form of deductibles and co-pays.

Regardless of whether they choose Tricare Prime, Tricare Extra, or Tricare Standard, the Department of Defense funds top-quality health care for active duty personnel and their families at little to no out-of-pocket cost.

TABLE 1
Health insurance costs to active duty personnel and their families

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual deductible	None	\$150/individual or \$300/family for E-5 and above; \$50/\$100 for E-4 and below	\$150/individual or \$300/family for E-5 and above; \$50/100 E-4 and below
Annual enrollment fee	None	None	None
Civilian outpatient visit	No cost	15 percent of negotiated fee	20 percent of allowable charges for covered service
Civilian inpatient admission	No cost	\$ 16.85/day rate (multi-day stay) or \$25 charge per admission, whichever is greater	\$ 16.85/day rate (multi-day stay) or \$25 charge per admission, whichever is greater
Civilian inpatient behavioral health	No cost	\$20/day rate (multi-day stay) or \$25 charge per admission, which is greater	\$20/day rate (multi-day stay) or \$25 charge per admission, which is greater
Civilian inpatient skilled nursing facility care	No per diem charge per admission No separate cost share for separately billed professional charges	\$ 16.85/day rate (multi-day stay) or \$25 charge per admission, whichever is greater	\$ 16.85/day rate (multi-day stay) or \$25 charge per admission, whichever is greater

Source: Tricare Management Activity, "Tricare Costs," available at <http://www.tricare.mil/tricarecost.cfm>.

Military health insurance for retirees under 65

Members of the military who serve at least 20 years become eligible for generous retirement benefits, including health care coverage.

As part of this package, military retirees under the age of 65, known as working-age retirees, and their dependents remain eligible for free treatment at military treatment facilities, subject to availability. They also remain eligible for Tricare but become responsible for small annual enrollment fees for the plan of their choice and for co-pays for care at civilian facilities. (see Table 2 on page 9) To continue their Tricare Prime coverage, retirees under 65 pay an annual enrollment fee of only \$230 for individuals and \$460 for families.

These enrollment fees have not been raised since Tricare was first implemented in 1995.¹⁸ Had the fees been adjusted to reflect nationwide increases in health care costs, the family enrollment fee might have risen from \$460 per year to something closer to the average 2010 U.S. worker contribution for an employer-sponsored family plan: \$3,997.¹⁹

Working-age retirees don't pay an enrollment fee to transition to Tricare Extra or Tricare Standard. These plans do come with a small annual deductible and co-pays to civilian providers, shown in the table on the following page.

TABLE 2
Health insurance costs to military retirees under 65 and their families

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual deductible	None	\$150/individual; \$300/family	\$150/individual; \$300/family
Annual enrollment fee	\$230/individual; \$460/family	None	None
Civilian outpatient visits	\$12	20 percent of negotiated fee	25 percent of allowable charges for covered service
Emergency care	\$30	20 percent of negotiated fee	25 percent of allowable charges for covered service
Outpatient behavioral health visit	\$25/individual; \$17/group visit	20 percent of negotiated fee	25 percent of allowable charges for covered service
Civilian inpatient cost share	\$11/day (minimum \$25 charge per admission); no separate co-payment for separately billed professional charges	Lesser of \$250/day or 25 percent of negotiated charges plus 20 percent of negotiated professional fees	Lesser of \$535/day or 25 percent of billed charges plus 25 percent of allowable professional fees
Civilian inpatient skilled nursing facility care	\$11/day (minimum \$25 charge per admission)	\$250 per diem cost share or 20 percent cost share of total charges, whichever is less, institutional services, plus 20 percent cost share of separately billed professional charges	25 percent cost share of allowable charges for institutional services, plus 25 percent cost share of allowable for separately billed professional charges
Civilian inpatient behavioral health	\$40 per day; no charge for separately billed professional charges	20 percent of total charge. Plus, 20 percent of the <u>allowable</u> charge for separately billed professional services	High volume hospitals—25 percent hospital specific per diem, plus 25 percent of the allowable charge for separately billed professional services Low volume hospitals—\$202 per day or 25 percent of the billed charges, whichever is lower, plus 25 percent of the allowable charge for separately billed services

Source: Tricare Management Activity, “Tricare Costs,” available at <http://www.tricare.mil/tricarecost.cfm>.

Military health insurance for retirees 65 and over

All military retirees over 65 are eligible for Tricare for Life, a health insurance plan that supplements Medicare. There are no enrollment fees for Tricare for Life, but plan participants must purchase Medicare Part B and pay the premiums required for that plan. Tricare for Life pays for most expenses not covered by Medicare, ensuring that retired military personnel have access to top-quality, low-cost, health care for life.

The requirement to purchase Medicare Part B premiums means Tricare for Life beneficiaries have experienced some cost increases since the program’s creation in 2001, unlike working-age retirees who have experienced no fee increases since 1995. Because Medicare Part B premiums have been increased over time, military retirees over 65 “have faced the same substantial premium increases as civilian Medicare participants,” according to the Defense Department’s 10th Quadrennial Review of Military Compensation in 2008. Retirees under 65, “who typically have higher incomes than their older counterparts,” have enjoyed stable fees over the same period, the quadrennial review found.²⁰

Alternative Military health coverage for needy and wounded veterans

The Department of Veterans Affairs offers health care coverage to more than 7 million eligible veterans and dependents. Eligibility is based on a number of factors, such as financial need, service-related disabilities, former prisoner of war status, or receipt of a Purple Heart.²¹

The Veterans Affairs programs are completely separate from the military health care system provided by the Pentagon. Any efforts to reduce the Defense Department's health care spending would have no effect on VA health care, which is designed to provide for America's neediest, wounded, and disabled veterans, regardless of whether they completed a full military career and are therefore eligible for retirement benefits.²²

The range of options outlined above provide comprehensive lifetime care for our retired service members. But the current system is not sustainable over the long-term, as the growth trend in the military health care budget makes clear. In order to address soaring budgets, we must examine the current cost structure and make smart decisions about the level of cost sharing appropriate for the military health care system.

Military health care vs. federal civilian health care

Federal civilian employees and retirees receive coverage through the Federal Employees Health Benefits program. Federal civilian health benefits are generous and are, according to the U.S. Office of Personnel Management, "a significant piece of [each employee's] compensation package." Unlike military health care, however, civilian health premiums have been adjusted over the past decade in order to compensate for the dramatically increased cost of health care.²³

Federal civilian health insurance premiums grew by 65 percent from 2000 to 2005. Tricare premiums have not been raised since the program was created. That means that for an annual enrollment fee of \$230 per individual or \$460 per family, military retirees get coverage that would cost a civilian federal retiree approximately \$5000 a year.²⁴

Federal civilian employees can continue their government-subsidized health insurance coverage when they retire. Federal retirees over the age of 65, like all Americans, are also eligible to enroll in Medicare. For retirees who chose to receive coverage through both the Federal Employees Health Benefits program and Medicare, the primary payer is Medicare while FEHB is the second payer.

Recommendations for reform

Any plan to reduce the soaring costs of Tricare must first address the contentious issue of whether military retirees are entitled to free medical care for life. This section first explores the provenance of that belief. We then propose a four-pronged framework for Tricare reform, and recommend a series of direct actions that will save the Defense Department \$15 billion a year in health care costs.

None of our recommendations would in any way impact health coverage for active duty troops or their families. In fact, instituting fair cost sharing for military retirees should contribute to the long-term sustainability of the military health care system, thus ensuring that free, high-quality care will be available to our active duty troops and their dependents over the long term.

Free health care for life?

U.S. law does not guarantee military retirees free medical care for life, yet asking retirees to share costs with taxpayers often invokes claims of a “broken promise.” Retirees and their lobbyists, like the Military Officers Association of America, argue that free care is among the benefits they were promised in exchange for at least 20 years of service in the armed forces.²⁵ Tricare for Life provides a system of lifetime care for retired service members and their dependents, at a modest cost to beneficiaries. But recent proposals by Secretary Gates to raise fees for working-age retirees have reopened the debate about free benefits allegedly promised to military retirees.

The U.S. Court of Appeals for the Federal Circuit weighed in on the issue in 2002 in *William O. Schism and Robert Reinlie v. United States*. The plaintiffs, retired Air Force veterans, claimed that declining space in military treatment facilities and the transition from free military health care to fee-based Medicare at age 65 (before the advent of Tricare for Life) deprived them of a promised

benefit. “At the time the retirees joined the Air Force, recruiters allegedly promised free lifetime medical care for them and their dependents in exchange for serving 20 years,” the court said in its decision.²⁶

Indeed, the court found evidence that some recruiters and other officials may have inappropriately led recruits and service members to believe that they would receive free care for the rest of their lives in return for serving a full career in the military. “[T]he government concedes such promises were made in good faith and relied upon,” the court said. Schism and Reinlie cited military recruitment materials, such as a Navy brochure distributed to naval officers by the secretary of the Navy in 1945 “indicating that retired Navy personnel would receive free medical care.”²⁷

Of course, CHAMPUS, Tricare, and Medicare did not exist in 1945. Free care at that time was available only at military medical facilities.

The court ultimately ruled that the government was not obligated to provide free care, despite the promises made, because “Congress—and only Congress—can authorize the benefits that a retired federal employee, whether civilian or military, is entitled to receive.” The court found that while Congress had repeatedly exercised its authority to prescribe military benefits, it had never authorized defense officials to create benefits outside of those guaranteed by law—and that existing law did not obligate the Defense Department to provide free lifetime care. In fact, the court noted that Air Force regulations “expressly provided for medical care for military retirees only as space was available.”²⁸ Moreover, as Secretary Gates noted in his congressional testimony on February 16, 2011, “once [Congress] acknowledged a fee [for Tricare] the idea that [health care] was free for life was done away with.”²⁹

Schism and Reinlie appealed to the Supreme Court, which in 2003 declined to hear the case.

A four-pronged reform framework

Secretary Gates’s proposal to raise health care fees for military retirees under age 65 is not the Pentagon’s first attempt at tackling the department’s rising health care costs. Gates’s proposal would net \$8 billion in savings over five years through a combination of changes in enrollment fees, subsidies to nonmilitary hospitals, pharmacy co-pays, and “management efficiencies.” (see box, page 4)

The Gates plan is modest in comparison to more detailed plans for addressing cost growth in the military health system.³⁰ More comprehensive proposals have been made by the Pentagon's 2007 Task Force on the Future of Military Health Care, the military's 2008 Quadrennial Review of Military Compensation, as well as analysis of military health care options by the Congressional Budget Office, and President Obama's deficit commission.

While they differ in specifics, all these proposals coalesce around four important strategies for creating a sustainable system of military health care. According to these proposals, Congress and the Defense Department must:

- Restore the cost-sharing balance between taxpayers and beneficiaries established when Tricare was formed in 1995
- Limit double coverage for working-age retirees above a certain income level
- Create incentives to reduce the overuse of Tricare for Life services
- Establish procedures to ensure fair future cost sharing

The Defense Department should select the best policy solutions out there for each of these four categories. Before we recommend our preferred menu of options, let's explore the policy options in each category in more depth.

Reinstitute a fair cost-sharing balance

In 2007, the Defense Department's Task Force on the Future of Military Health Care said "health coverage for military retirees should be very generous, but not free."³¹ Indeed, Congress and the Pentagon imposed small fees for Tricare's generous benefits when it was created in the mid-1990s. This cost-sharing balance was intended to ensure the sustainability of the Tricare system, and responsible use of taxpayer money.

Since 1995, however, Congress has lost control of military health care costs, rejecting on three occasions Pentagon requests for fee increases.³² Congress's failure to adjust Tricare fees to compensate for rising health care costs—or even inflation—means Tricare's cost-sharing provisions are seriously outdated and now contribute to the federal government's \$1.5 trillion deficit. Congress must act to restore Tricare's original balance between fees and benefits, even if doing so is politically unpalatable. Lawmakers and defense officials could significantly improve Tricare's finances by gradually implementing increased fees for working-age retirees, and for retirees over 65 based on their ability to pay.

Coverage for military retirees should be very generous, but not free.

Proposals for working-age retirees

Because Tricare fees have not been adjusted for inflation, working-age retirees pay less in real terms for health care today than they did in 1995. The Defense Department task force and the Congressional Budget Office have both examined fee increases for working-age retirees as a way to reduce military health care costs.

The task force recommended gradually increasing the enrollment fees, deductibles, and co-pays paid by working-age retirees who elect to remain on Tricare. It suggested that these increases be tiered according to a retirees' retirement pay, and that these fees be subject to future adjustment to preserve the cost-sharing balance originally established under Tricare.³³ This approach would reduce the taxpayer's burden while ensuring that military retirees of all income levels retain access to top quality care.

The Congressional Budget Office's analysis was similar. It found that the Defense Department could save \$25 billion in outlays between 2010 and 2019 by raising Tricare Prime enrollment fees to \$550 for individuals and \$1,100 for families), raising co-pays for visits to civilian providers, and raising the Tricare Standard and Tricare Extra annual deductibles to \$350 for individuals and \$700 for families. The CBO also suggested that the Defense Department could add a small annual fee, of \$50 for single coverage and \$100 for families, for Tricare Standard and Tricare Extra beneficiaries.³⁴

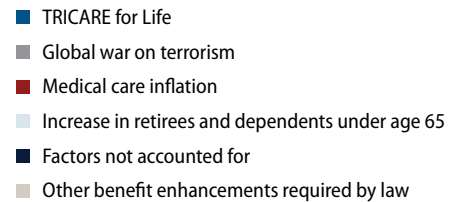
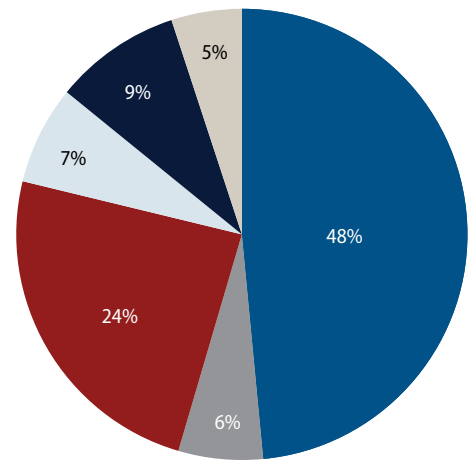
Proposals for retirees over 65

Tricare for Life, the Medicare supplement for retired service members, charges no enrollment fees or premiums. It essentially provides free, high-quality health care to military retirees. As Figure 1 shows, Tricare for Life has been a significant cause of rising military health expenses since the program was introduced in 2001.

Even a modest \$120 annual enrollment fee would provide a more sustainable cost-sharing balance between retirees over 65 and American taxpayers, according to the Task Force on the Future of Military Health Care. This fee could be indexed over time.

FIGURE 1
Tricare for Life has been a significant cause of rising military health costs

Defense Department estimates of factors contributing to defense health care spending increases, FY 2000 to FY 2005



Source: U.S. Government Accountability Office, "DOD's 21st Century Health Care Spending Challenges," p. 14, available at <http://www.gao.gov/cghome/d07766cg.pdf>.

The Defense Department would save about \$6 billion in 2013 alone if the task force's recommendations for retirees of all ages were implemented, according to the Congressional Budget Office.³⁵

Limit double coverage for working-age retirees above a certain income level

Virtually all retired service members, many of whom are in their early 40s or 50s, pursue second careers after leaving the military. These working-age retirees can remain on Tricare under current rules even if they are eligible to receive coverage through their new employers, or through their spouse's employer-sponsored plan. Given the high quality and low cost of Tricare, it's understandable that many retirees choose that option.³⁶ The 2007 defense task force on health care costs cited survey data showing that "the majority (60 percent) of retirees who are eligible for private insurance through their employer are instead using Tricare."³⁷

That means American taxpayers are footing the health care bills of retired service members who have and can afford other options—effectively subsidizing health care costs for their private employers. Consider the case of retired Marine Lieutenant Colonel Francis Brady, now employed by the consulting firm Booz Allen Hamilton. *The New York Times* reported last year that although "Brady enjoys a six-figure salary and generous benefits" through the consulting firm, in addition to his military retired pay of at least \$50,000 a year, "he and his family remain on the military's bountiful lifetime health insurance, Tricare, with fees of only \$460 per year."³⁸

Two of the co-authors of this paper proposed in a 2009 *American Interest* column that Congress and the Pentagon explore means-testing retired service members who accept military health care. The Defense Department and Congress could mandate that working-age retirees above a certain income level can only enroll in Tricare if they don't have access to other plans through their employer or spouse. That would reduce Tricare expenses while ensuring that low-income or unemployed veterans retain access to health care.³⁹

Create incentives to reduce the overuse of Tricare for Life services

Tricare for Life resembles private "Medigap" insurance in that it supplements Medicare coverage. By dramatically reducing enrollees' out-of-pocket expenses, however, Tricare for Life eliminates disincentives to unnecessary care and leads

to inflated expenses. To address this issue, President Obama's deficit commission recommended modifying Tricare for Life so that it wouldn't cover the first \$500 of an enrollee's out-of-pocket expenses and only cover 50 percent of the next \$5,000 in Medicare cost sharing. That would reduce overuse of care, saving money for both Medicare and Tricare, the commission found.⁴⁰

The Congressional Budget Office analyzed a similar proposal, in which Tricare for Life would not cover the first \$525 of out-of-pocket expenses, and only cover 50 percent of the next \$4,725 in costs. That would "reduce the federal spending devoted to TFL beneficiaries by about \$14 billion through 2014 and by about \$40 billion through 2019," the CBO found.⁴¹

[Establish procedures to ensure fair future cost sharing](#)

One-time fee increases for retirees will not control future cost growth in the military health care system. The Defense Department and Congress should develop a fair way to regulate future cost sharing between Tricare enrollees and the U.S. government.

The Defense Department's 10th Quadrennial Review of Military Compensation considered a variety of ways to control military health care spending, including high-deductible health plans in combination with health savings accounts and subsidies to retirees who choose civilian insurance. The review panel ultimately rejected those options, but recommended a number of other cost saving proposals, including linking military health care costs to civilian premiums.

The quadrennial review said that setting Tricare Prime, Tricare Standard, and Tricare Extra premiums at a fixed percentage of Medicare Part B premiums would ensure that the program costs were adjusted based on the increasing cost of care, as well as on the ability of each beneficiary to contribute to his or her care. The panel recommended setting Tricare deductibles at the same level as Medicare deductibles, but suggested eliminating deductibles for preventive care.

The panel also said the Defense Department should create incentives for beneficiaries to use low-cost prescription options, such as the Tricare mail-order pharmacy.⁴²

Implementation and savings

Many of the above recommendations are overlapping and Congress need not implement all of them. But taken together they do illustrate the tremendous potential for savings in the Tricare system.

Phasing in the following menu of specific actions over the next four fiscal years would save about \$15 billion a year by the end of fiscal year 2015, enough to effectively freeze the cost of the military health care system at fiscal year 2011 levels.

The gradual drawdown of U.S. forces in Iraq and Afghanistan should support these reductions by allowing the U.S. military to eliminate the approximately 92,000 active duty positions that were added to the ground forces after September 11, 2001. Slowing the intake of entry-level personnel would ultimately result in fewer people receiving care under the military health care system.

A plan to save \$15 billion a year

In order to control costs and ensure the sustainability of the Pentagon's generous health care system, Congress, the president, and the Department of Defense should undertake the following measures:

Phase in fees for military retirees

Congress and the Defense Department should gradually increase Tricare enrollment fees paid by working-age retirees. The fees should be tiered based on retirement pay. Additionally, Tricare for Life enrollees should pay a \$120 per person annual enrollment fee, as recommended by the Task Force on the Future of Military Health Care.

Savings: \$6 billion a year

Increase cost sharing to encourage responsible use

Tricare for Life should not cover the first \$500 of an enrollee's out-of-pocket expenses, and should be limited to 50 percent of the next \$5,000 in Medicare cost sharing, as recommended by the president's fiscal commission.

Savings: \$4 billion a year

Limit double coverage and peg Tricare premiums to Medicare Part B costs

Tricare coverage should be limited to working-age military retirees below certain income limits, or those who don't otherwise have access to insurance through a spouse or civilian employer. Additionally, to ensure that Tricare fees continue to be adjusted in the future, Tricare premium levels should be pegged to Medicare Part B premiums. Estimating the savings is difficult, but our conservative estimate is \$5 billion a year.

Savings: \$5 billion a year ⁴⁴

Total savings: \$15 billion a year

Tricare began as a series of pilot programs, a gradual process that included an independent evaluation of the effort completed in 1993.⁴⁵ While the steps outlined above do not constitute an overhaul of the system comparable to the transition from CHAMPUS to Tricare, a similar process of gradual implementation and outside evaluation should be put in place to ensure that military retirees continue to receive high-quality care at a reasonable cost.

Conclusion

Any effort to reform the military health care system must be mindful of the special burden shouldered by military service members and their families. For the first time in its history, this country has waged significant and extended wars without a draft or raising taxes. That means the burden of conflicts has fallen on a small percentage of Americans. Any proposed reduction in military health care spending could be perceived as an added burden on these already overburdened men and women.

However, our recommendations do not impact wounded, disabled, or needy veterans. Their care is provided by the Veterans Administration, which has a health care system separate from that of the Department of Defense. Nor do the recommendations in this paper affect active duty personnel and their dependents.

Our proposals to slow down the growth in military health costs would only affect military retirees, many of whom had left the service before 9/11. Moreover, the vast majority of Americans who served in Iraq and Afghanistan (as well as World War II, Korea, and Vietnam) will not serve a full career in the military, which is the requirement for receiving Tricare through retirement. Only about 15 percent of enlisted service members and half of all officers will serve the 20 years required to become eligible for military retirement benefits.⁴⁶

Moreover, while 50 percent of officers do retire with benefits, their monetary compensation package is substantial. A lieutenant colonel or Navy commander retiring after 20 years receives around \$45,358 a year indexed to inflation for the rest of their lives—which in many cases may be another 40 years.⁴⁷ A brigadier general or rear admiral retiring after about 30 years gets around \$102,306 a year in retirement pay. A military officer who serves 35 years can receive as much as \$140,000 a year.⁴⁸

Thanks to legislation passed in 1999, the retirement pay of service members who joined since 1986 is already 25 percent more than they were promised when they signed up. And because Tricare fees have not risen to reflect inflation or higher costs of living over the past 15 years, beneficiaries' health care costs have actually declined substantially since the mid-1990s.

The changes we propose are not likely to have any effect on recruiting or retention. There were no problems with recruiting or retention before Congress and the Clinton administration increased retirement pay by 25 percent and created Tricare for Life. In fact, the quality of the force at that time was at an all-time high.

Under our proposals, military retirees and their dependents will retain access to high-quality health care at a cost far below what civilian retirees pay. In calling for modest fee increases, we are merely recommending a return to the principles that have guided our system of providing health care for retirees for over 40 years. Regardless of their income level or job station, all retirees would still be eligible for free care at military facilities on a space-available basis.

Military insurance plans that allow people to receive care at civilian facilities must maintain a balance between fees and benefits in order to ensure responsible use of taxpayer dollars and keep the military health care system sustainable for future generations. Failing to maintain this balance is no different than failing to adjust retirement pay to reflect changes in the cost of living.

It's important we finally put to rest the claim that military retirees were promised free health care for life outside of military facilities, and that any change in this system violates a promise. There is no legal basis for this claim, particularly considering that CHAMPUS, Tricare, and Tricare for Life did not exist when many of today's retirees joined the military.

Secretary Gates's recent proposal is commendable but insufficient to bring the costs under control. We recommend adopting instead some of the changes suggested by the 2007 Task Force on the Future of Military Health Care, the Quadrennial Review on Military Compensation, the president's deficit commission, and our recommendations to limit coverage for military retirees above certain income levels.

This menu of changes, phased in over four years, would reduce military health care costs by about \$15 billion a year by 2015. That means the military health care budget could be maintained essentially at 2011 inflation-adjusted levels for the foreseeable future.

While the Defense Department must continue to provide top quality care to our men and women in uniform—and their dependents, and our military retirees—the Pentagon's health care system simply cannot afford to continue on its current trajectory without undermining military readiness and increasing our already debilitating deficit.

The Pentagon's
health care system
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