

TRICARE REFORM:
CREATING A SUSTAINABLE PATH TOWARD
QUALITY MILITARY HEALTH CARE

by
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A capstone project submitted to Johns Hopkins University in conformity with the
requirements for the degree of Master of Arts in Public Management

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- Etaf Khan

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MEMORANDUM

FOR SENATOR RICHARD J. DURBIN, CHAIRMAN OF THE DEFENSE
APPROPRIATIONS SUBCOMMITTEE, UNITED STATES SENATE

FROM ETAF KHAN, POLICY ADVISOR

SUBJECT LEGISLATIVE PROPOSAL TO ADDRESS TRICARE'S GROWING
COSTS AND OUTDATED STRUCTURE

DATE MAY 5, 2014

I. ACTION-FORCING EVENT

In January 2014, the Congressional Budget Office (CBO) released a report that highlighted the rapid increases in military health care costs and potential funding issues as a result of future defense spending caps in the Budget Control Act (BCA) of 2011.¹ The 42-page report identifies the need to control military health care spending to avert crowding out other defense priorities and offers ways to reduce military health care spending.

II. STATEMENT OF THE PROBLEM

Escalating Military Health Care Costs in a Fiscally-Constrained Environment

The rise of military health care costs is unsustainable. It continues to become a larger share of a shrinking defense budget, crowding out other critical national security programs. Military health-care expenditures have more than doubled, from \$15.4 billion in FY 1996, \$19 billion in FY 2001 to \$48.7 billion in FY 2013.² It is expected to grow to \$70 billion by 2028.³ As a share of defense spending, health care has grown from 4% of the

¹ Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care* (January 2014), accessed on January 27, 2014, <http://www.cbo.gov/publication/44993>.

² John L. Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013), accessed on March 4, 2014, <http://www.aei.org/papers/foreign-and-defense-policy/defense/preserving-the-military-health-care-benefit-needed-steps-for-reform/>.

³ United States Government Accountability Office, *Military Health System: Sustained Senior Leadership Needed to Fully Develop Plans for Achieving Cost Savings*, Testimony Before the Subcommittee on Military Personnel,

Department's base budget in 1990, to 6% of the base budget in 2000, and 10% in 2012.⁴

Without reform, the CBO estimates that by 2028, health care will take 11% of the DoD's budget, with an average annual growth of six percent. In dollars, the cost will grow from \$51 billion in FY2013 to \$65 billion by FY2017 and to \$95 billion by FY2030.⁵

DoD leaders and research organizations have underscored the need to curb the rapid cost growth for a long time. Since 2007, the Government Accountability Office (GAO) has consistently identified concerns regarding the sustainability of military health care benefits.⁶ In 2010, former Secretary of Defense Robert Gates said health care costs are "eating the Department of Defense alive."⁷ In a 2012 report, the CBO asserted that the cost per capita of providing military health care would increase at a substantially greater rate than inflation.⁸ Again in November 2013, General Ray Odierno told Congress that the cost of an Army soldier "has doubled since 2001," and it's going to "almost double again by 2025."⁹

Committee on Armed Services, House of Representatives (February 2014), accessed on February 28, 2014, <http://www.gao.gov/assets/670/661149.pdf>

⁴ Congressional Budget Office, *Long-Term Implications of the 2014 Future Years Defense Program* (November 2013), accessed February 4, 2014, www.cbo.gov/publication/44683.

⁵ Don J. Jansen, *Military Medical Care: Questions and Answers*, Congressional Research Service (January 2, 2014), accessed on February 4, 2014, <https://www.fas.org/sgp/crs/misc/RL33537.pdf>.

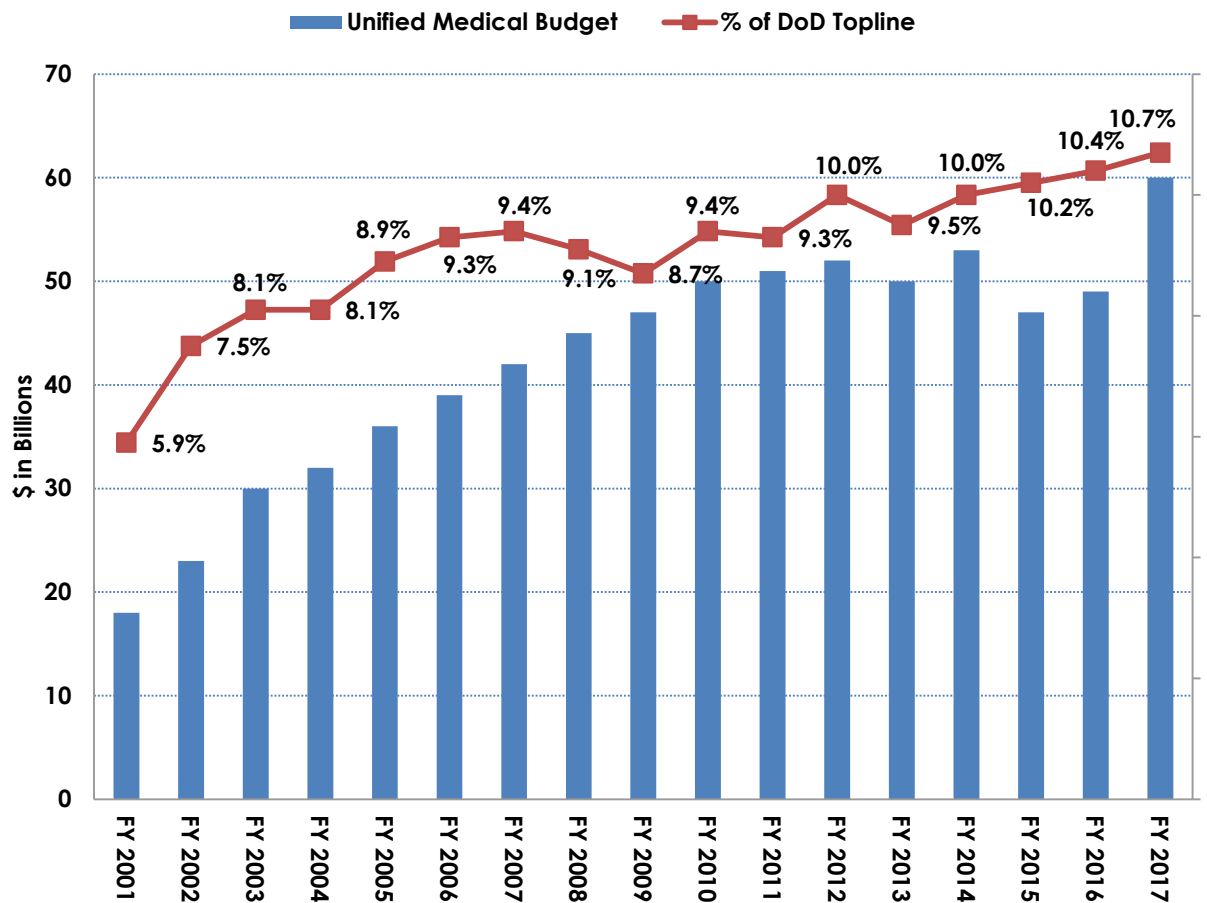
⁶ United States Government Accountability Office, *TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated*, Report to Congressional Committees (May 2007), accessed on March 9, 2014, <http://www.gao.gov/assets/270/261452.pdf>.

⁷ Robert M. Gates, "Eisenhower Library (Defense Spending)," Speech given in Abilene, Kansas (May 8, 2010), accessed January 31, 2014, <http://www.defense.gov/speeches/speech.aspx?speechid=1467>.

⁸ Congressional Budget Office, *Costs of Military Pay and Benefits in the Defense Budget* (November 2012), accessed on January 27, 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/11-14-12-MilitaryComp_0.pdf.

⁹ Walter Pincus, *Personnel Costs are a Growing Threat to Defense, Military Leaders Tell Congress*, Washington Post (November 13, 2013), accessed on January 31, 2014, http://www.washingtonpost.com/world/national-security/personnel-costs-are-a-growing-threat-to-defense-military-leaders-tell-congress/2013/11/13/016e7c12-4af5-11e3-ac54-aa84301ced81_story.html.

Graph 1. The Rise of DoD Health Care Costs in the Overall Defense Budget.



**Information compiled from the 2014 CBO Report*

As the largest source of discretionary funding, the Defense budget has recently become a target for generating savings as Washington lawmakers struggle to deal with the national debt crisis. Former Chairman of the Joint Chiefs of Staff Michael Mullen said that the national deficit was the “single greatest threat to U.S. national security¹⁰,” as the BCA of 2011 set into motion a process for cutting federal spending across both Defense and non-

¹⁰ Tyrone C. Marshall, Jr., *Debt is Biggest Threat to National Security, Chairman Says*, The American Forces Press Service (September 22, 2011), accessed on January 27, 2014, <http://www.defense.gov/news/newsarticle.aspx?id=65432>.

defense accounts. Funding is reduced by more than \$1 trillion over the ten years from 2012 to 2021, relative to the CBO's baseline from 2010. Since no consensus was made on additional deficit reduction, the law required automatic sequestration of funds beginning on January 2, 2013.

Defense spending caps established under the BCA of 2011 (and modified by the American Taxpayer Relief Act of 2012 and the Bipartisan Budget Act of 2013) constrains the total DoD budget through 2021. In FY2013, Defense spending was cut by 9.5%. From 2014 through 2021, the DoD is required to cut \$54.7 billion each year, an approximate 10% cut in the Defense budget. However, unlike the automatic cut of all defense programs, the Appropriations Committees will decide how to spread the reductions to meet the funding caps.¹¹

In the environment of a shrinking federal budget, military health care reform is necessary as it continues to consume a larger portion of a down-sized defense budget. Rising military health care costs potentially hampers the benefit that provides health care to over nine million beneficiaries in the long-term. It also squeezes budgets for the research, development, and procurement of essential weapons systems, affecting jobs in the federal government and the private sector. As a result, the trend of rising military health care costs puts pressure on overall military readiness. Without meaningful ways to significantly control the cost growth of military health care, national security may become vulnerable.

¹¹ Richard Kogan, *How the Across-the-Board Cuts in the Budget Control Act Will Work*, Center on Budget and Policy Priorities (April 2012), accessed on February 4, 2014, <http://www.cbpp.org/cms/?fa=view&id=3635>.

III. HISTORY

Evolution of TRICARE

In order to tackle the growing cost trend of military health care, it is important to understand the development and progress of the DoD health care program. TRICARE is the primary vehicle that delivers health care to over nine million military beneficiaries. Historically, military treatment facilities (MTF) provided health care to military personnel and their dependents. If military physicians were not available in a certain specialty, or if the MTF was overcrowded, then military personnel and their families would go through a referral system to get treated by civilian medical personnel.

▪ **CHAMPUS (1966 – 1993)**

Before TRICARE, Congress passed the Dependents Medical Care Act of 1956 (Public Law 84-569), which authorized the DoD to contract medical care to civilian health care plans in order to provide timely and quality healthcare for family members of AD soldiers and retirees. The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was established in 1966 by the Military Medical Benefits Amendments of 1966 (Public Law 89-614). On January 1, 1967, retirees, their dependents, and certain surviving family members of deceased military sponsors became eligible for CHAMPUS.¹² In the late 1980s, CHAMPUS demonstration projects like the CHAMPUS Reform Initiative (CRI) were tested to offer family members more benefit choices in California and Hawaii.¹³

¹² TRICARE Fundamentals Online Public Course, “Who We Are & Our History,” TRICARE University, accessed on March 9, 2014, http://www.tricare.mil/tricareu/pco_ppt/20091130/01_who_we_are_public_our_history.pdf.

¹³ United States General Accounting Office, *Despite TRICARE Procurement Improvements, Problems Remain*, Defense Health Care Report to Congressional Requesters (August 1995), accessed March 10, 2014, <http://www.gao.gov/archive/1995/hc95142.pdf>

▪ **TRICARE (1993 – Present)**

After the success of the demonstration projects, in 1993, the DoD and Congress extended the CRI and renamed it to TRICARE. TRICARE brings together the health care resources of the Army, Navy, and Air Force, and supplements them with networks of civilian health care providers. TRICARE offers three plan options for AD, Activated Guard and Reserves (AGRs), retired members of the uniformed services, their dependents, and survivors:

1. **TRICARE Prime** (like health maintenance organization (HMO)),
2. **TRICARE Standard** (like Fee for Service), and
3. **TRICARE Extra** (like Preferred Provider Network).

For a smooth transition to TRICARE, healthcare coverage, deductibles, cost shares, and claim-filing rules stayed the same for existing CHAMPUS participants. Military personnel are automatically enrolled in TRICARE Prime. However, dependents and retirees have to select their TRICARE option.¹⁴

TRICARE Expansion

Since inception, TRICARE experienced several restructuring initiatives, including the realignment of contract regions, base realignment & closures, and beneficiary pool expansions. Between 2001 and 2012, Congress expanded TRICARE by adding 17 new programs, covering new procedures, and extending plan restrictions. These expansions increased the pool of eligible beneficiaries from 8.2 million to 9.1 million.¹⁵ Most of the growth in beneficiaries occurred in the retirees, National Guard (NG) members, reservists &

¹⁴ “TRICARE Benefits Explained,” Military.com, accessed on March 14, 2014, <http://www.military.com/benefits/tricare/your-tricare-benefits-explained.html?comp=7000022774319&rank=2>

¹⁵ Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care*, 10.

dependents populations. TRICARE for Life (TFL) and TRICARE Reserve Select are two programs that contribute to the increase of beneficiaries.

- **TFL (2000 – Present)**

TFL serves as a second payer program for Medicare-eligible military retirees.¹⁶ Congress enacted TFL in response to complaints from retirees who felt that the DoD’s “promise of free health care for life” was being broken.¹⁷ Prior to TFL, TRICARE coverage expired at age 65, which forced military retirees, their families, and survivors to rely on Medicare as their only payer for health care. The program requires beneficiaries to enroll in Medicare Part B, which charges annual premiums based on income. For services covered by both Medicare and TFL, Medicare pays first, then TFL pays the remaining balance. When Medicare does not cover a service, TFL is the first payer. TFL essentially eliminates the out-of-pocket expenses for Medicare-eligible retirees and their families. About 1.6 million people enrolled in 2012.¹⁸

- **TRICARE Reserve Select**

In 2005, lawmakers created TRICARE Reserve Select, designed for the NG and reservists who were mobilized and deployed in Iraq and Afghanistan. Prior to TRICARE Reserve Select, guardsmen and reservists became TRICARE-eligible only after they served

¹⁶ DoD, *Evaluation of the TRICARE Program – Access, Cost, and Quality: Fiscal Year 2013 Report to Congress* (February 2013), p. 87, accessed on March 14, 2014, <http://go.usa.gov/jX9H>.

¹⁷ To entice reenlistment and retention, the military promised free health care for life as a “delayed pay” to supplement the substandard pay compared to civilian pay. Between the early 1940s and December 1956, the United States Code (USC) designated that MTFs provide authorized and free medical care for medical retirees and their dependents on a space-available basis. In 1956, AD personnel started paying into Social Security, which enabled them to be eligible for Medicare at age 65. CHAMPUS ceased funding to provide care for military retirees at MTFs and required copays for retirees and their dependents, similar to MEDICARE. TRICARE did not provide insurance to military retirees and their dependents age 65 and over, forcing them to purchase supplemental insurance. Information taken from *White Paper – A Briefing on the History of Military Retirees, Their Dependents, and Survivors’ Health Care (An Issue of the Honor and Trust in the US Government)*, accessed on March 12, 2014, <http://www.vfw6872.org/History%20of%20Military%20Healthcare.htm>.

¹⁸ Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care*, 11.

on AD for more than 30 days. Eligibility ended when they were demobilized. Under TRICARE Select, eligible NG and reservists are given the option to purchase TRICARE Standard and Extra coverage.¹⁹ Furthermore, the program was expanded in 2007 to include almost all NG and Reserve members as long as he or she is not also eligible for the Federal Employee Health Benefits programs.

The number of TRICARE Reserve Select has grown dramatically. At the end of 2007, there were 35,000 enrollees (including dependents), and by 2002, there were more than 240,000 enrollees. Enrollment in this program may continue to increase after 2014 because of the Affordable Care Act (ACA). The TRICARE Reserve Select premium is favorable to the expected premiums for the plans in the health insurance exchanges under ACA, and is only slightly higher than the penalty for not having insurance.²⁰

¹⁹ To be eligible, members had to have served on AD for at least 90 consecutive days since September 11, 2001, in support of overseas combat operations like those in Iraq and Afghanistan. IBID, 13.

²⁰ Susan D. Hosek, *Healthcare Coverage and Disability Evaluation for Reserve Component Personnel: Research for the 11th Quadrennial Review of Military Compensation*, RAND Corporation (2012), accessed on March 1, 2014, www.rand.org/pubs/monographs/MG1157.

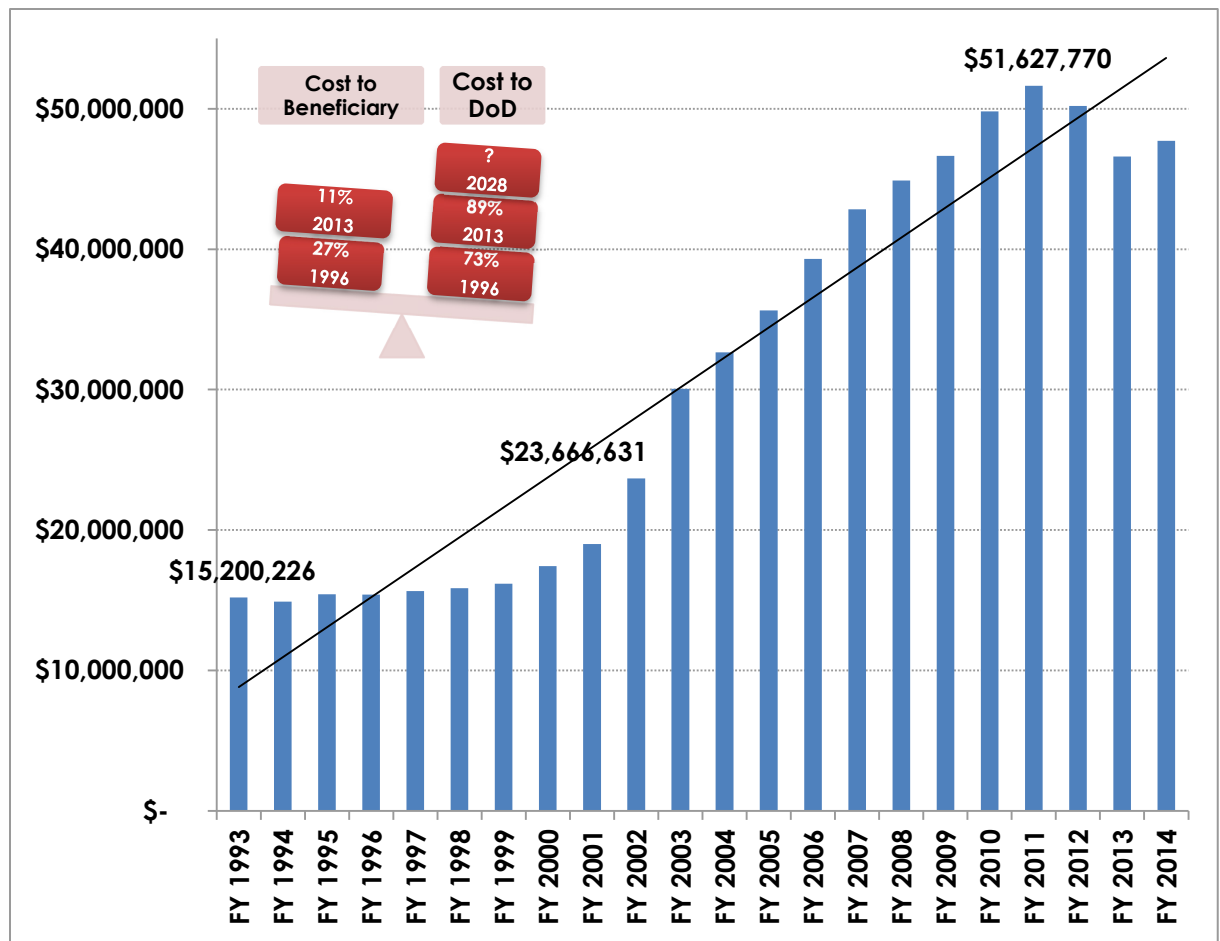
Table 1: TRICARE Expansion Between 2000 – 2012²¹

2000	<ul style="list-style-type: none"> - Expansion of TRICARE Retiree Dental Program to dependents. - Catastrophic cap for unenrolled retirees, their family members, & survivors reduced from \$7,500 to \$3,000. - DoD waives charges for AD Prime Remote family members through Aug 31, 2000. - TRICARE benefits expanded to cover school physicals.
2001	<ul style="list-style-type: none"> - TRICARE eliminates Prime copays for AD family members (ADFM). - TRICARE Senior Pharmacy benefit begins. - TRICARE simplifies and reduces copay structure for prescription drugs. - AD Service members get permanent chiropractic care benefit in MTFs.
2002	<ul style="list-style-type: none"> - TRICARE for Life benefits begins. - TRICARE Prime Remote benefit begins for ADFMs.
2003	<ul style="list-style-type: none"> - TRICARE Prime Remote is modified to allow residing family members to remain enrolled when sponsors undergo PCS on unaccompanied tour. - Requirement for Guard/Reserve sponsor's activation orders TRICARE Global Remote Overseas benefit begins. - Requirements for TRICARE Standard beneficiaries to obtain a Non-availability Statement eliminated except for mental health.
2004	<ul style="list-style-type: none"> - TAMP coverage permanently extended to 180 days following AD, making "early benefit" permanent for NG & Reserve Members called to AD.
2005	<ul style="list-style-type: none"> - TRICARE Reserve Select (TRS) benefit begins.
2006	<ul style="list-style-type: none"> - Opportunity to purchase TRS extended to all qualifying members of NG & Reserve. - Gastric bypass, and other gastric procedures covered under TRICARE. - Family members given a 30-day period to submit a TRICARE Prime enrollment form.
2007	<ul style="list-style-type: none"> - Anesthesia & other dental care for certain children & other beneficiaries authorized. - Eligibility expanded for Selected Reserve members. - Claims processing under TRICARE program and Medicare program is standardized. - Mental health screening & services for members of the Armed Forces are enhanced. - TRS is simplified and opened to all Reservists other than those with Federal Employees Health Benefits Plan (FEHBP).
2008	<ul style="list-style-type: none"> - Mental health care program is included in the definition of health care.
2009	<ul style="list-style-type: none"> - AD Dental Program is implemented. - Extended Care Health Option (ECHO) government liability is increased to \$36,000 per year for certain services. - TRICARE Pharmacy manufacturer refunds are established (retroactive to January 2008).
2010	<ul style="list-style-type: none"> - TRICARE Overseas Program begins health care delivery. - TRICARE Retired Reserve (TRR) program is launched, allowing gray-area retirees to purchase TRICARE health coverage for themselves and eligible family members.
2011	<ul style="list-style-type: none"> - TRICARE Young Adult (TYA) begins offering TRICARE Standard coverage to certain beneficiaries through age 25. - TRICARE Pharmacy announces copay decreases for the home delivery option, coinciding with increases to copays for retail pharmacy purchases. - TRICARE Prime enrollment fee is adjusted and can now be changed annually (frozen for survivors and certain significantly injured or ill retirees).
2012	<ul style="list-style-type: none"> - Copays for authorized preventive services eliminated. - TYA extended to offer TRICARE Prime Coverage.

²¹ DoD, *Evaluation of the TRICARE Program – Access, Cost, and Quality: Fiscal Year 2013 Report to Congress* (February 2013), p. 87

New and expanded benefits are a significant contribution to DoD's growing costs. In addition, out-of-pocket expenses for the beneficiary – including enrollment fees, deductibles, coinsurance rates, and copayments – have remained relatively the same or even decreased since TRICARE's inception in 1995. Therefore, the proportion of TRICARE costs paid by the beneficiary has declined since implementation. When TRICARE was fully implemented in 1996, a working age retiree's family of three who used civilian care contributed roughly 27% of the total cost of its health care. Today, that percentage has dropped to less than 11%.

Graph 2. Military Health Care: DoD Unified Medical Budget (FY 1993 – FY 2014)



**Data compiled from President's Budget Justification Books from 1994 to 2014*

Previous Attempts to Address TRICARE's Growing Costs

Several reforms to address growing costs were placed forward to Congress that increased the out-of-pocket expenses for beneficiaries. Overall, the reforms did not affect AD members and were mainly targeted toward controlling costs for retirees and dependents. So far, these proposals have been met with resistance by Congress, and predictably by military/veteran service organizations.

▪ The George W. Bush Administration

Under a proposal called *Sustain the Benefit*, the FY 2007 President's Budget (PresBud) first proposed changes to curb the costs of DoD health care by focusing on working-age retirees and their independents. The proposal would charge them an annual enrollment fee for TRICARE Standard, a significantly increased annual enrollment fee in TRICARE Prime, and increased annual deductibles, and retail pharmacy co-payments (copays). According to the DoD, the proposal generated a savings estimate of \$11 billion over five years.²² Congress rejected the proposal, but did establish the DoD Task Force on the Future of Military Health Care ("Task Force") in Section 711 of the FY 2007 National Defense Authorization Act (NDAA), Public Law 109-364. The Task Force comprised of both military and civilian officials with expertise in health care budget issues, who evaluated efforts to improve and sustain defense health care over the long term and examine the cost-sharing structure.²³

In a final December 2007 report, the Task Force found that costs for working-age retirees have been fixed in dollar terms since TRICARE's inception and have declined by a

²² United States Government Accountability Office, *TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated*, 6.

²³ The authorizing language in the John Warner National Defense Authorization Act for Fiscal Year 2007 (Public Law 109-364, section 711, pp. 2284-2287).

factor of 2-3. The Task Force recommended cost-share increases, phased-in enrollment fees, and deductibles to restore the cost-sharing relationship. The Task Force also recommended the fees and deductibles to be tiered based on pay level of military retirees. The FY 2009 PresBud proposals were based on the Task Force's recommendations.²⁴ The measures below estimated a savings of \$1.2 billion just in FY 2009 alone.²⁵ Congress prohibited the DoD from increasing fees, deductibles, copays, and other charges.

▪ **The Barack Obama Administration**

Although the FY 2010 and FY 2011 PresBuds did not contain any legislative proposals to increase TRICARE cost-shares, former Defense Secretary Robert Gates expressed concern about the impact of increasing TRICARE costs and criticized the inaction by Congress. He said, "In recent years, the Department has attempted modest increases in premiums and copays, but has been met with furious response from the Congress and veterans groups. The proposals routinely die an ignominious death on Capitol Hill."²⁶

The PresBuds for 2012 and 2013 proposed several of the cost-sharing increases proposed by the Bush Administration, Task Force recommendations, and input from the GAO and CBO. Some of the reforms included linking enrollment fees to medical inflation, new TFL enrollment fees, and raising deductibles for retirees. The FY 2013 PresBud asked for military retirees' contribution to rise from 11 to 14% of their total health care costs and

²⁴ Congressional Budget Office, *The Effects of Proposals to Increase Cost Sharing in TRICARE* (June 2009), <http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/102xx/doc10261/TRICARE.pdf>.

²⁵ Don J. Jansen, *Increases in TRICARE Costs: Background and Options for Congress*, Congressional Research Service (May 14, 2009), accessed on March 4, 2014, www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA501362.

²⁶ Gates, "Eisenhower Library (Defense Spending)."

would have generated a savings of \$12.9 billion between FY 2013 and FY 2017.²⁷ Similar proposals in the FY 2014 PresBud were to have generated estimated savings between \$902 million and \$9.3 billion through FY 2028.

Senators Carl Levin and John McCain endorsed some of President Obama's cost-share increase proposals, including a new enrollment fee for TFL.²⁸ While that proposal was unsuccessful, Congress approved the Prime enrollment fee increases (subject to an annual cost-of-living adjustment (COLA)) for new retirees and the new pharmacy copays for 2012. For 2013, Congress allowed a modest increase in pharmacy copays and created the Military Retirement Modernization Commission (MRMC) to conduct a military compensation and retirement review and offer ways for modernization.²⁹ The other proposals for additional cost-share increases were rejected due to the "firmly-held sense of Congress that prior service to the nation is a pre-payment of health care benefits in retirement."

Although Senator Lindsey Graham did express interest for including fee increases, Congress rejected all TRICARE proposals in the FY 2014 PresBud.³⁰ Congress said it had "already put TRICARE on a sustainable path through reforms in several recent NDAAAs... [and] DoD's record of incorrectly calculating TRICARE costs and their repeated requests to transfer billions in unused funds out of the program to cover other underfunded defense

²⁷ Lawrence J. Korb, Alex Rothman, and Max Hoffman, *Reforming Military Compensation – Addressing Runaway Personnel Costs is A National Imperative*, Center for American Progress (May 7, 2012), accessed on March 4, 2014, http://www.americanprogress.org/wp-content/uploads/issues/2012/05/pdf/military_compensation.pdf.

²⁸ Tom Philpott, *Key Senators Back TRICARE Fees; Retiree COLAs Return*, The Fleet Reserve Association (November 2012), accessed on March 24, 2014, <http://www.fra.org/AM/Template.cfm?Section=Home&CONTENTID=12917&TEMPLATE=/CM/ContentDisplay.cfm>.

²⁹ The About Section from *the Military Compensation and Retirement Modernization Commission* website, accessed on March 14, 2014, <http://www.mcrmc.gov/index.php/about>.

³⁰ Rick Maze, *Senate Panel Oks Lower Raise, But Opposes Tricare Hikes*, Navy Times (June 11, 2013), accessed on March 30, 2014, <http://hrana.org/news/2013/06/senate-panel-oks-lower-raise-but-opposes-tricare-hikes/>.

priorities raises questions about repeated claims by the DoD that the Defense Health Program is unsustainable.”³¹ In May 2013, Representative Joe Wilson (R – S.C.), chairman of the personnel subcommittee cited several reasons for the bipartisan resistance inside the HASC for boosting TRICARE fees: (1) U.S. troops are still fighting terrorism across the world, and (2) Defense officials have overstated health care costs enough so that they were able to reprogram on average \$400 million a year. He said that he believes that the commitments made to service members and retirees to sustain the value of their health benefits (even presumably as health costs continue to climb) “should be maintained.”³²

▪ **Resistance from Military Advocacy Groups**

Moreover, there are over 50 veterans service organizations (VSOs) and military advocacy groups who generally oppose any out-of-pocket cost increases for the beneficiary. In March 2014, retired Air Force Colonel Mike Hayden, who is from the Military Officers Association of America (MOAA), said that the proposals are “breaking faith to change the rules for someone with 10 years – or one year – of service.” He says that the proposals in the most recent PresBud for FY15 raises “the most questions over medical care costs to personnel on recruiting duty or living far from the MTF, the ability of military facilities to handle new patients, and the noticeable shortage of physicians who accept TRICARE patients.”³³ From the Fleet Reserve Association, legislative programs director John Davis

³¹ Terry Howell, *House and Senate Said to Agree on TRICARE and Military Pay*, Military.com (December 10, 2013), accessed on February 28, 2014, <http://militaryadvantage.military.com/2013/12/house-and-senate-agree-on-tricare-and-military-pay/>.

³² Tom Philpott, *House Panel Rejects Pay Cap, Most TRICARE Hikes*, Military.com (May 23, 2013), accessed on March 29, 2014, <http://www.military.com/benefits/2013/05/23/house-panel-rejects-pay-cap-most-tricare-hikes.html>.

³³ Patricia Kime, *Senators Weigh Impact of Proposed TRICARE Fee Hikes*, Air Force Times (March 27, 2014), accessed on March 28, 2014, <http://www.13wmaz.com/story/news/local/robins-air-force-base/2014/03/27/tricare-fee-hike-proposed/6948791/>.

does not necessarily oppose TRICARE consolidation but oppose cost-share increases to beneficiaries, citing concerns with negative impact on retention and recruitment.³⁴

Following CBO's January 2014 report that proposed cost-share increases for retirees has the most potential to generate significant DoD savings, Veterans of Foreign Wars spokesperson Joe Davis voiced strong opposition. Davis questioned CBO's numbers and said that the report indicated that the Pentagon is "opening up a new front in the war on retirees," and that it was a "threat to the all-volunteer force."³⁵

▪ **Call for Reform from Independent Organizations**

In the aforementioned CBO report (which was prepared at the request of Representative Paul Ryan) examined three ways for controlling TRICARE costs: better management of chronic diseases, more effective administration of the military health care system, and increased cost-sharing for retirees who use TRICARE. Of the three approaches, the CBO said only the cost-share increases for retirees could produce significant savings for the DoD. The report laid out options that could produce savings from roughly \$20 to \$60 billion dollars.³⁶

The National Committee on Fiscal Responsibility and Reform (commonly known as the Simpson-Bowles Commission) endorsed cost-share increases that were previously proposed by the CBO and the Government Accountability Office.³⁷ In specific, the Simpson-Bowles Commission recommended restricting first-dollar coverage for TFL (along

³⁴ Ibid.

³⁵ Richard Sisk, *CBO Studies Removing Retirees from TRICARE Prime*, Military.com (January 21, 2014), accessed on March 28, 2014, <http://www.military.com/daily-news/2014/01/21/cbo-studies-removing-retirees-from-tricare-prime.html>.

³⁶ Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care*, 1.

³⁷ Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013),12.

with other Medigap plans) to constrain over-utilization of care and reduce overall spending.³⁸ Another debt-reduction proposal, the Domenici-Rivlin plan recommended increasing TRICARE premiums and drug copays.³⁹ The Concord Coalition's Zero-Deficit Plan and the Galston-MacGuineas Plan have also put forth cost-increase proposals.⁴⁰ In addition to bipartisan collaborations, other research organizations have weighed in on ways to reform military health care: the Defense Business Board, the Quadrennial Review of Military Compensation, the Center for American Progress, the RAND Corporation, the Heritage Foundation, and the American Enterprise Institute. Although these groups are divided on the details of their reforms, they all say that the status quo is unsustainable.

IV. BACKGROUND

Developing a successful way forward for controlling escalating TRICARE costs requires a basic understanding of the comprehensive TRICARE benefit and the contributing factors to its rapid cost growth. Coverage and costs depend on which category the beneficiary falls under (AD, working-age retiree, or retiree older than 65) and on the plan that he or she selects (Prime, Extra, Standard, or TFL).⁴¹ TRICARE's largest cost growth

³⁸ Senator Alan Simpson and Former White House Chief of Staff Erskine Bowles, *The Moment of Truth*, Report of the National Commission on Fiscal Responsibility and Reform (December 2010), accessed on March 28, 2014, http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.

³⁹ Senator Pete Domenici and Dr. Alice Rivlin, *The Domenici-Rivlin Debt Reduction Task Force Plan 2.0*, Bipartisan Policy Center (November 2010), accessed on March 28, 2014, http://pgpf.org/sites/default/files/sitecore/media%20library/Landers/Post_Election_Fiscal_Cliff/Solutions_Initiative_II/bpc_si2.pdf.

⁴⁰ Joshua Green, *Why Won't Americans Listen to Alan Simpson and Erskine Bowles?*, BloombergBusinessWeek (February 28, 2013), accessed on March 29, 2014, <http://www.businessweek.com/articles/2013-02-28/why-wont-americans-listen-to-alan-simpson-and-erskine-bowles#p2>.

⁴¹ Rod Powers, *Understanding Military Medical Care*, About.com, accessed on March 4, 2014, <http://usmilitary.about.com/cs/healthcare/a/medicalcare.htm>.

drivers include: (1) new and expanded benefits, (2) low & outdated cost structure, and (3) general medical trend inflation.

The TRICARE Benefit

DoD provides health care to almost ten million service members, retirees, and their dependents through the TRICARE program.

▪ TRICARE Beneficiaries

1. AD personnel & their dependents (ADFMs): AD members and ADFMs are automatically enrolled in TRICARE Prime, in which health care is essentially free. There are no enrollment fees, deductibles, or monthly premiums for health care under TRICARE Prime. While AD members are required to use TRICARE Prime, their dependents can choose to enroll in TRICARE Extra or TRICARE Standard, which offer more flexibility in choosing doctors in exchange for slightly higher costs in the form of deductibles and copays.
2. Working-age retirees (served 20+ years) & their dependents: Working-age military retirees who serve at least 20 years become eligible for TRICARE coverage. All retirees regardless of length of service and their dependents remain eligible for free treatment at MTFs, subject to availability. Military retirees who have served at least 20 years are allowed to remain on TRICARE and are responsible for small annual enrollment fees for the plan of their choice (Prime, Standard, Extra) and for copays for care at civilian facilities.⁴² Retirees younger than 65 that choose Prime pay an enrollment fee of \$274/individual and \$578/family. These enrollment fees were raised only once since TRICARE was first implemented in 1995 and are subject to the COLA.⁴³ The average U.S. worker's contribution for an employer-sponsored family plan was \$4,129 in 2011.⁴⁴
3. Medicare-eligible retirees (served 20+ years) & their dependents: All Medicare-eligible military retirees are also eligible for TFL, which supplements Medicare. There are no current enrollment fees for TFL, but plan participants must purchase Medicare Part B and pay the required premiums. TFL pays for most expenses not covered by Medicare. The requirement to purchase Medicare Part B premiums means that TFL beneficiaries have experienced some cost increases since the

⁴² Korb, Rothman, and Hoffman, *Reforming Military Compensation: Addressing Runaway Personnel Costs is a National Imperative*, 15.

⁴³ Jansen, *Increases in TRICARE Costs: Background and Options for Congress*, 1.

⁴⁴ The Kaiser Family Foundation, *Employer Health Benefits 2011 Annual Survey* (2011), accessed on March 14, 2014, <http://ehbs.kff.org/pdf/2011/8225.pdf>.

program's creation in 2001. This is unlike retirees under 65 who have not experienced any fee increases since TRICARE's inception.⁴⁵

▪ **TRICARE Health Insurance Options**

The three basic health plans under TRICARE are Prime, Standard, and Extra. TRICARE Standard and Extra meet the requirements for the minimum essential coverage under the Affordable Care Act. While activated Guard and Reserve members are automatically enrolled in TRICARE Prime, military dependents and retirees must choose among three TRICARE options.

TRICARE Prime: A voluntary HMO-type option, in which MTFs are the principal source of health care. This option operates similar to a health maintenance organization (HMO) and provides enhanced preventative care and vision benefits. Additional Prime options include Prime Remote, Prime Overseas, and Prime Remote Overseas. Beneficiaries must choose a primary care physician and obtain referrals and authorizations for specialty care. In return for these restrictions, beneficiaries (retirees and their families only) are responsible for comparatively small copayments for each visit. There is an annual enrollment fee for TRICARE Prime for military retirees and their dependents. There is no enrollment fee for ADs and ADFMs. As an HMO, TRICARE Prime offers fewer out-of-pocket costs than TRICARE Standard and Extra, but less freedom of choice.

TRICARE Standard: A fee-for-service option similar to the original CHAMPUS program. It is available to all non-AD members, AC retirees, retirees from the Reserve Component age 60 or older, and their eligible dependents. Beneficiaries can use any civilian health care provider payable under TRICARE regulations. The beneficiary is responsible for paying an annual deductible, coinsurance, and may be responsible for certain other out-of-pocket expenses. Coverage under TRICARE Standard is automatic as long as the patient's

⁴⁵ U.S. Department of Defense, *Report of the Tenth Quadrennial Review of Military Compensation: Volume I*.

information is current in the Defense Enrollment Eligibility Reporting System. They are responsible only for the annual deductible and small copays. This option features the broadest flexibility for beneficiaries and usually does not require referrals for specialty care. The tradeoff is that beneficiaries typically pay more out of pocket on top of an annual deductible. They also do not have a primary care manager responsible for coordinating the totality of their health care needs. Many beneficiaries use TRICARE Standard if they have civilian health care coverage through their employer or prefer a doctor outside the TRICARE provider network.

TRICARE Extra: A preferred provider option that saves money, similar to a traditional fee-for-service plan. Enrollment is automatic as long as you're registered in the Defense Enrollment Eligibility Reporting System (DEERS) and show TRICARE eligibility.

Table 2: Current TRICARE Health Plans Costs⁴⁶

	Enrollment	Costs	Service
PRIME	Annual Fee - Individual: \$274 - Family: \$548 <i>No fee for ADFMs* (auto enrollment)</i>	Copayment for authorized care in the TRICARE provider network = \$12/visit	Priority access to MTFs and TRICARE network providers.
Standard	Not Required	- 25% cost-share of negotiated costs. - 20% cost-share for ADFMs.	Seek care from any provider.
Extra	Not Required	- 20% cost share of negotiated costs. - 15% cost-share for ADFMs.	Seek care from TRICARE network providers.
TFL	Not required	- Medicare Part B & its premiums	Supplements Medicare

⁴⁶ From the TRICARE website, "Health Plan Costs," Tricare.mil, accessed on March 7, 2014, <http://www.tricare.mil/Costs/HealthPlanCosts/>.

Continuation Table 2: Current TRICARE Health Plans Costs⁴⁷

	Deductible	Advantages	Eligible Beneficiaries
PRIME	None.	Little to no out-of-pocket costs. Portability (worldwide coverage)	- AD service members & their dependents - Working-age retirees & their dependents
Standard	- Individual: \$150 - Family: \$300 *Same for ADFMs of E-5 & above. *For E-4 & below: - Individual: \$50 - Family: \$100	Freedom to seek care from any providers but required to file own claim. If the provider is a nonparticipating TRICARE provider, patients may be required to pay up to 15% above the allowable charges.	- AD dependents - Working-age retirees & their dependents
Extra	Not Required	Discounted cost-shares and no claims to file.	- AD dependents - Working-age retirees & their dependents
TFL	N/A	Pays for most expenses not covered by Medicare. Access to inexpensive, to-quality health care for life.	- Retirees 65 and over

Pharmacy Program: All TRICARE beneficiaries, including Medicare-eligible retirees, may fill prescription medications at MTF pharmacies, through Mail Order Pharmacy (TMOP) or at retail network and non-network pharmacies.

⁴⁷ From the TRICARE website, "Health Plan Costs," Tricare.mil, accessed on March 7, 2014, <http://www.tricare.mil/Costs/HealthPlanCosts/>.

Table 3: Pharmacy Program Prescription Cost to Beneficiary

MTFs	<ul style="list-style-type: none">• \$0 (up to a 90-day supply)• Non-formulary not usually filled at MTFs.
TMOP	<ul style="list-style-type: none">• \$0 generic (up to 90-day supply)• \$13 brand name formulary (up to 90-day supply)• \$43 non-formulary
Retail Network Pharmacy	<ul style="list-style-type: none">• \$5 generic (up to 30-day supply)• \$17 brand name (up to 30-day supply)• \$44 non-formulary <p>*<u>Note:</u> If user wants a 90-day supply, the copayment for each 30-day supply is required.</p>
Retail Non-Network Pharmacy	<ul style="list-style-type: none">• AD member will receive full reimbursement after filing a claim.• All others in Prime pay 50% cost share after point-of-service deductible is met. <p>Users of other TRICARE plans pay:</p> <ul style="list-style-type: none">• \$17 or 20% of total cost, whichever is greater after annual deductible is met for generic or brand name formulary.• \$44 or 20% of total cost, whichever is greater, after annual deductible is met for non-formulary.

Driving Factors Increasing DoD Health Care Costs

The majority of military health care funding is for purchased care, in-house care, and accrual payments. DoD, experts, and policymakers have targeted increases in these areas to identify ways to reduce future spending. The main cost drivers are (1) new and expanded TRICARE benefits, (2) the low & outdated cost-share to beneficiaries, and (3) general medical trend inflation. In result, these two incentives are positively correlated with more cost-driving factors: an increase in the number of TRICARE beneficiaries and TRICARE program utilization.

▪ **New and Expanded TRICARE Benefits**

Since TRICARE's inception, Congress has added 40 new benefits and expanded the program to AD members, reservists, their dependents, and retirees. Aside from the added TFL and TRICARE Reserve Select described in the prior *History* section, some of the other key benefits include TRICARE Senior Pharmacy, the reduction of the Catastrophic Cap, and TRICARE Young Adult.⁴⁸

- *TRICARE Senior Pharmacy (2001)*: A comprehensive prescription drug benefit not provided in Medicare. Benefits include standardizing copayments and lowering the costs of generic medications.⁴⁹
- *Catastrophic Cap Reduction (2001)*: The maximum amount that non-ADFMs have to pay for TRICARE-covered medical expenses. In the 2001 NDAA, the cap was reduced from \$7,500 to \$3,000.⁵⁰
- *TRICARE Young Adult (2011)*: Premium-based plan that offers TRICARE Prime or Standard for qualified adult-age dependents who have aged out of TRICARE benefits.

Increase in TRICARE Beneficiaries: Expansions and new benefits from 2000 to 2010 caused the increase in number of eligible beneficiaries, going from 6.8 million to almost ten million. This increase represents a 43% real cumulative growth in the eligible population.⁵¹ The expanded pool also changed the profile of the primary TRICARE beneficiary. Of the approximately ten million beneficiaries, only 15% of them are AD members. AD dependents represent another 21%, for a total of approximately 36% of the

⁴⁸ Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013),7.

⁴⁹ U.S. Department of Defense, DoD Implements TRICARE Senior Pharmacy Program: Fact Sheet (March 20, 2001), accessed on March 16, 2014, www.defense.gov/releases/release.aspx?releaseid=2871.

⁵⁰ U.S. Department of Defense, "TRICARE Choices: At a Glance," accessed on March 14, 2014, www.humana-military.com/library/pdf/choices-at-a-glance.pdf.

⁵¹ Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013),6.

beneficiary population. Both working-age and Medicare-eligible retirees and their dependents represent 53% of the TRICARE-eligible beneficiaries.⁵² Since 2013, the working-age retiree population has begun to decrease. However, this is causing an increase in the Medicare-eligible/TFL beneficiary population. The working-age retirees are aging out and moving to TFL benefits.

Increase in TRICARE Utilization: The increase in TRICARE utilization is partially due to the higher number of beneficiaries, namely retirees who are more likely to have health concerns than AD & AD dependent counterparts, who are younger and typically healthier. For example, the CBO found that in 2010, working-age retirees and their families obtained three times more 30-day prescriptions per user and TFL users obtained six times more 30-day prescriptions as AD members and their families.⁵³ Inpatient usage by TFL users was almost three times greater than that of working-age retirees and their families and five times greater than usage by AD members and their families. Working-age retirees used 25% more outpatient services than AD members and their families, and TFL beneficiaries used 50% more.

▪ **Low & Outdated Cost-Share for TRICARE Beneficiaries**

The larger pool of TRICARE participants and utilization is also fostered by its financial incentive. With cost shares much lower than what is paid by most civilian consumers for private insurance, TRICARE is more financially-attractive. TRICARE's low out-of-pocket costs have only gone down since its mid-1990s inception while cost-sharing for civilian health plans have increased at least as rapidly as per capita health care costs

⁵² U.S. Department of Defense, *Evaluation of TRICARE Program: Access, Cost, and Quality: Fiscal Year 2012 Report to Congress*, 10.

⁵³ Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care* (January 2014),12.

nationwide.⁵⁴ In 1996, a working-age retiree paid 27% of their families' health care costs; today, they pay 11%. Today's TRICARE beneficiary costs are outdated.

TRICARE/Federal Civilian Health Coverage Comparison: Federal civilian employees and retirees receive health care coverage through the Federal Employees Health Benefits (FEHB) program. According to the U.S. Office of Personnel Management, health benefits for federal civilians are generous and a “significant piece of [each employee’s] compensation package.” Over the past decade, civilian health premiums have been adjusted over the past ten years to adjust for the dramatically increased cost of health care.⁵⁵ These adjustments did not occur in TRICARE.

To compare, health care premiums for federal civilians grew 65% from 2000 to 2005, while TRICARE premiums were raised once since the program’s inception – by \$5/month for a family and \$2.50/month for an individual. Therefore, while federal civilians pay approximately \$5,000 for family coverage annually, TRICARE beneficiaries pay \$548.⁵⁶ Essentially, TRICARE beneficiaries pay about 11% of what federal civilians pay for annual HMO-like coverage and almost nothing for annual PPO-like coverage.

⁵⁴ Ibid.

⁵⁵ Office of Personnel Management, *Guide to Federal Benefits for Federal Civilian Employees*, accessed on March 14, 2014, <http://www.opm.gov/insure/archive/08/guides/70-01/intro.asp>.

⁵⁶ Robert Gates, statement on Department Budget and Efficiencies, January 6, 2011, Washington, D.C., accessed on March 14, 2014, <http://www.defense.gov/Speeches/Speech.aspx?SpeechID=1527>.

Table 4: TRICARE/FEHB¹ Family Benefit Comparison

	Annual Family Premium (Enrollee Portion)	Family Deductible	Office Visit Copay (In-Network)	Retain Brand Script Copay	Catastrophic Limit per Family
FEHBP Blue Cross/Blue Shield Standard (HMO-like)	\$5,204	\$700	\$20	30%	\$5,000
TRICARE Prime (HMO-like)	\$548	\$0	\$12	\$17	\$3,000 ²
FEHBP Kaiser High (PPO-like)	\$4,581	\$0	\$10	\$30	\$4,500
TRICARE Standard (Fee-for-Service)	\$0	\$100-300 (depending on pay)	20-25%	\$17	\$3,000
TRICARE Extra (PPO-like)	\$0	N/A	15-20%	\$17	\$3,000

^{1/} FEHBP data is for 2013.

^{2/} For TRICARE Prime, the \$548 enrollment fee counts toward the catastrophic limit.

Increase in TRICARE Beneficiaries: The comparatively low cost-share led to an increase of people switching from more expensive plans to TRICARE. TRICARE is designed to be supplementary insurance for retirees with other coverage, but many working-age retirees with access to other plans choose TRICARE. For example, in its FY2013 Budget Request Overview, the DoD cited that over 85% of retirees age 45-49 and 50% of retirees between 60-64 had access to other group health insurance, but chose TRICARE instead.⁵⁷ Out of the three million military retirees and dependents with access to civilian plans, two million choose TRICARE, saving themselves and their companies thousands of dollars at the cost of DoD and taxpayers.⁵⁸

⁵⁷ U.S. Department of Defense, *Overview – United States Department of Defense Fiscal Year 2013 Budget Request*.

⁵⁸ Korb, Rothman, and Hoffman, *Reforming Military Compensation: Addressing Runaway Personnel Costs is a National Imperative*, 19.

Increase in TRICARE Utilization - Moral Hazard: The lower cost-sharing burden also drives increased usage. The majority of the eligible beneficiaries, the retirees, utilize TRICARE resources much more than AD personnel and their dependents. In its FY2013 report to Congress, the DoD estimated that in 2012, the average Prime enrollee used 50% more outpatient services than the average civilian in an HMO.⁵⁹ From 2005 to 2010, the per capita use of outpatient and pharmacy services increased by more than 20 percent. The use of inpatient services remain mostly constant. Around 70-80% of care is delivered by private contractors in the form of purchased care. Most of the outpatient utilization growth occurred in purchased care.⁶⁰

▪ **Medical Cost Trend Inflation**

The factors increasing the costs of all public and private U.S. plans are the same factors increasing the costs of TRICARE. However, TRICARE is experiencing additional increases because of its aging beneficiaries' tendency to over-utilize purchased care (the civilian TRICARE network) and underutilize DoD in-house/direct care. If a PRIME beneficiary selects a civilian TRICARE network provider, the DoD pays in full for every dollar of service provided to a beneficiary at a civilian clinic. This increases costs because in an MTF, the only cost for the DoD would be for variable expenses like medicine and supplies for the visit. These types of variable expenses usually comprise of 10-40% of the visit's expenses. Other costs like doctors and facilities are fixed and are already paid for from the DoD budget, regardless of its use. For example, in the purchased care system, a \$1,000 trip to the doctor would cost the DoD the full \$1,000. The same visit to an MTF would only cost between \$100 and \$400.

⁵⁹ Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care* (January 2014),15.

⁶⁰ Ibid.

- **Low MTF Utilization**

Until they reach full capacity, MTFs are a lower cost alternative. Most of the major MTFs are operating at less than 50% capacity, with others far below 50%.⁶¹ Programs like the Right of First Refuse have been put in place to help reverse the increased utilization of purchased care network, but it has not been successful. MTFs are the lowest-cost alternative (on a variable cost basis) and an essential part in both the benefits and readiness mission.

Potential Impact From Maintaining the Status Quo

Inability to control military health care costs may have unintended consequences that affect the quality of health care provided to beneficiaries and the readiness capability of the MTFs.

- **Impact on Beneficiaries**

The current structure and utilization has also resulted in TRICARE providing less-than-optimal care to beneficiaries. Although Prime beneficiaries are enrolled, many Standard retiree beneficiaries may not fully enroll and selectively choose just the pharmacy benefit or use TRICARE as only “filler” coverage for a specific episode of care. This selective picking and choosing results in miscommunication between the beneficiary and health care professional and is ultimately “bad medicine,” where care is not coordinated due to care from multiple sources.⁶²

The MHS has started to implement the Patient-Centered Medical Home (PCMH) concept in its MTFs. The PCMH is a team-based model of primary care that coordinates and integrates the patient’s needs using evidence-based medicine. A recent study on this

⁶¹ Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013),10.

⁶² Ibid.

approach has documented an average decrease in inpatient days, decrease in inpatient admissions, and decrease in emergency room/urgent care visits. This approach has been documented by private organizations as well. TRICARE retirees who are not fully-enrolled do not receive the benefit of this best-practice concept because of the lack of coordination in care. The PCMH also lowers costs, so ultimately, the selective beneficiaries end up increasing the cost of health care for the DoD.⁶³

- **Impact on the MTF Readiness Capability**

The primary mission for MTFs is to maintain the physical readiness of the fighting force and the readiness of MTF medical providers to provide quality health services. During the Afghanistan and Iraq wars, MTF staff faced deployments leading to an increase in DoD's beneficiaries turning to the purchased care network. The intention of expanding TRICARE with the purchased care network option was to provide beneficiaries more access to quality health care, especially when MTF professionals are deployed and MTFs are understaffed during wartime. However, this leaves a capability gap in terms of maintaining readiness of fully-trained medical providers. With more beneficiaries using civilian network providers, especially retirees, the medical training for MTF staff is not at the highest level. The suboptimal training adversely impacts the readiness of MTF staff to provide quality health services and the physical readiness of AD troops.⁶⁴

- **Broader Impact**

DoD's total medical costs have more than doubled from 2001 to 2013 and went from representing 6% of the total DoD budget in 2001 to more than 10% in 2013. In an

⁶³ Linda M. Pikulin, Eric W. Christensen, and CDR Jamie Lindly, *FY12 Medical Home Port Evaluation* (September 2012), Center for Naval Analysis, accessed on March 15, 2014, www.cna.org/sites/default/files/research/DRM-2012-U-001777-final.pdf.

⁶⁴ Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013), 10.

environment of fiscal constraints, the share of the health care spending could become an even portion of the total DoD spending. Rising health care costs will reduce resources available to fund other high priority DoD programs. Lack of reform not only harms the capabilities of the military health care system and its beneficiaries, but it also may threaten national security.

V. DESCRIPTION OF THE POLICY PROPOSAL

Policy Option:

TRICARE 2.0 – Creating a Sustainable Path Forward to Quality Military Health Care

Authorization: To address out-of-control TRICARE costs and its broader negative effects, introduce a bill to Congress. The proposed policy option below is moderately-based on the current TRICARE proposals in the FY 2015 President’s Budget. However, there are modifications in implementation times and an even more gradual phased-in approach for instituting TRICARE fee increases. The fee increases mainly target retirees.

- A portion of the savings generated from this bill will help offset the impact of Defense cuts in other areas such as readiness and modernization from sequestration. Another portion of the savings will be allocated to help reduce the overall federal budget deficit.
- This bill should be introduced in 2015, after the 2014 Congressional elections.

Implementation: Similar to the Consolidated TRICARE Health Plan proposal in the FY 2015 President’s Budget, TRICARE 2.0 seeks to consolidate the three current plans under TRICARE (Prime, Extra, and Standard) into one plan in which copays will be based on the type of beneficiary (military pay) and the care provider (MTF, Network, Out-of-Network). Also, authorizations will no longer be required. However, this proposal largely differs in offering an even more gradually phased-in approach to cost-share increases to the beneficiary. Details of the proposal are as follows:

▪ **Proposed Fees & Copay Structure**

Introduction of Annual Participation Fee (APF) for Retirees: After TRICARE is consolidated to a single TRICARE 2.0 plan in CY 2016, all retirees, their dependents, and survivors of retirees (except survivors of those who died while on AD) will be required to pay a participation fee for each year of care. There will be no more automatic enrollment, and there will be an open season enrollment for one-year period of coverage (similar to commercial plans). Fees will be phased in over four years, starting at 25% of the full fee above in 2016, and increasing to 50% of the full fee in 2017, to 75% in 2018, and to 100% in 2019. For example, an individual in Tier 1 will pay \$52 in 2016, \$102 in 2017, \$153 in 2018, and then the full \$204 in 2019. Once fees are completely phased in, they will be indexed to a minimum percentage of medical inflation and COLA each year. The APF will be determined by pay and linked to a proportional-fee formula.

Table 5: Proposed APF Fees for Retirees

<i>APF Fees for Retirees</i>	Individual	Family
Tier 1 (Lower pay*)	\$204	\$408
Tier 2 (High pay)	\$290	\$580

**Pay ranges to be determined.*

New Three-Tiered Copay Structure for Retirees: TRICARE 2.0 determines visit copays based on the health care provider.

Table 6: Proposed Visit Copays

<i>Copays</i>	Primary	Specialty
MTF	\$10	\$20
In-Network	\$20	\$30
Out-of-Network	25% of Bill Based on Allowed Amounts	25% of Bill Based on Allowed Amounts

Introduction of TFL Annual Fees for Medicare-Eligible Retirees: Starting in 2016, TRICARE 2.0 will initiate a 2% enrollment fee of gross retired pay up to a \$600 ceiling for a

family of two. The annual fee would be gradually phased over four years and is based on a percentage of retired pay (similar to Medicare Part B).

- Retirees currently receiving TFL benefits are grandfathered in.
- General and Flag Officers would pay a special rate of \$800 for a family.
- Individual rates would be half of the family rate.
- Fee would be indexed to a yearly retirement COLA.

Pharmacy Copay Modifications for ADFMs and Retirees: Mail-order will be mandatory

for all maintenance prescriptions.

Table 7: Proposed Pharmacy Copays

COPAYS						
	Current	FY15	FY16	FY17	FY18	FY19
MTFs	\$0	\$0	\$0	\$0	\$0	\$0
Retail (30-day supply)						
Generic	\$5	\$5	\$6	\$7	\$8	\$9
Brand	\$17	\$26	\$28	\$30	\$32	\$34
Non-formulary	\$44	Available on a limited basis.				
Mail-Order (90-day supply)						
Generic	\$0	\$0	\$0	\$0	\$0	\$0
Brand	\$13	\$26	\$28	\$30	\$32	\$34
Non-formulary	\$43	\$51	\$54	\$58	\$62	\$66

Catastrophic Cap & Deductibles Modifications for ADFMs and Retirees: Starting in

2016, the APF will not count toward the catastrophic cap. Deductibles will only apply to out-of-network care. There will be fixed fees at MTFs, and in-network fees do not apply.

Both the catastrophic cap and deductible will be indexed to COLA.

Table 8: Proposed Pharmacy Copays

	<u>Network</u>	<u>Combined</u>
<i>ADFM's</i>	\$1,500	\$2,000
<i>Retirees + Dependents</i>	\$3,000	\$5,000

▪ **Exemptions.**

1. AD Service Members, ADFMs, and Medically-retired Members & Survivors will have no additional fees and are exempt from annual participation fees and copays for medical care visits.

2. ADFMs will be subject to increases in pharmacy copays, catastrophic cap & deductibles.
3. Medically-retired Members & Survivors will receive the same treatment as ADFMs.

▪ **Establishment of TRICARE 2.0 Transition Team**

Upon passage of this legislation, a transition team will be created to stand-up the start to complete restructure of TRICARE for implementation in 2016. The transition team will be in charge of registering all beneficiaries, who will be required to register, update their pay each year, and indicate the intended TRICARE usage for that year.

▪ **Mandatory Report to Congress: TRICARE Costs & Medical Trend Inflation**

In order to monitor medical inflation growth as it changes over time, a team will be created to study the medical trend inflation each year and report the yearly adjustments every four years. The four factors that should be evaluated are: medical price inflation, TRICARE utilization, TRICARE user population, and medical technology inflation.

VI. POLICY ANALYSIS

Restructuring TRICARE and gradually implementing small cost-share increases to annual fees, TFL, catastrophic caps, deductibles, and pharmacy benefits will create a path toward achieving quality, long-term military health care by modernizing the TRICARE program structure and starting to control the rapid escalation of health care costs. Although a complete reconstruction of the TRICARE benefit will undergo administrative, socializing, and financial growing pains, it will ultimately result in a more efficient and sustainable benefit for the military.

Modernizing the TRICARE Structure Increases Efficiency

▪ **Simplified and Flexible Structure Better Reflects Current Utilization**

Many argue that the original purpose of TRICARE for retired personnel was to supplement benefits provided by civilian employers or by Medicare. In addition, there is an

equity issue among service members as only about 15% of enlisted personnel and half of officers actually serve the 20 years to retire from the military. Most members who served in Iraq and Afghanistan will not benefit from the low-cost health care provided to military retirees.⁶⁵

The new TRICARE 2.0 structure will update the system to more accurately capture service utilization. Turning three health plans (Prime, Standard, and Extra) into one integrated plan allows for a simpler system that will provide open provider access to all beneficiaries. Beneficiaries will have freedom of choice with no changes to the scope of covered medical care.⁶⁶ Beneficiaries can also continue to see their current providers or adjust their providers depending on their particular episode of care and/or financial situation. Under the consolidated plan, prior Extra beneficiaries will see decreased out-of-pocket expenses with the shift to fixed copayments instead of percentage-based expenses.

Furthermore, the new structure transitions from an HMO model to PPO form, which is what most patients prefer today. Currently, TRICARE surveys show that highest patient satisfaction comes from the PPO-like Standard/Extra patients. These preferences provide evidence that patients today prefer choice and flexibility. Referral and authorization requirements will be removed, which increases choice and decreases administrative burden. Primary care will no longer act as a gatekeeper, which was one of the top complaints from TRICARE Prime patients.

The PPO-like structure will also produce more efficiency with better use of MTFs. Currently, TRICARE shows over-utilization of purchased care and under-utilization of MTFs. Under the new structure, beneficiaries have more financial incentive to use MTFs,

⁶⁵ Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care* (January 2014), 26.

⁶⁶ U.S. Department of Defense, *Overview – United States Department of Defense Fiscal Year 2015 Budget Request*.

which are the most cost-efficient provider for the DoD. Beneficiaries can still use network and non-network providers but will pay a higher out-of-pocket for them. The consolidated plan also allows opportunity for increased market share and potentially stronger leverage in negotiations with network providers. All three of these changing results will help offset costs for the DoD.

▪ **Enrollment Requirement Reduces Wasteful Spending**

Mandatory registration/enrollment will also help offset costs to the DoD. Enrolling all beneficiaries will minimize selective usage and improve medical outcomes, which will reduce wasteful spending for the DoD. Currently, there are many Standard and Extra retiree beneficiaries who are not fully enrolled in the system and choose to use TRICARE selectively for its pharmacy benefit or to choose whichever plan (private or TRICARE) is most beneficial for a particular episode of care. Using multiple providers results in poor communication and a lack of coordination in care.⁶⁷ Becoming fully enrolled would help ensure that participants benefit from a more coordinated care program.

Complete enrollment also helps TRICARE reduce excess payments in the system. A 2006 survey revealed that about half of TRICARE beneficiaries under 65 with private insurance also use TRICARE.⁶⁸ For these retirees, TRICARE is a second payer, which presents a coordination problem. If TRICARE is not aware of the retiree's private insurance, it will pay first and mistakenly fund the care as a primary payer. Requiring beneficiaries to designate whether they are using TRICARE as primary or supplemental will

⁶⁷ Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013), 12.

⁶⁸ Louis T. Mariano et al., *Civilian Health Insurance Options of Military Retirees: Findings from a Pilot Survey* (2007), National Defense Research Institute and Rand Health, www.rand.org/content/dam/rand/pubs/monographs/2007/RAND_MG583.pdf.

help fix the coordination issue and provide more transparency to the type of users in the system. Full enrollment will help eliminate these erroneous payments.⁶⁹

Previously, independent organizations have proposed that working-age retirees above a certain level of income can enroll in TRICARE only if they don't have access to other plans through their employer or spouse.⁷⁰ This requirement would limit double-coverage but still ensure that low-income and unemployed retirees retain access to health care. While this TRICARE 2.0 does not propose the same limitation for high-earning working-age retirees, increased cost-share, especially APFs will discourage double-coverage behavior.

Small, Gradual Increases Alleviate Budget, Steps Toward Sustainability

▪ Budgetary Implications

The current TRICARE structure is expensive and does little to constrain use due to little to no annual fees, little to no copays, and generous catastrophic caps & deductibles. These cost shares to the beneficiary have not been updated for 18 years. Not only will small, gradual cost increases start to achieve a more reasonable cost-share balance, but it will also update the current health care cost structure to provide high quality care.

Currently, retirees pay no fee for Extra or Standard coverage and \$572/\$286 (family/individual) for Prime coverage in 2016. The phased-in cost-share increases in TRICARE 2.0 would have a lower projected savings than the TRICARE reform in FY 2015 PresBud.

⁶⁹ Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013), 12.

⁷⁰ Korb, Rothman, and Hoffman, *Reforming Military Compensation: Addressing Runaway Personnel Costs is a National Imperative*, 24.

Table 9. Projected FY15-19 APF Reform Savings from FY2015 PresBud⁷¹

	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	TOTAL: FY15-19
\$ in Millions	(\$88)	\$620	\$1,079	\$1,132	\$1,188	\$3,931

Under TRICARE 2.0, there is just one APF, but it is further determined by pay. Lower-earning retirees will have lower APFs than higher-earning retirees. This ensures fairness for lower-income retirees. The fees are also phased-in over four years to minimize the sharp rip off the band-aid. Once the fees are phased in, this option proposes a minimum medical inflation link to sustain future growth costs. The total savings achieved will be smaller and slower than the PresBud, but this option still produces budgetary savings with less of the shock factor to beneficiaries. Furthermore, once phased in, linking the fees to medical inflation can help offset the slower savings growth and will be more updated.

While the average Medigap plan comparable TFL coverage had a \$2,100 premium per individual in 2009, there are currently no annual fees for TFL. TRICARE 2.0 implements a modest TFL APF in a gradual phased-in approach over four years. To ensure fairness for existing users, the TFL annual enrollment fee only applies to new TFL beneficiaries (retirees and their dependents who become Medicare-eligible after enactment). Since working-age retirees are aging out, a larger population will face APFs. However, they will be new TFL users – who did not experience free TFL beforehand. The new TFL APF fee will curb future cost growth for the TFL benefit from aging-out retirees. Since it is the same proposal as the PresBud, the projected budgetary savings is approximately \$4 billion.

⁷¹ Tom Philpott, 'Consolidated' Tricare: Higher User Fees, More Freedom, Herald.net (March 21, 2014), accessed on March 21, 2014, <http://www.heraldnet.com/article/20140321/BIZ/140329966/1005/%91Consolidated%92-Tricare-Higher-user-fees-more-freedom>.

Table 10. Projected FY15-19 Savings from TFL Fee

\$ in Millions	FY15	FY16	FY17	FY18	FY19	TOTAL: FY15-19
TFL Fee (MERHCF Accrual)	\$78	\$81	\$85	\$89	\$93	\$427
Pharmacy Copays & Mandatory Mail Order (MERHCF Accruals)	\$649	\$679	\$701	\$728	\$762	\$3,518
Total MERHCF Accrual Savings	\$727	\$760	\$786	\$818	\$855	\$3,945

Additionally, the pharmacy copay changes in TRICARE 2.0 fully incentivize the use of mail order and generic drugs. The changes are phased-in over a 10-year period to ease transition to higher costs, and prescriptions filled at MTF will still be at no cost to beneficiaries.⁷² The proposal also requires that prescriptions for long-term maintenance medication be filled through MTFs or the TRICARE mail-order pharmacy. These proposals strengthen MTFs to recapture patient care by encouraging beneficiaries to visit MTFs for refills, which may lead to them seeking more of their care at the MTF.

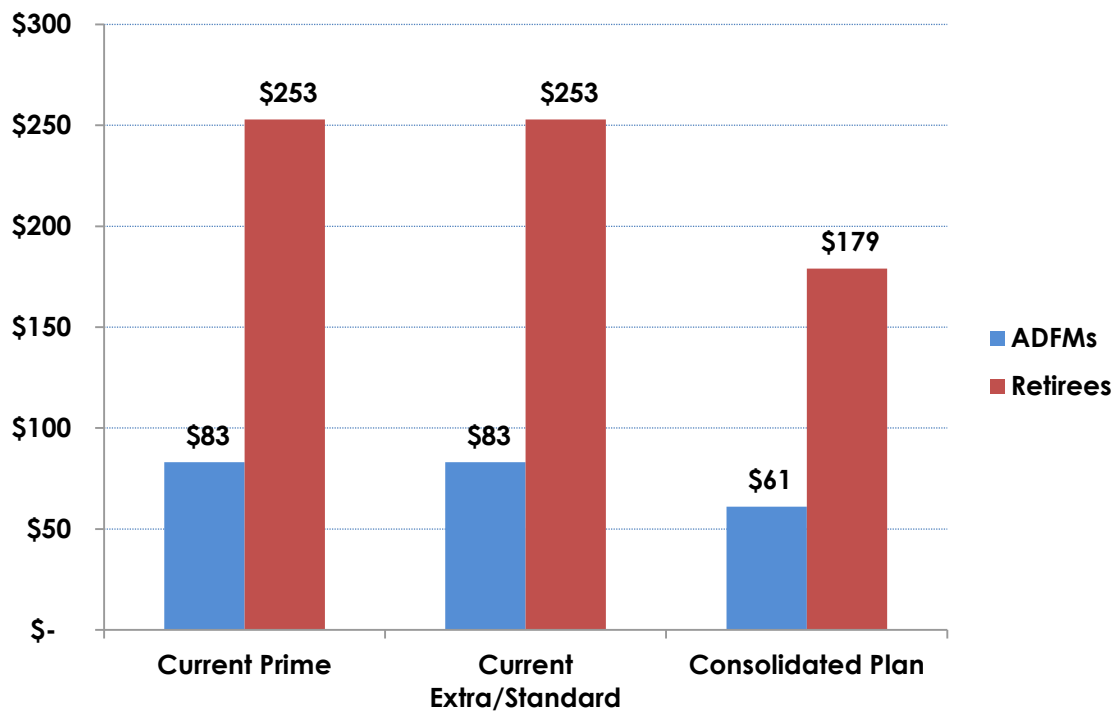
Table 11. Projected FY15-19 Savings from Pharmacy Copays Changes

	FY15	FY16	FY17	FY18	FY19	TOTAL: FY15-19
\$ in Millions	\$180	\$269	\$301	\$335	\$402	\$1,487

The out-of-pocket Rx changes depend on the use of MTFs over network and non-network providers. Patients who rely primarily on MTFs for care will generally experience lower out-of-pocket costs under TRICARE 2.0. The lower Rx costs at MTFs will incentivize more utilization at the MTFs.

⁷² U.S. Department of Defense, *Overview – United States Department of Defense Fiscal Year 2015 Budget Request*.

Graph 3. Projected CY 2016 Average Rx Out-of-Pocket Costs for a Family of Three

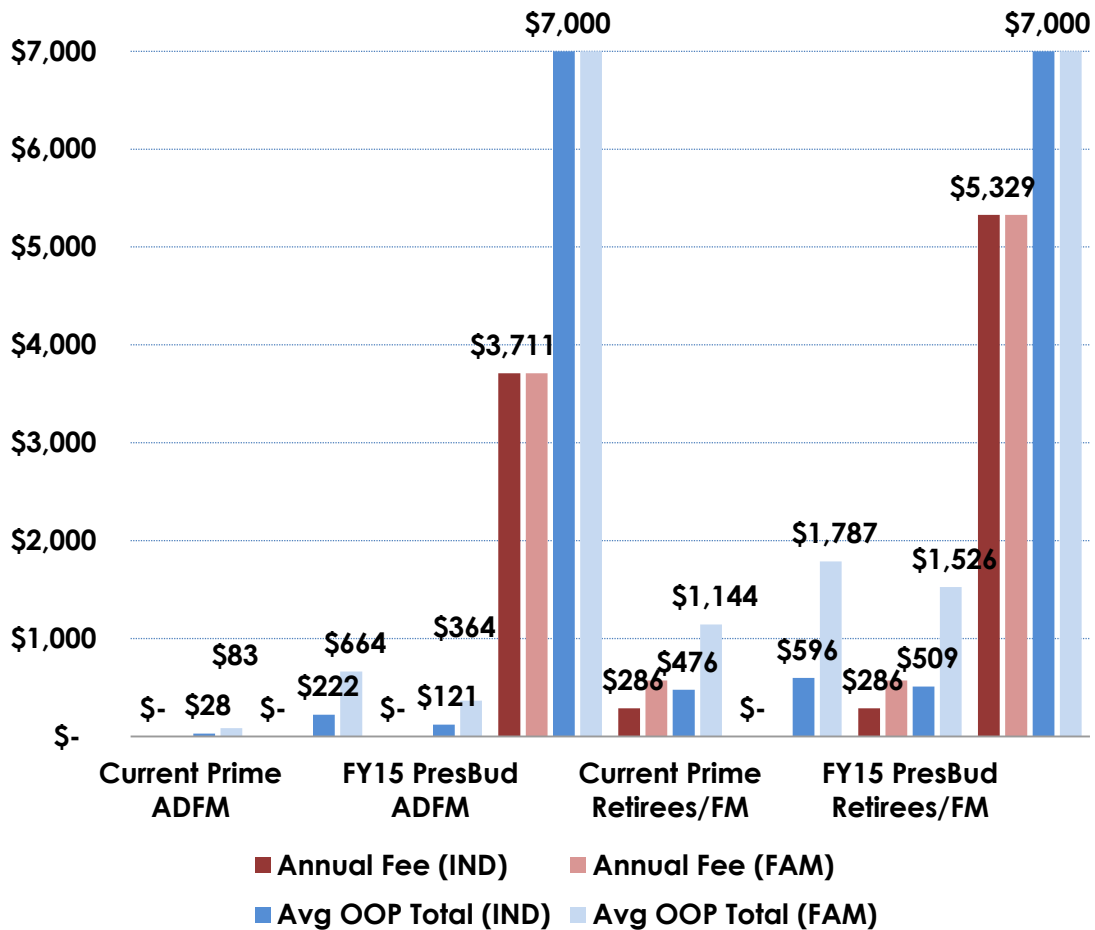


▪ **Maintaining Low Out-of-Pocket Costs for America’s Military**

Although TRICARE 2.0 includes minimal cost increases, the proposed reforms maintain zero cost-share for active duty personnel, their dependents, and provide them priority health care access. The proposed cost-share increases are mainly targeted toward retirees. Mirroring best practices of most other major private and public health care plans, cost share adjustments that better reflect the actual cost of care would rationalize the use of health care resources and improve accountability.⁷³ Nonetheless, TRICARE 2.0 still offers a comprehensive health benefit at a lower cost in comparison to most other employer-sponsored health benefit plans. TRICARE will still be one of the most competitive health plans with the lowest out-of-pocket expenses than other employees.

⁷³ Kokulis, *Preserving the Military Health Care Benefit: Needed Steps for Reform*, American Enterprise Institute (October 17, 2013), 12.

Graph 4. MHS Plan Comparison of Enrollment Fees & Out-of-Pocket Costs in FY15



Furthermore, the small increases are customized, fixed, and phased in so that the financial burden of the increase is not sudden. Those receiving lower retired pay will have lower fee increases and those receiving higher retired pay will have slightly higher fee increases. The phased-in approach will provide time for beneficiaries to adjust to increased payments. Since the increases would occur in FY2016, a year after TRICARE the financial burden or even drop-off will be minimized. Adversely, slowing the cost-share increases lessens the budgetary savings over the next four years.

One-time fee increases will not sustain budgetary control. In order to maintain a balance in future cost growth, it is important to add medical inflation adjustments to the fees

and cost-shares once they are fully phased in after four years. The mandatory report on medical cost trends will increase the likelihood of achieving long-term budgetary savings and efficiencies. Mandating a quadrennial report to Congress that evaluates TRICARE's costs and the medical trend inflation helps to monitor and self-update cost growth over time. Linking medical trend inflation to cost-sharing fees will keep them updated to accurately reflect the changing cost trends of medical care.

Potential Implementation & Behavioral Setbacks

▪ Implementation Challenges

Implementing the re-structuring of TRICARE will be difficult from a technological, cooperation, and time perspective. Since MHS is worldwide with over nine million beneficiaries, changing a system will be a large undertaking. Systems will need to either be updated or completely replaced, which could lead to more spending and is time-consuming. Once the systems are set up, then it will take time for the administrators to acquire implementation skills. Program managers will need to develop and conduct training workshops for administrators. Subsequently, administrators will need to conduct information and awareness seminars to minimize transition challenges.

On the receiving side, completing the enrollment requirement will also face setbacks. Since retirees are not currently required to enroll in Standard or Extra, rolling out the completion of enrolling all beneficiaries will also be a cumbersome process. Also, the requirement to provide the type of care (primary or supplemental) that a beneficiary intends to use for TRICARE may be a decision-making process that will take time. The transition to a consolidated system will face implementation challenges and possibly take more than one year before it's ready for prime-time exposure.

- **Behavioral Risks**

Another drawback of the restructuring is the potential risk of current providers choosing not to participate in the new consolidated plan. The new plan will still require TRICARE contracts to establish networks and obtain discounts. There will be a requirement to renegotiate contracts with modifications in copays and deductibles. If the provider decides not to stay with TRICARE, the consolidated plan may unintentionally affect the ability of the beneficiary to continue using a network provider. It is highly unlikely that changing to a consolidated plan will cause any meaningful change in provider participation with significant TRICARE awareness.

Additionally, current retirees can argue that the proposed cost-sharing increases are unfair. Some retirees may have continued their period of AD service on the assumption that they would receive subsidized medical care after retirement. Therefore, increasing costs for the retiree would impose an unanticipated financial burden on them. Also, expectations of low out-of-pocket expenses in the future may play an important role in encouraging older members to remain in service for an entire career. Longer-serving members are an advantage for our military as they are better-equipped with skills and experience. Removing the “promise of free lifetime health care” incentive would no longer be a motivating factor to join and stay in the military.

Another possible drawback is the effect that increased costs can have on the health of the beneficiary. The CBO cites that economic studies on civilians reveal that cost-sharing increases reduce the amount of health care that people use. For individuals with chronic conditions, low incomes, and the elderly, the prospect of higher out-of-pocket expenses may cause them to cut back on preventative care and/or appropriate use of pharmaceuticals.

This may result in greater need for acute care and more expensive services.⁷⁴ However, none of these studies have evaluated TRICARE beneficiaries, who are not elderly and tend to use health care services more than the average citizen. Moreover, CBO suggests that cost-share increases may foster more disciplined use of medical resources. Still, higher cost-shares could delay patients from seeking care, resulting in adverse health outcomes.

VII. POLITICAL ANALYSIS

Political Hurdles: Military Advocacy Resistance & Congressional Elections

Making changes to TRICARE, especially with new costs and fee increases, is a major political hurdle. One large and powerful contingent of stakeholders that oppose the idea of TRICARE fee reform is the military retirees.⁷⁵ Veterans and military advocacy groups like the MOAA have been resistant to TRICARE reforms that shift any costs to beneficiaries for years.⁷⁶ As both parties in Congress covet the allegiance of the country's 22 million veterans and their families, lawmakers have consistently avoided raising fees.⁷⁷ Moreover, TRICARE reform would not only be unpopular with America's veterans, but it would also be unpopular with veterans in Illinois. More than 700,000 of the 22 million veterans live in Illinois.⁷⁸ Veteran voters in Illinois have already indicated resistance to TRICARE changes

⁷⁴ Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care* (January 2014), 26.

⁷⁵ Patricia Kime, *CBO: Bar Younger Retirees from TRICARE Prime, Save \$90 Billion*, The Army Times (January 17, 2014), accessed on April 17, 2014, <http://www.armytimes.com/article/20140117/BENEFITS06/301170020/CBO-Bar-younger-retirees-from-Tricare-Prime-save-90-billion>.

⁷⁶ Brendan McGarry, *Senator: Find \$2B to Undo Troop Benefit Cuts*, Military.com (March 26, 2014), accessed on April 20, 2014, <http://www.military.com/daily-news/2014/03/26/senator-find-2b-to-undo-troop-benefit-cuts.html>.

⁷⁷ Alan Fram, *Senate Blocks Dems' Bill Boosting Vets' Benefits*, Associated Press (February 27, 2014), accessed on April 20, 2014, <http://www.washingtontimes.com/news/2014/feb/27/senate-heads-toward-showdown-vote-on-veterans-bill/?page=all>.

⁷⁸ From the Mark Kirk Senate.gov website, "Supporting Our Veterans," accessed on April 26, 2014, <http://www.kirk.senate.gov/?p=general&id=91>.

proposed by Simpson-Bowles.⁷⁹ They have also voiced concern over the idea of eliminating TRICARE Standard.⁸⁰ In 2011, Illinois was ranked #8 in the top ten states to live in for military retirees.⁸¹ Introducing TRICARE reform would cause a decrease in popularity among veteran voters and lower chances of re-election in November 2014.

With the 2014 Congressional elections coming up and a Senate majority at stake, introducing any TRICARE changes in 2014 not only loses Illinois veteran voters but also threatens support from other members of Congress seeking re-election. Reelection worries is evidenced by the passage of the Bipartisan Budget Act (BBA) of 2013 (sponsored by Representatives Paul Ryan and Pat Murray), which raised sequestration caps for 2014 and 2015 and delayed the issue of reducing the national deficit. For Republicans, it delayed Defense spending cuts.⁸² Specifically, Republican leaders Senators Mitch McConnell and John Cornyn knew that they would take an immediate political hit from the Tea Party wing. However, they also knew that their vote to raise the debt-limit would increase their party's chances of gaining a majority in the Senate.⁸³ On the Democratic side, Senators Mark Pryor, Jeanne Shaheen, Kay Hagan, Mark Begich, and Jeff Merkley, are all vulnerable incumbents that are in-cycle this 2014. They introduced and championed legislation to repeal \$6 billion

⁷⁹ From Congress.org, *Letter to Senator Richard Durbin (D-Illinois): Proposed TRICARE Changes* (November 20, 2011), accessed on April 25, 2014, https://ssl.congress.org/congressorg/bio/userletter/?id=210&letter_id=7613472721.

⁸⁰ From Congress.org, *Letter to Senator Richard Durbin (D-Illinois): TRICARE Health Providers* (July 28, 2009), accessed on April 25, 2014, https://ssl.congress.org/congressorg/bio/userletter/?letter_id=3713382421.

⁸¹ Cory Stophlet, *Recommended Top 10 Best States for Military Retirement*, Yahoo.com (March 30, 2011), accessed on April 26, 2014, <http://voices.yahoo.com/recommended-top-10-best-states-military-retirement-8141106.html>.

⁸² Ezra Klein, *Here's What's In Paul Ryan and Patty Murray's Mini-Budget Deal*, The Washington Post (December 10, 2013), accessed on April 26, 2014, <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/12/10/heres-whats-in-paul-ryan-and-patty-murrays-mini-budget-deal/>.

⁸³ Carl Hulse and Jonathan Martin, *Retreat on Debt Fight Seen as GOP Campaign Salvo*, The New York Times (February 17, 2014), accessed on April 26, 2014, <http://www.nytimes.com/2014/02/18/us/politics/behind-debt-limit-retreat-a-gop-eye-on-retaking-the-senate.html?ref=nationaldebtus&r=0>.

of COLA adjustments to military pensions that were in the BBA of 2013, in order to score political points with veterans and swing voters.⁸⁴

Both parties are ducking the issue of TRICARE reform under the cover of waiting for military compensation and reform recommendations by the MCRMC. Members of both the House and Senate Armed Services Committee, including Senators Lindsey Graham and Kirsten Gillibrand indicated that they do not want to make any decisions on TRICARE reform until after the MCRMC recommendations, which are expected in early 2015.⁸⁵ Introducing any TRICARE reform in general is risky, and passage of TRICARE changes before 2015 would not be politically viable.

Overcoming Political Obstacles, Forwarding Long-term Benefits

▪ Bill Introduction After Timing Vulnerabilities

Illinois' military retirees' support, the upcoming 2014 congressional elections and the pending recommendations of the MCRMC are political disadvantages to championing TRICARE reform. However, introducing the proposal in 2015 surpasses timing vulnerabilities from the 2014 congressional elections and release of the MCRMC's recommendations. It also puts more distance from two very costly and emotion-inducing wars in Iraq and Afghanistan. The national debt-ceiling crisis will once again be front and center with 2016 looming ahead. Introducing TRICARE legislation in 2015 allows more time for evaluation after other proposals have been presented.

⁸⁴ Meredith Shiner, *Vote on Pryor Bill Just the Start of Senate's 2014 Political Madness*, Roll Call (February 10, 2014), accessed on April 26, 2014, <http://atr.rollcall.com/vote-on-pryor-bill-just-the-start-of-senates-2014-political-madness/>.

⁸⁵ Patricia Kime, *CBO: Bar Younger Retirees from TRICARE Prime, Save \$90 Billion*, The Army Times (January 17, 2014), accessed on April 17, 2014, <http://www.armytimes.com/article/20140117/BENEFITS06/301170020/CBO-Bar-younger-retirees-from-Tricare-Prime-save-90-billion>.

After 2014, worries for re-election will not surface for at least another 4-5 years. With political timing hurdles out of the way, introducing the aforementioned TRICARE proposal will have political gains in both the short and long term. Proposing to allocate savings from the proposal to other areas in the DoD budget and to reduce the federal deficit appeals to defense contractors, shows courage to attack “big problems,” and also shows allegiance to military leadership and the Administration, who are proponents of TRICARE reform.

▪ **Appeal to Defense Contractors, Biggest Campaign Contributors**

One of the strongest motivations for passing the proposal is its appeal to CEOs of defense contractors. The nation’s biggest defense contractors are some of the biggest contributors to the Durbin re-election bid. Becoming head of the Appropriations Defense Subcommittee last year has unraveled a wave of contributions from Defense executives, making you the top recipient of defense industry contributions among all members of Congress this election cycle.⁸⁶ According to the Center for Responsive Politics, corporate political action committees and individual employees have donated more than \$250,000. Out of the top five contributors to the campaign committee, four of them are defense contractors.⁸⁷ Since January 2013, contractors like Northrop Grumman, Lockheed Martin, Cooney & Conway, and Boeing contributed over \$3.8 million in donations.⁸⁸ Top donor

⁸⁶ Austin Wright, *Defense CEOs Ante Up for Dick Durbin, Jack Reed*, The Politico (April 24, 2014), accessed on April 26, 2014, <http://www.politico.com/story/2014/04/dick-durbin-jack-reed-defense-105999.html>.

⁸⁷ From the Open Secrets.org website, *Sen. Dick Durbin: Top Donors* section, accessed on April 26, 2014, <https://www.opensecrets.org/politicians/contrib.php?cycle=2014&cid=N00004981&type=I>.

⁸⁸ Donny Shaw, *Defense Contractors Are Top Contributors to Sen. Durbin’s Re-Election Bid*, Maplight.org (March 12, 2014), accessed on April 27, 2014, <http://maplight.org/content/73424>.

Boeing Co. is the country's second largest defense contractor and is headquartered in Chicago and is currently building the Air Force's new fleet of aerial refueling tankers.⁸⁹

From 2000 to 2013, over \$68 billion has been awarded to 138,748 defense contracts awarded to over 7,000 contractors in the state of Illinois. Starting from 2010, the number of contracts awarded has started to decline, going from over 15,000 contracts awards in 2010 to about 11,000 contracts in 2013.⁹⁰ Helping defense contractors secure contracts with the DoD is already aligned to previous efforts. This is evidenced in the support for University of Illinois Labs acquiring a \$70 million grant from the DoD for digital manufacturing.⁹¹ This opportunity creates a new research facility in Chicago that could result in thousands of jobs.⁹² Furthermore, many military retirees (who the reforms are targeted towards) take jobs with defense contractors and consultants. A report by Citizens for Responsibility and Ethics in Washington and the Brave New Foundation found that 70% of retired three-and-four star generals took jobs with defense contractors or consultants.⁹³ This is reportedly a decline, so perhaps securing more contracts will also assuage the military retirees that will have renewed opportunity for jobs.

⁸⁹ Frank Oliveri, *Durbin to Chair Defense Appropriations Panel*, Roll Call (January 25, 2013), accessed on April 26, 2014, http://www.rollcall.com/news/durbin_to_chair_defense_appropriations_panel-221119-1.html?pg=1.

⁹⁰ From the *Government Contracts Won* website, "Defense Contractor Search by State," accessed on April 26, 2014, <http://www.governmentcontractswon.com/search.asp?pg=2&type=dt&criteria=IL&rc=7411&prevpage=1>.

⁹¹ John Pletz, *Chicago Wins \$70 Million Grant for UI Labs*, Crain's Chicago Business (February 22, 2014), accessed on April 27, 2014, <http://www.chicagobusiness.com/article/20140222/BLOGS11/140229927/chicago-wins-70-million-grant-for-ui-labs#>

⁹² Ibid.

⁹³ Luke Johnson, *Report: 70 Percent of Retired Generals Took Jobs with Defense Contractors or Consultants*, The Huffington Post (November 20, 2012), accessed on April 27, 2014, http://www.huffingtonpost.com/2012/11/19/defense-contractors-generals_n_2160771.html.

TRICARE 2.0 alleviates and opens up constraints in other areas of Defense spending, where defense contractors can benefit. Supporting the proposal is a short-term political win creating more defense-related jobs in Chicago, adding to the state economy. It is also a long-term advantage in building an alliance with the politically powerful military complex and securing contributions for future political aspirations.

▪ **Building a Legacy: Forging the Path to Sustainable Military Health Care Benefits**

In addition to keeping contributors happy, a proposal to modernize TRICARE may help build a long-term career legacy and help future political aspirations. Although military retirees may initially be resistant to any TRICARE fee changes, supporting the proposal shows a willingness to create a long-term realistic plan for providing health benefits to the military and retirees. On top of that, you have already given an unpopular vote to make provisions to TRICARE that was previously proposed in the Simpson-Bowles Commission. Therefore, supporting this proposal would not be a big shock to your veteran and other interested constituents.

On the flip side, supporting both a restructure to better reflect usage and a gradual and phased-in approach for fees shows a level of sensitivity for veterans. The measure to grandfather existing TFL beneficiaries and exempting ADFMs from fee increases also shows strong consideration of affordability of new bills. Since the current HMO-like structure is administratively burdensome and results in systematic inefficiencies, most beneficiaries and advocacy groups will be more amenable to restructuring TRICARE. Moreover, supporting a long-term TRICARE reform shows a commitment to providing quality health care for years to come. Going a step further, allocating some of the savings to reducing the overall federal deficit shows an even larger dedication to attacking one of the nation's biggest problems: the debt-ceiling crisis. This issue has constantly been in the revolving door for media

attention since 2011. Current legislation averted the crisis temporarily. After the 2014 elections, the issue is likely to jump to center stage as fears of sequestration surface again. As far as public concern, polls routinely show that 84% of Americans think it is “extremely important” or “very important” to deal with the federal budget deficit.⁹⁴ However, the debt-ceiling crisis doesn’t seem to translate into public pressure during elections.

Since 2015 is not an election year, there will be more time to focus on balancing the budget. Support for the proposal shows courage to deep-dive into a large and ominous issue. Introducing the proposal shows that effort was given to comprehensively evaluate and restructure an outdated system. The gesture of introducing the proposal reveals selflessness as it reveals strong concern for the future well-being of the country, not just political aspirations. However, if successful, it has the potential to contribute to the Durbin legacy for major legislative accomplishments.

▪ **Allegiance to DoD Leadership and the Administration**

As discussed in the *Background* section of this memorandum, the Obama Administration has put forth multiple TRICARE reforms without passage success. Introducing TRICARE reform that is similar to the reforms proposed in the FY15 President’s Budget strengthens the relationship with the Administration. Allegiance for the White House allows more access to the Administration and perhaps more influence and wielding ability for future support of causes and proposals.

DoD officials have already said that they have “done everything else” to reduce bills while “being fair to beneficiaries,” and that dismissing their TRICARE changes would leave

⁹⁴ Joshua Green, *Why Won't Americans Listen to Alan Simpson and Erskine Bowles?*, Businessweek.com (February 28, 2013), accessed on April 25, 2014, <http://www.businessweek.com/articles/2013-02-28/why-wont-americans-listen-to-alan-simpson-and-erskine-bowles>.

a \$2.1 billion shortfall.⁹⁵ At a hearing on March 26, 2014, DoD Comptroller Robert Hale emphasized that with \$30 billion in sequester cuts, rejecting the TRICARE proposals in the President's Budget would cause cuts to come out of readiness and modernization.⁹⁶ As noted in previous sections, top military leaders like Defense Secretary Chuck Hagel, Army General Martin E. Dempsey, and General Ray Odierno have shown support for comprehensive reform and TRICARE fee increases in order to provide promised benefits in the future.⁹⁷ Championing TRICARE reform forms an alliance and stronger relationship with military leaders. A positive relationship with the military brass will be beneficial being the relatively new chairman of the Defense Appropriations subcommittee without a military background.

It is even possible that introducing TRICARE reform will open up an opportunity for bipartisanship in Congress. Senator Lindsey Graham supports reducing the overall Pentagon budget and restructuring the military pay and benefits system. Even Representative Paul Ryan has shown a willingness to risk working-age military retirees' support for lessening Defense cuts in other areas. He championed a reduction in COLA adjustment in the BBA of 2013. Furthermore, Senator John Cornyn and Representative Buck McKeon are also top recipients from defense sector contributors. The general Republican view to not cut Defense spending in modernization and readiness and aspirations to balance the federal debt may open up opportunities for constructive bipartisanship.

⁹⁵ Amy Bushatz, *Pentagon Outlines Increased Tricare Fee Proposal*, Military.com (March 5, 2014), accessed on March 29, 2014, <http://www.military.com/daily-news/2014/03/05/pentagon-outlines-increased-tricare-fee-proposal.html>.

⁹⁶ Kime, *Senators Weigh Impact of Proposed TRICARE Fee Hikes*.

⁹⁷ Jim Garamone, *DoD Takes Holistic View of Slowing Military Compensation Growth*, U.S. Department of Defense (February 24, 2014), accessed on April 25, 2014, <http://www.defense.gov/news/newsarticle.aspx?id=121701>.

VIII. RECOMMENDATION

Introduce the TRICARE 2.0 proposal in 2015.

As CBO and multiple other studies have shown, TRICARE cost-growth is rapidly escalating and needs to be controlled. Costs continue to grow even while the DoD budget is facing a \$1 trillion-cut in the next five years. By 2015, congressional elections will have already occurred, other recommendations for TRICARE reform will be set forth, and there will be more distance from two costly wars, and relief from the BBA of 2014 will be lifted. This sets the stage for debt talks again. The demand to modernize and control military health care is going to be more visible and necessary. TRICARE 2.0 updates the military health benefit program with a baby-step approach to cost-share increases. The customized nature of TRICARE 2.0 offers practical, viable, and sustainable measures to address escalating military health care costs.

Even in 2015, this proposal is a large undertaking that is likely to face initial resistance by military advocates. However, the risk to reform is temporary from policy and political standpoints. TRICARE 2.0 offers to help restore a reasonable cost-sharing balance gradually and in small increments. The policy and political benefits are long-term and have the potential to outweigh the initial negative reaction and growing pains. By placing focus on legislation that can help its own program, the DoD, and the national debt crisis, there is an opportunity to achieve a successful career legacy and military health care program.

From the policy perspective, modernizing the TRICARE structure will be easier to use by beneficiaries and will better reflect today's military health care needs. There will be implementation and behavioral challenges. However, once implementation is complete, TRICARE 2.0 will offer better operational efficiency, which ultimately increases beneficiary satisfaction. Initial reaction by retirees to modest cost-share increases will also be tough. It

may even cause those who need health care to drop off. But, the slow, gradual, and phased-in approach eases cost increases to retirees, producing less of a financial burden. Slight increases to out-of-pocket expenses will help alleviate the fast-growing TRICARE costs. Moreover, the increases put TRICARE on a path toward sustainability. This is vital in maintaining and even increasing the ability to provide quality health care to America's military in the long-term. From a broader policy perspective, it also adds flexibility toward other areas in Defense and in the overall federal budget.

While TRICARE 2.0 has long-term benefits for military health care, the DoD budget, and the federal deficit, the reform will not be popular among military advocacy groups and Congress members who have a strong interest in representing them. However, 2015 is not an election year, which provides primetime space for a large reform such as TRICARE 2.0. Introducing the proposal in 2015 jumps over political hurdles such as elections and waiting for the MCRMC recommendations. There will be more knowledge on alternative proposals, less re-election pressure, and more time sell the proposal. In addition, allocating some of the achieved savings to other areas of DoD spending will secure a strong relationship with powerful Defense contractors who are some of the largest campaign donors. Furthermore, tackling TRICARE reform is long overdue. If successful, this will enhance career legacy and open up new opportunities. It reveals initiative to tackle the nation's biggest problems and shows compassion for the future health of the country. Again, the initial political resistance will be relatively temporary, but the long-term political benefits have great potential.

Overall, the recommended proposal is better than maintaining the status quo. As a big-money program, there is room to create major savings with small modifications. It has viable potential in achieving high-yield success in three major issues in the US today: military

health care, national security, and reducing the national deficit. TRICARE 2.0 is a bill with the capacity to begin better government spending. Most importantly, TRICARE 2.0 puts forth a sustainable path towards providing quality health care to the nation's most prized asset, its military.

Curriculum Vitae

Etaf Khan was born on February 11, 1983 in Anaheim, California. Before arriving to the Johns Hopkins University, Khan received her undergraduate education at the College of William and Mary, double-majoring in Hispanic Studies and Government. During her tenure at William and Mary, she performed on-site research on the Spanish national government's socialization of women's health policy. For her concentration in Government, she studied the agenda-framing and administrative structures of international organizations, particularly the United Nations Population Fund. Khan currently works at the Office of the Secretary of Defense (Comptroller) as a budget analyst, overseeing the Defense Health Program and the National Guard Military Personnel appropriations.