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CBO

Approaches to Changing Military Health Care

OCTOBER 2017

Notes

Unless otherwise indicated, all years referred to in this report are federal fiscal years (which run from October 1 to September 30 and are designated by the calendar year in which they end), and all dollar amounts are expressed in 2017 dollars. Amounts are adjusted to remove the effects of general inflation using the price index for per capita gross domestic product, with values of that index projected by the Congressional Budget Office.

Numbers in the text and tables may not add up to totals because of rounding.

Data underlying Summary Figure 1 and additional details about CBO's cost-estimating methodology are posted along with this report on CBO's website.

On the cover—

Major Chad Hampton (left), an orthopedic surgeon with the 30th Medical Brigade of the U.S. Army Europe, assists in repairing a broken femur in the operating room at the 37th Military Hospital in Accra, Ghana, during a medical readiness training exercise. Photograph by Captain Charles An, U.S. Army Africa.

Contents

Summary

The Department of Defense (DoD) provides health care through its Military Health System (MHS), an organization that oversees the delivery of health care at home and abroad through a program known as TRICARE. The two primary purposes of that system are to ensure that service members are healthy enough to deploy (sometimes called medical readiness) and that military clinicians and other providers are adequately trained to care for personnel during both peacetime and wartime (sometimes called operational readiness.) A third function of the MHS is to provide health benefits as an additional form of compensation for military personnel and eligible retirees. DoD spends about $50 billion annually on the MHS.

Policymakers and analysts have raised concerns about DoD's rising health care costs, the quality of care provided at its facilities, and how well the department's medical establishment prepares for wartime missions. Efforts to change the system are complicated, however, partly because the resources used to accomplish the various goals are often intermingled or unclear. For this report, the Congressional Budget Office examined several broad, illustrative approaches that might address policymakers' concerns. In addition, the agency estimated the costs of two options that have been proposed specifically to make changes to TRICARE.

How Does DoD Provide Health Care?

The MHS provides direct care through its own system of clinics and hospitals—both in combat settings and at military installations that can be visited by TRICARE beneficiaries. It also purchases care from civilian providers by means of regional contracts. Within the United States, direct care accounts for about 40 percent of care provided through the MHS, and purchased care for the remaining 60 percent.

The following groups of people are eligible to participate in TRICARE (with the respective populations at the beginning of 2016 shown in parentheses):

- All members of the four military branches, including members of the National Guard and reserves, as well as members of the Coast Guard and the commissioned corps of the Public Health Service and of the National Oceanic and Atmospheric Administration (1.9 million);
- Families of current uniformed service members (2.0 million); and
- Military retirees and their families (5.4 million).

In general, care received at military treatment facilities (MTFs) is free for participants. For care by contract providers, participants face deductibles and other cost-sharing requirements that vary, depending on the type of plan they select, but those amounts are usually less than required by civilian health plans. In most cases, TRICARE beneficiaries pay just a small fee or premium, if any, for that coverage.

What Broad Approaches Might Improve How Health Care Is Supplied or Funded?

CBO examined three broad approaches and two specific options that would change the way DoD provides or funds health care (see Summary Table 1). The approaches would fundamentally change how health care is supplied but would not focus on what beneficiaries pay for care or the effects of those costs on the demand for health care. Each of the approaches has the potential to directly or indirectly reduce costs, improve the quality of care, or improve operational readiness (or at least more clearly identify the costs of ensuring readiness). But because the costs or savings of those approaches would depend on many programmatic details, CBO did not estimate savings that might result from implementing them.

Approach 1: Focus the Direct Care System on Operational Readiness

Under this approach, the system would focus on providing care to service members and on training military clinicians and other providers. Most care provided to

Summary Table 1.

Alternatives That Might Address Concerns About the Military Health System

	Approaches to Ensuring Readiness and Lowering Costs			Options Whose Costs CBO Estimated	
	Approach 1: Focus the Direct Care System on Operational Readiness	Approach 2: Pay Fixed Amounts per Person to TRICARE Contractors	Approach 3: Change the Way That Military Departments Pay for Health Care in MTFs	Option 1: Increase Cost Sharing for Most Beneficiaries Who Use TRICARE	Option 2: Replace TRICARE With a Choice of Commercial Insurance Plans for Most Beneficiaries
Concerns About Operational Readiness					
MTF providers use different skills than those needed for deployment	X				
Volume of care at some U.S.-based MTFs is too low to ensure medical proficiency	X				X
Concerns About DoD's Rising Health Care Costs					
Medical force is larger than that needed for combat	X		X		
Costs of ensuring operational readiness are not apparent	X		X		X
No mechanism exists for ensuring an efficient direct care system	X	X	X	X	X
Beneficiaries' use of TRICARE is increasing		X		X	X

Source: Congressional Budget Office.

X signifies that the relevant approach or option might address a particular concern.

"Operational readiness" indicates that military clinicians and other providers are adequately trained to care for personnel during both peacetime and wartime.

DoD = Department of Defense; MTFs = military treatment facilities.

families and retirees would be outsourced to the private sector, substantially reducing the size of the direct care system. The effect on federal spending would depend on whether DoD was able to eliminate excess capacity (facilities, equipment, and clinical personnel no longer needed to treat families and retirees) and whether private-sector care proved to be more or less costly than direct care.

Approach 2: Pay Fixed Amounts per Person to TRICARE Contractors

This approach would give contractors more latitude to restructure provider networks, reimburse providers, and determine patients' cost sharing. Such a transformation could save DoD money, but MTFs would need to be restructured or closed and patients would probably need to pay a larger share of their costs to generate significant savings.

Approach 3: Change the Way That Military Departments Pay for Health Care in MTFs

In general, each military department (Army, Navy, and Air Force) currently manages its own MTFs and controls its own medical operations in the wartime theater. This approach could take one of two possible forms. One would involve paying fixed amounts per beneficiary to MTFs for health care services. Another would use an internal pricing mechanism—known as a working capital fund—for military departments to purchase care in MTFs for their beneficiaries. The goal of each change would be to better distinguish the costs of providing health care from the costs of ancillary activities related to ensuring medical and operational readiness. (Ancillary activities include functions conducted at medical command headquarters, the education and training of medical personnel, and veterinary services, including the care of working animals.) Decisionmakers within DoD and the Congress could better allocate resources if those costs were known.

What Would Be the Effects of Two Specific Options?

CBO analyzed two options that have been proposed to make changes to the MHS (see Summary Table 1). Earlier work by CBO found that people using military health services pay a lower share of their health care costs than most civilians with employment-based coverage. Those lower costs encourage people to switch to TRICARE and to use health care services more than comparable civilians. In CBO's judgment—which is informed by the agency's earlier work—policy changes that would increase beneficiaries' cost sharing have the greatest potential to generate significant savings for DoD and the federal government as a whole. Both options were assumed to go into effect in January 2020.

Option 1: Increase Cost Sharing for Most Beneficiaries Who Use TRICARE

This option would keep the current structure of TRICARE and the Military Health System intact but would increase the out-of-pocket costs paid both by active-duty TRICARE users who wish to buy coverage for their families and by users who have retired from the military but are not yet eligible for Medicare (sometimes called working-age retirees, they are generally between the ages of 40 and 65). Under the option, savings would accrue directly to the government because beneficiaries would use fewer health care services. Savings would also be generated when beneficiaries switched to a cheaper TRICARE plan or to other sources of health insurance. Consequently, the option would primarily affect the demand for, rather than the supply of, health care.

Option 2: Replace TRICARE With a Choice of Commercial Insurance Plans for Most Beneficiaries

This option, which is based on reforms proposed by the Military Compensation and Retirement Modernization Commission, would offer commercial insurance and incorporate MTFs into those networks. It would substantially restructure the TRICARE benefit and its delivery system, including adding new cash allowances for families of active-duty personnel and raising out-of-pocket costs for working-age retirees. The option would change the supply side of the market as well as the demand side.

Effects of the Options

CBO assessed the effects of these options in the "steady state"—that is, when the policy changes would be fully implemented, which CBO projects would happen by 2031. If lawmakers reduced discretionary funding accordingly, the net effect of the options on the deficit would be an annual decrease of roughly $2.5 billion under Option 1 or an annual increase of $700 million under Option 2 (evaluated at the midpoint of the likely range of outcomes, in 2017 dollars).[1] (See Summary Figure 1.) The first option would, on net, decrease costs to DoD and other agencies by $2.9 billion per year (in 2017 dollars) but would cause a small ($0.4 billion) net increase in the deficit from reduced tax revenues and greater mandatory spending (mostly the former).[2] By contrast, the second option could result in a small ($0.2 billion) annual decrease in discretionary costs and a slightly larger increase in the deficit ($0.9 billion) from reduced revenues (and a small change in mandatory spending.)

The estimated effects of Option 2 on discretionary costs are highly uncertain, however, largely because incorporating military treatment facilities and providers into commercial insurance networks would bring significant changes to beneficiaries and DoD and thus could be very difficult to implement. In particular, if operations at military treatment facilities could not be fully funded by reimbursements for providing care, any excess capacity would need to be reduced or subsidized by DoD through appropriations. The greatest uncertainty associated with the estimates for Option 2 involves the extent to which DoD would reduce any excess capacity in the Military Health System as a result of the lower demand for health care at those facilities.

Evaluating the two options on a per-family basis provides additional insights (see Summary Table 2). In 2031, the first year in which the full budgetary effects of both of the options would occur, implementing Option 1 or Option 2 would result in lower annual costs to the government—by about $2,000 or $600, respectively, per retiree family. But under Option 2, that family's out-of-pocket costs would more than triple, from about $1,900 per year to about $7,500 per year.

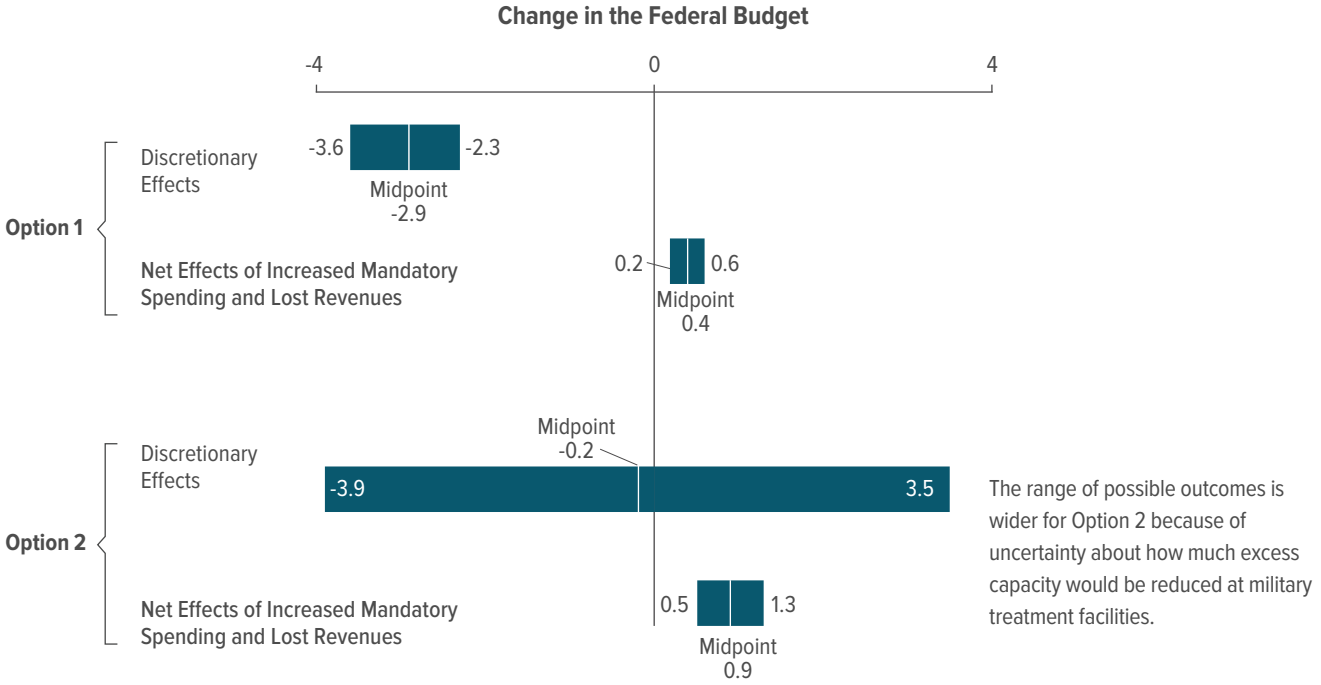
1. For the discretionary effects of the options, changes in outlays would approximately equal the changes in budget authority.

2. Discretionary spending is controlled by annual appropriation acts that specify the amounts that are to be provided for a broad array of government activities. Mandatory spending is governed by statutory criteria and is not normally controlled by the annual appropriation process.

Summary Figure 1.

Likely Ranges of Possible Savings or Costs in 2031 Under the Two Options Examined by CBO

Billions of 2017 Dollars



Source: Congressional Budget Office.

Option 1 would increase cost sharing in TRICARE for the families of active-duty personnel and for working-age retirees.

Option 2 would replace TRICARE with a choice of private insurance plans from which the families of active-duty personnel and working-age retirees could choose.

Estimated annual effects are shown in the "steady state"—that is, when the benefit changes would be fully implemented and any capacity reductions would have been made, which CBO projects would happen by 2031. For discretionary effects, outlays would approximately equal budget authority.

The likely ranges reflect the middle two-thirds of the range of possible outcomes. Savings or costs could be even larger or smaller than those displayed here.

For an average active-duty family, the cost to the government would decrease slightly under Option 1 but increase substantially under Option 2, CBO estimates. That increase would occur in part because of the allowances paid to those families, but primarily because TRICARE prices would no longer be constrained by Medicare rates and because subsidies would be required if DoD maintained excess capacity in its military treatment facilities.

Summary Table 2.

Estimated Cost of Health Care for an Average Family Using TRICARE in 2031

2017 Dollars

	Working-Age Retirees and Their Families[a]			Families of Active-Duty Personnel[b]		
Total Cost	Current Program	Option 1	Option 2	Current Program	Option 1	Option 2
To the Government	24,100	22,100	23,500	24,300	24,200	27,100
To a Family	1,900	3,300	7,500	300	300	0 [c]

Source: Congressional Budget Office.

A family is defined as a household that relies on TRICARE for 100 percent of its health care.

Estimated annual costs are shown in the "steady state"—that is, when the benefit changes would be fully implemented and any capacity reductions would have been made, which CBO projects would happen by 2031.

The potential subsidies that the Department of Defense would have to provide under these options to retain capacity at military treatment facilities are uncertain, and so the potential cost to the government is also uncertain. CBO estimates that the likely range of such costs could be $21,900 to $22,400 per retiree family under Option 1; $21,000 to $26,000 per retiree family under Option 2; and $22,700 to $31,400 per active-duty family under Option 2.

a. The average retiree family consists of three people, including the retiree sponsor who is not yet eligible for Medicare.

b. The average active-duty family consists of three people, not including the sponsor.

c. Under Option 2, an active-duty family would receive an allowance covering average out-of-pocket costs of $7,900.

CHAPTER

1

Overview of the Military Health System

The Department of Defense (DoD) pursues its two primary goals for the Military Health System (MHS)—ensuring that active-duty personnel are healthy enough to serve and that military clinicians are adequately trained—by providing care directly through its own system of clinics and by training its own medical personnel. It also pursues a third objective—providing care for military families and retirees through the TRICARE program. Just over half (52 percent in 2016) of all care is purchased from the private sector and offered to beneficiaries through TRICARE's health plans; the remainder of care is obtained directly at treatment facilities operated by DoD.

In 2016, DoD spent $51 billion to provide medical care, dental care, and prescription drug coverage to more than 8 million service members, retirees, and their eligible family members. Between 2000 and 2012, the costs of providing that care increased rapidly. Such expenditures have continued to grow since 2013, although at a more modest rate that is in line with civilian health care costs. Much of the cost increases are attributable to new and expanded health care benefits and to financial incentives to use those benefits.

Policymakers have recently focused on two areas of concern: the extent to which DoD achieves its primary goals for readiness and ways to control the rising costs of both direct and purchased care.

Goals of the Military Health System

The primary purpose of the MHS is to ensure readiness, which DoD defines as having two elements.[1] First, the system aims to ensure that all active-duty personnel (as well as activated members of the National Guard and reserves) are medically ready to serve—often called medical readiness. For example, all personnel are screened at military treatment facilities (MTFs) before they deploy overseas and again when they come home. The facilities care for those who fall ill or who are wounded or otherwise injured in the line of duty, although the military departments themselves provide care in combat settings.

Second, the system aims to guarantee that its personnel and facilities are ready to provide the high-quality care that military personnel will require in combat and during peacetime—often called operational readiness. Achieving that goal involves choices about "capacity"—specifically, the number of military medical personnel deemed necessary to treat patients, the mix of specialties in which providers should be proficient, the size of facilities, and the amount of equipment required to care for deployed forces.

DoD pursues its readiness goals by operating its own system of clinics and hospitals and by training its own uniformed doctors, nurses, corpsmen, dentists, administrators, and other specialists. In doing so, it is responsible for certifying that its facilities are run efficiently and that its providers are adequately trained. Within DoD, the Assistant Secretary of Defense (Health Affairs) exercises authority, direction, and control over medical resources. At the same time, each military department (Army, Navy, and Air Force), under its surgeon general, manages its MTFs and controls medical operations in the wartime theater.

One perceived advantage of this system is that each military department trains its providers to have the skills that meet the medical needs of their uniformed personnel in combat, and each must ensure that those providers perform their tasks with enough frequency to ensure competence. One drawback, however, has been significant duplication across DoD for some health and administrative services (such as information technology, medical education and training, research, and resource management). As a means of reducing that duplication, DoD established the Defense Health Agency (DHA) in 2013 to administer the MHS and to combine shared services. The Congress gave DHA additional administrative

1. See Department of Defense, *Health Service Support*, Joint Publication 4-02 (July 2012), www.dtic.mil/doctrine/new_pubs/jp4_02.pdf (1.6 MB).

responsibilities for the military treatment facilities in the National Defense Authorization Act for Fiscal Year 2017 (NDAA; Public Law 114-328). Beginning on October 1, 2018, DHA will be responsible for the administration of MTF budgets, health care management, military construction, and other central functions. The military departments, however, will retain their own medical commands and continue to be responsible for ensuring medical and operational readiness and providing health care at the MTFs.

The primary means by which military medical personnel develop and maintain their skills during peacetime is by providing care at MTFs to service members, their families, retirees, and their families. The latter three groups account for about 80 percent of the care provided; consequently, the mix of cases that military providers encounter during peacetime does not match the types typically seen in combat. For example, a large percentage of the cases at MTFs involve childbirth and the care of newborns. In addition, DoD has found that care provided at MTFs is usually more expensive than that offered by civilian providers who treat military beneficiaries; but the higher costs may be justified because MTFs are required to ensure readiness.[2] In essence, therefore, DoD is paying a premium—the size of which is difficult to calculate—in the name of military readiness by operating its own facilities with its own personnel and providing care to so many patients other than those currently serving in the military.

A third function of the MHS is to provide health benefits as an additional form of compensation for military employees and eligible retirees. After cash pay, subsidized health insurance is the largest element of the military compensation package.[3] Most large employers offer health insurance to their employees, but few operate their own medical systems, and most require their employees to pay a greater share of costs than DoD does. The proportion of employers who offer health insurance to their retirees has been shrinking as well.

The Military Health System and TRICARE

In addition to overseeing the delivery of health care in combat settings and other theaters of operation, the MHS provides health care benefits through a program called TRICARE. Under TRICARE, beneficiaries can receive care at MTFs and through a network of providers in the private sector. In 2015, about 8 million of the 9.3 million people eligible to receive health care through TRICARE used the system.[4] Managing, supporting, and providing health care services that year required about 84,000 military personnel and 65,000 federal civilian personnel working in 55 hospitals and 373 medical clinics. The TRICARE network supplemented the care delivered in the MTFs with about 550,000 private providers and 3,800 hospitals.

The 9.3 million people eligible for TRICARE fall into three broad categories:

- All members of the military, including members of the National Guard and reserves (1.9 million). Those serving on active duty must use TRICARE.
- Family members of those who are currently serving (2.0 million at the end of 2015). Family members are not required to use the system, but more than 80 percent do.
- Military retirees and their families (5.4 million at the end of 2015). Retirees and their families are also not required to use the system, but more than three-quarters do. (To qualify for military retirement, an individual must serve 20 years or more, although disability retirement is sometimes granted sooner.)

Most people who join the military do not remain for an entire career and therefore are not eligible for TRICARE when they leave. When they complete their service, they become veterans. Many veterans are eligible for care through the Veterans Health Administration (VHA), the medical program of the Department of Veterans Affairs

2. See Department of Defense, *Report on Military Health System Modernization: Response to Section 713 of the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (P.L. 113-291)* (February 8, 2016), pp. iii–v, https://go.usa.gov/xncKp (PDF, 11 MB).

3. See Congressional Budget Office, *Costs of Military Pay and Benefits in the Defense Budget* (November 2012), www.cbo.gov/publication/43574.

4. TRICARE, which is funded and managed by DoD, is available to members of all seven branches of the uniformed services: the Army, Navy, Marine Corps, Air Force, Coast Guard, Public Health Service, and the National Oceanic and Atmospheric Administration. The first four (military) branches represent about 97 percent of the total uniformed corps. See Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress* (February 2016), pp. 12 and 18, https://go.usa.gov/x9hDN.

(VA). As a distinct system from the MHS, VHA provides care directly in its own hospitals and clinics, but in certain circumstances veterans may access outside providers at VHA's expense.[5] This report does not address VHA care.

TRICARE's Health Plans

Most TRICARE plans are for beneficiaries who are not eligible for Medicare. That includes active-duty personnel, their families, and retirees and their family members who are under age 65 (and not otherwise eligible for Medicare). Military personnel who serve on active duty for 20 years or more, or who become medically disabled while serving, are eligible to retire from the military. Because most members join the military between the ages of 18 and 25, few retirees are old enough to qualify for Medicare immediately upon retirement. Those who are eligible for Medicare can participate in the TRICARE for Life (TFL) plan.

TRICARE Plans for Beneficiaries Not Eligible for Medicare

Although some smaller TRICARE plans are available to select subgroups, most military users receive their health care through one of three major plans: TRICARE Prime, TRICARE Extra, or TRICARE Standard. (See the appendix for the current costs to beneficiaries of the three TRICARE plans.)

- *TRICARE Prime* is a managed care option similar to that provided by a health maintenance organization (HMO). Of the nearly 8 million people who used the TRICARE benefit in 2015, nearly two-thirds (4.8 million) were enrolled in Prime.[6] Like civilian HMOs, the plan's features include a primary care manager (either a military or civilian health care provider) who oversees care and provides referrals to visit specialists. Active-duty service members are required to use Prime. They pay no annual enrollment fee or premium for the coverage, nor do they incur other out-of-pocket expenses (such as copayments and deductibles) for the medical care they receive. Their family members must enroll annually—also at no cost—if they wish to participate in the plan. Retired military members who are not yet eligible for Medicare and their families may also enroll, but they are charged an annual enrollment fee (similar to a premium) and may also incur some out-of-pocket expenses.

- *TRICARE Extra* mirrors a civilian preferred provider organization (PPO). Compared with TRICARE Prime, Extra allows participants more freedom to select providers, but users have higher out-of-pocket costs. Civilian providers who are designated as preferred accept a reduced payment from TRICARE in return for the business that the local military treatment facility refers to them, and the providers agree to file all claims for participants.

- *TRICARE Standard* allows beneficiaries even greater freedom to select providers than do Prime and Extra, but out-of-pocket costs are higher. Beneficiaries must pay any difference between a provider's billed charges and the rate of reimbursement allowed under the plan, although the maximum amount that the provider can bill is capped. By law, the reimbursement rate is tied to Medicare's allowable charges. (Such plans are known as indemnity insurance or fee-for-service plans.)

Beneficiaries who have not enrolled in Prime can receive care under Extra, Standard, or both. When beneficiaries choose an in-network provider for medical care, they are automatically covered under Extra; if they choose an out-of-network provider for a different medical service (even within the same year), they are automatically covered under the Standard plan. As of 2017, neither of those plans requires beneficiaries to enroll, although both have an annual deductible for outpatient care. Users of Extra or Standard can access MTFs for free, but unlike Prime enrollees, they get appointments only when space is available. The Congressional Budget Office estimates that there were over 1 million users of Extra and Standard in 2015, although some of those users relied on civilian health insurance or other payers in addition to TRICARE.

Lawmakers recently authorized changes to the TRICARE program that would increase the share of costs paid by many beneficiaries. Beginning on January 1, 2018,

5. The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113-146) temporarily authorized VA to spend up to $10 billion for purchased care from outside health providers to ensure that veterans meeting certain criteria do not experience long waits for VHA appointments or long drives to VHA facilities.

6. See Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress* (February 2016), p. 13, http://go.usa.gov/x9hDN.

Standard and Extra will be combined into a single preferred provider option called Select. Beneficiaries who enroll in Select will pay less when they choose in-network providers than they will for out-of-network providers. Most of the new provisions would affect military members entering the service on or after January 1, 2018 (see Box 1-1).

TRICARE for Life

Designed to supplement Medicare coverage, TFL requires beneficiaries to enroll in Parts A (hospital insurance) and B (medical insurance) of Medicare; Part B requires payment of annual premiums based on income, but TFL charges no annual premium or enrollment fee.[7] For inpatient and outpatient services that are covered by both Medicare and TRICARE, TFL pays the difference between Medicare's allowable costs and the Medicare payment rate (which is typically about 80 percent of the allowable cost); in other words, TFL covers Medicare's cost-sharing requirements. Thus, with the exception of pharmacy copayments, TFL largely eliminates out-of-pocket costs for retirees and their families.[8]

DoD reports that 2.1 million people were covered by TFL in 2015. The TFL benefit appears to cover a greater share of costs than private Medicare supplemental plans: DoD estimates that out-of-pocket costs for eligible beneficiaries were 54 percent less than those incurred by their civilian counterparts who have Medicare and supplemental insurance coverage.[9]

DoD finances the TRICARE for Life program differently from other TRICARE plans. For the latter, it pays the costs directly from its operation and maintenance and military personnel accounts. But for TFL, it uses accrual funding: DoD pays what actuaries estimate to be the amount necessary to fund future health care benefits for members currently serving in the military (referred to as accrual payments). Those accrual payments are made to the Medicare-Eligible Retiree Health Care Fund (MERHCF), an account established to pay for the health care of Medicare-eligible retirees. When retirees seek care from TRICARE, MTFs or private providers are reimbursed for the cost of that care by the MERHCF. The military services have no discretion in determining accrual rates, which are set by an actuarial board; they budget an amount equal to the accrual rates (one rate for active-duty personnel and another for reservists) multiplied by the average number of active-duty personnel and reservists currently in the force. In 2016, DoD made accrual payments to the MERHCF totaling about $7 billion. That same year, outlays from the MERHCF to reimburse private providers and MTFs for care delivered to Medicare-eligible retirees totaled $10 billion. Those two sums differ because the former is an estimate of future costs for current service members, whereas the latter measures current costs for people who have already retired from the military.

Direct and Purchased Care

The MHS offers direct care using military providers at hospitals, clinics, and other facilities that are overseen by the military departments and DHA. About 40 percent of military health care (measured by workload) is provided by that system. The costs include staff salaries, expenditures on medical supplies, and costs for the operation and maintenance of MTFs.

The overall capacity of the direct care system is more than sufficient to provide care to the fewer than 2 million active-duty personnel. To keep its facilities busy and to provide training and experience to its military medical personnel, DoD has for decades offered care to families of active-duty personnel and military retirees when space is available. However, the capacity of the direct care system as a whole is not sufficient for the roughly 8 million people who want to receive their health care from TRICARE. Some MTFs have excess capacity, but they may not be conveniently located for retiree populations; and some MTFs may not provide the services needed. The ability to treat family members and retirees

7. Between 1966, the year Medicare began to provide benefits, and 2002, the year TFL went into effect, military retirees could use TRICARE (or its predecessor program) only until they became eligible for Medicare; 86 percent of them purchased supplemental insurance to cover the costs that Medicare would not. See Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress* (February 2016), p. 105, https://go.usa.gov/x9hDe.

8. Neither Medicare Part B nor TFL covers pharmacy copayments, so retirees must pay those out of pocket. However, like all TRICARE beneficiaries, military retirees can obtain up to a 90-day supply of prescription drugs from military pharmacies for free. They also can go to in-network civilian pharmacies and pay $10 for a 30-day supply of a generic drug and $24 for a brand-name drug (although some brand-name drugs may cost more). Home delivery is available as well. See www.tricare.mil/CoveredServices/Pharmacy/Costs.

9. See Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress* (February 2016), pp. 13 and 106, https://go.usa.gov/x9hDe.

is stretched further when military providers who staff the MTFs in peacetime deploy to support combat operations. Therefore, DoD contracts with regional networks of civilian providers of health care to deliver the remaining 60 percent of care to DoD beneficiaries.

Health care provided through the direct care system (including pharmaceuticals dispensed by military pharmacies) is generally free to users, whereas care from civilian providers—purchased care—may include very modest copayments or coinsurance, depending on the category of beneficiary and the type of health plan the beneficiary chooses. Unlike most commercial plans, TRICARE allows beneficiaries to access care without enrolling. TRICARE's contracts with providers resemble those used by many commercial insurance companies in that they are fee-for-service arrangements—that is, providers are reimbursed for care as they deliver it. However, DoD has not instituted other contracting arrangements, including capitated payments (generally, a fixed amount per enrollee per year) or value-based contracts (alternative payment methods that contain explicit cost-efficiency and quality performance measures). Several researchers have asserted that such models can be more efficient (and less costly) than fee-for-service contracts.[10] However, the savings from switching to those models might be smaller for TRICARE than for commercial plans because payments to network providers under TRICARE are based by statute on Medicare rates, which are lower than the rates paid by most civilian health plans.

The Costs of Military Health Care

DoD expects to spend about $50 billion for the MHS in 2017, and the Administration has requested an appropriation of $51 billion for 2018. In later years, the health system's costs will increase if its growth reflects anticipated national trends in health care costs—mostly a function of rising per capita costs rather than changes in the number of TRICARE users.

In 2014, CBO analyzed the causes of increases in DoD's health care spending between 2000 and 2012 to identify approaches to constrain future spending.[11] CBO found that most of the growth could be explained by two factors:

- *New TRICARE benefits.* A decade of legislative changes had added new groups of beneficiaries and expanded access for existing beneficiaries.
- *Financial incentives to use TRICARE.* Because beneficiaries' cost-sharing burden had been declining, TRICARE had become increasingly attractive when compared with other options for health care coverage. In addition, those relatively low costs had encouraged existing beneficiaries to use more health care services.

By contrast, the medical costs of military operations in Iraq and Afghanistan over the past decade had a comparatively small effect on DoD's spending.

Military retirees and their families generally pay much less for health care than comparable civilian families do.[12] DoD has estimated that, in 2015, the family of a retiree enrolled in a civilian HMO would pay nearly six times as much as a similar family with coverage under TRICARE Prime. A family who used a civilian PPO would pay more than five times the amount a similar military family would pay for coverage under TRICARE Extra or Standard.[13]

As a result of those differences in costs, a rapidly growing share of military retirees and their families are relying on TRICARE rather than participating in health insurance provided by civilian employers or purchasing insurance on their own. In 2002, about 47 percent of military retirees signed up for private health insurance, but by 2015 that figure had dropped to 18 percent, indicating

10. See Bruce E. Landon and others, "The Relationship Between Physician Compensation Strategies and the Intensity of Care Delivered to Medicare Beneficiaries," *Health Services Research*, vol. 46, no. 6 (December 2011), pp. 1863–1882, http://doi.org/10.1111/j.1475-6773.2011.01294.x; Lee N. Newcomer, "Changing Physician Incentives for Cancer Care to Reward Better Patient Outcomes Instead of Use of More Costly Drugs," *Health Affairs*, vol. 31, no. 4 (April 2012), pp. 780–785, http://doi.org/10.1377/hlthaff.2012.0002; and Roger G. Kathol, Frank deGruy, and Bruce L. Rollman, "Value-Based Financially Sustainable Behavioral Health Components in Patient-Centered Medical Homes," *Annals of Family Medicine*, vol. 12, no. 2 (March 2014), pp. 172–175, http://doi.org/10.1370/afm.1619.

11. See Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care* (January 2014), www.cbo.gov/publication/44993.

12. Ibid., pp. 13–15.

13. See Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress* (February 2016), pp. 101 and 103, https://go.usa.gov/x9hDN.

Box 1-1.

Recent Changes to the TRICARE Program

In December 2016, lawmakers authorized changes to the TRICARE program that will take effect over the next several years.[1] Specifically, beginning on January 1, 2018, TRICARE Extra and Standard will be merged into a single plan known as TRICARE Select. The new program will include both the in-network benefits that are currently part of the Extra plan and out-of-network (fee-for-service) benefits available through Standard. All beneficiaries will need to enroll in TRICARE Select to receive coverage. Enrollment will be free until January 1, 2020. Beginning in 2020, current working-age retirees who wish to use Select must pay an enrollment fee of $150 for individual coverage or $300 for family coverage.[2]

Changes to other out-of-pocket costs will take effect for those who enter service after January 1, 2018. Those changes will create two distinct fee schedules: one for those who entered military service before January 1, 2018, and another for those who enter afterward (see the table). Beneficiaries who use TRICARE Select will have a new schedule of copayments instead of the coinsurance currently required by Extra and Standard (which those who enter service before January 1, 2018, will continue to pay). In addition, future retirees (those who enter service on or after January 1, 2018, and complete a career or who retire for medical reasons) will pay triple the fee paid by their predecessors to enroll in Select. The enrollment fees for both groups, however, will increase annually by the rate of the cost-of-living adjustment for military retired pay.

Other adjustments tied to the cost of living will apply only to the costs paid by those who enter military service on or after January 1, 2018. The annual deductible and catastrophic cap for members who enter service in 2018, for example, will increase each year, whereas the deductible and cap for those who entered service before that year will be fixed.

1. The National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328) was passed by the Congress on December 8, 2016, and signed into law by President Obama on December 23, 2016.

2. The new fees can be instituted only 90 days after a report is submitted to the Congress by the Comptroller General of the United States. The report must evaluate TRICARE coverage and access and be completed by February 1, 2020.

Continued

greater reliance on TRICARE.[14] In addition, low out-of-pocket costs, the increasing expense of employment-based insurance plans, and other factors have led to higher usage rates for inpatient and outpatient care among enrollees in TRICARE Prime than DoD has reported for comparable civilians enrolled in HMOs.[15]

Areas of Concern for Policymakers

Policymakers have raised concerns about the department's preparation for wartime missions, the quality of care provided at its facilities, and its rising health care costs. Efforts to change the system are complicated, however, partly because the resources used to accomplish the various goals are often intermingled or unclear.

Improving the Operational Readiness of Medical Providers and the Quality of Care in MTFs

The MHS regularly exceeds the goals it sets for ensuring that soldiers, sailors, airmen, and Marines are ready to deploy—that is, the first element of medical readiness. The second element—preparing military medical personnel to provide high-quality care during combat missions and at home—has been more problematic for the following reasons:

- *Mismatches in medical specialties.* DoD has had difficulty ensuring that its clinical personnel are adequately prepared to provide the types of care the department expects will be most in demand on combat missions because those clinicians receive most of their training at MTFs, and most of the patients at MTFs are families or retirees.

14. Ibid., p. 100.

15. Ibid., pp. 85–90.

Box 1-1. Continued

Recent Changes to the TRICARE Program

Costs Incurred by Different Types of Beneficiaries as a Result of Changes Enacted in the National Defense Authorization Act for Fiscal Year 2017

	Active-Duty Personnel Who Entered Service Before 2018 and Their Families	Active-Duty Personnel Who Enter Service in 2018 or Later and Their Families	Working-Age Retirees Who Entered Service Before 2018 and Their Families	Working-Age Retirees Who Enter Service in 2018 or Later and Their Families
Enrollment Fees				
HMO (Prime)	None	None	$282.60 or $565.20 in 2017 for individual and family coverage, respectively. Increases each year with COLA.	$350 or $700 for individual and family coverage, respectively. Increases each year with COLA.
PPO (Select)	None	None	Currently, none. Beginning in 2020, $150 or $300 for individual and family coverage, respectively; disability retirees and certain survivors will be exempt. Increases each year with COLA.	$450 or $900 for individual and family coverage, respectively. Increases each year with COLA.
Deductibles				
HMO (Prime)	None	None	None	None
PPO (Select)	Range from $50 to $300, depending on pay grade and whether individual or family coverage. No annual increase.	Range from $50 to $300, depending on pay grade and whether individual or family coverage. Increases each year with COLA.	$150 or $300 for individual and family coverage, respectively. No annual increase.	Range from $150 to $600, depending on whether individual or family coverage and in-network or out-of-network use. Increases each year with COLA.
Coinsurance and Copayments				
HMO (Prime)	None	None	Copayments are the same as under current law. DoD could raise copayments annually.	Higher copayments that increase each year with COLA.
PPO (Select)	Coinsurance of 15 percent (in network); 20 percent (out of network). No copayments.	New copayments (in network). Copayments increase each year with COLA. Coinsurance 20 percent (out of network).	No copayments. Coinsurance 20 percent (in network); 25 percent (out of network).	New copayments (in network). Copayments increase each year with COLA. Coinsurance 25 percent (out of network).
Catastrophic Cap				
HMO (Prime)	$1,000. No annual increase.	$1,000. Increases each year with COLA.	$3,000. No annual increase.	$3,500. Increases each year with COLA.
PPO (Select)	$1,000. No annual increase.	$1,000. Increases each year with COLA.	$3,500 starting in 2020. No annual increase.	$3,500. Increases each year with COLA.

Source: Congressional Budget Office, using information from the National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328).

Beginning on January 1, 2018, TRICARE Extra and Standard will be combined under a common name, TRICARE Select.

Unless another year is specified, the costs shown will be in effect in 2018.

Most families of active-duty personnel are enrolled in Prime, which resembles an HMO. Cost sharing for them under the new plan will be similar to that for the current plan.

Enrollment fees and other costs (copayments and deductibles) will increase annually by the rate of the COLA for military retired pay.

COLA = cost-of-living adjustment for retiree pensions (equal to the annual increase in the consumer price index); DoD = Department of Defense; HMO = health maintenance organization; PPO = preferred provider organization.

- *Mismatches in clinicians' proficiency.* A related issue is whether military providers are able to deliver high-quality care. In MTFs, patients often receive types of care that are delivered infrequently, and low volumes are often associated with low quality: The general medicine practiced in most MTFs means there is little clinical specialization, which can adversely affect the outcomes of complex medical procedures and surgeries required in combat settings.

One recent study by the Institute for Defense Analyses documented a shift in recent conflicts toward smaller medical facilities with more specialized trauma capabilities in operational theaters, but the study noted that those specialties were in short supply in the military medical corps today. Instead, the military medical departments retain specialists whose skills are better matched to peacetime beneficiary care—particularly those involving childbirth, infant care, and conditions associated with aging.[16]

A recent report by CNA, a nonprofit research and analysis organization, examined whether the volume of typical surgeries performed at MTFs was sufficient to ensure high-quality outcomes.[17] CNA's researchers examined health care studies of the civilian sector and found that surgeons who perform a higher volume of procedures have lower complication rates, lower repeat operation rates, and lower mortality rates than surgeons who perform a lower volume of procedures. The CNA report identified standards set in the civilian sector for the number of procedures per hospital that must be performed each year to substantially lower the likelihood of adverse events. The study evaluated MTFs by applying the relationships between quality and volume that have been established in the literature for civilian hospitals. According to that study, most patients in civilian settings receive care in high-volume settings, but most patients in DoD's direct care system receive care in low-volume settings. Few doctors in the MHS met the volume targets that the literature indicated were associated with high-quality care and better outcomes. The researchers asked whether one can consider providers to be medically ready if they do not perform enough procedures to ensure that their skills meet civilian benchmarks.

Between August 2014 and May 2015, DoD released two internal studies of the direct care system and the readiness of its medical providers. The first review, which spanned the period from October 2010 to May 2014, focused on efficiency at MTFs.[18] DoD's researchers found that overall access, quality, and safety were good, but that performance varied widely among different clinics and hospitals. Surgical complications were statistically more frequent than expected in almost half (8 of 17) of the MTFs that voluntarily reported data on morbidity (the incidence of disease) and mortality to the American College of Surgeons in 2013, and there were persistent problems in three MTFs, although three others were performing at the top tier nationally.[19]

The second study examined whether access to medical care met defined standards, whether the quality met specific benchmarks, and whether effective processes were in place to ensure safe medical care.[20] One overarching finding was that no methodology existed to determine the amount and types of procedures performed within MTFs that were considered necessary to support medical readiness. Without knowing that workload, determining the optimal number of MTFs, or their capacity, was not possible. Both studies recommended reorganizing the responsibilities and governance of the MHS to support better collaboration and alignment among DHA and the military medical departments.

Controlling Costs

The high and rising costs of the MHS constitute the second area of concern for policymakers. That issue has two interrelated components—the cost of ensuring operational readiness and the cost of providing care to TRICARE's 8 million users.

16. See John E. Whitley and others, *Medical Total Force Management*, IDA Paper P-5047 (Institute for Defense Analyses, May 2014), http://tinyurl.com/y8gku45s (PDF, 3.67 MB).

17. See Holly Brevig and others, *The Quality-Volume Relationship: Comparing Civilian and MHS Practice* (CNA Corporation, January 2015), www.dtic.mil/docs/citations/ADA615315.

18. See Department of Defense, *Military Health System Review: Final Report to the Secretary of Defense* (August 2014), https://go.usa.gov/x9hN8.

19. Ibid., pp. 110–118. In 2013, 56 MTFs had inpatient facilities. The MHS does not require MTFs to report data on surgical quality to the American College of Surgeons.

20. See Department of Defense, *Military Health System Modernization Study Team Report* (May 2015), https://go.usa.gov/xncKp.

Identifying the Cost of Ensuring Operational Readiness. DoD allocates funding to different components and subcomponents of the MHS in ways that make it difficult to track the cost of ensuring operational readiness. Military physicians receive their salaries from their branch of service through the military personnel appropriation, for example. Individual hospitals receive an overall budget for their supplies, materials, and equipment. The base where the hospital operates is funded from another component. Therefore, it is difficult to distinguish between the costs of providing health care and the costs of activities needed to ensure readiness.

Better understanding of those costs could help decisionmakers develop more efficient ways of meeting DoD's readiness goals. As an example, researchers have noted that the total size of the medical force generally exceeds the requirements for operational readiness that the services have identified.[21] Furthermore, those requirements significantly exceed the number of medical units and personnel that have historically deployed to overseas operations. Military medical personnel deploy less than nonmedical personnel: Their deployment rates average one-fifth to one-third those of personnel with combat arms specialties. If the military medical establishment is too large for wartime missions and providers see too few patients to maintain their proficiency, DoD may be paying more than necessary for readiness. More transparency of the costs of providing that readiness could help DoD operate the MHS more efficiently.

Controlling the Cost of Providing Care. Separating the costs of providing care to the MHS's 8 million users from the costs of ensuring readiness is difficult because they overlap. Hence, the true cost of providing the health care benefit is uncertain, and determining how to lower those costs is challenging. An important factor contributing to that uncertainty—one that has persisted for decades—is whether care provided in the direct care system is more or less expensive than that offered by civilian providers. The answer would help shape future policy. If MTFs can provide health care less expensively than TRICARE contractors, policies that encouraged greater use of those facilities would not only improve the skills of military providers, thereby improving operational readiness, but also reduce the overall cost of care. If TRICARE contractors proved to be less expensive, however, DoD could potentially reduce the size of the direct care system without compromising readiness, outsource more care to the contractors, and thereby reduce spending.

However, the relative costs are unclear. A recent study compared certain procedures performed at MTFs with those performed by TRICARE network providers and found that procedures were on average about 35 percent less expensive when performed by network providers, who are paid at Medicare rates.[22] In another study, DoD acknowledged that the average cost of care provided to DoD beneficiaries in the direct care system is usually higher than the cost of purchased care. But the study's authors argued that MTF buildings and equipment represent "sunk costs" (that is, costs that have already been incurred and cannot be recovered), and the costs of operational uniformed personnel are fixed (because the number of military personnel is determined by readiness needs).[23] That study therefore finds that the direct care system should be filled to capacity, with excess care beyond that capacity sent to civilian providers.

Although costs can appear fixed in any given month or year, most economists would agree that costs vary over longer periods and that better information about relative prices could improve decisionmaking about the allocation of resources. Different funding mechanisms could provide that information. For example, the mechanism for funding TRICARE for Life—accrual funding—is meant to help policymakers consider the future costs of the current force. Such information for other portions of the MHS could help them determine the efficient size of the direct care system relative to the contracted networks, even when readiness is a concern.

21. See John E. Whitley and others, *Medical Total Force Management,* IDA Paper P-5047 (Institute for Defense Analyses, May 2014), http://tinyurl.com/y8gku45s (PDF, 3.67 MB)

22. Philip M. Lurie, *Comparing the Costs of Military Treatment Facilities With Private Sector Care,* IDA Paper NS P-5262 (Institute for Defense Analyses, February 2016), http://tinyurl.com/zpunu5k (PDF, 504 KB).

23. Department of Defense, *Military Health System Modernization Study Team Report* (May 29, 2015), p. 1, https://go.usa.gov/xncKp.

CHAPTER

2

Broad Approaches to Changing the Military Health System

In 2014, the Congressional Budget Office explored three approaches to reducing the Department of Defense's health care spending: better management of chronic diseases, more effective administration of the Military Health System, and increased cost sharing for retirees who use TRICARE.[1] The first two could be considered changes on the supply side of health care, while the third could be viewed as affecting the demand side. In CBO's assessment, only the last of those approaches had the potential to generate significant savings for DoD. The first two approaches would make changes to the way in which health care is supplied and might generate savings, but they would not address the primary drivers of health care costs for DoD. Since that report was published, however, policymakers have expressed interest in more fundamental changes to the system, particularly on the supply side. For example, in the National Defense Authorization Act for Fiscal Year 2017, the Congress directed the Defense Health Agency to take over the management of all of the military treatment facilities currently operated by the Army, Navy, and Air Force. Because of the continuing interest in how military health care is provided, this CBO analysis has a broader scope than the previous one.

Such analysis is complicated, however. Researchers have found that the effects of various supply-side changes have been mixed or more difficult to measure, in part because less evidence is available about their likely effects. For instance, estimating the effect of approaches that would make DoD's direct care system more efficient requires measuring some baseline level of efficiency. It can also be difficult to judge what form that greater efficiency might take: Would military or civilian providers see more patients, would military facilities close, would there be fewer providers, or would healthier people need less costly forms of care? Answering each of those questions can be challenging, which adds greater uncertainty to any estimates. However, even though some of the approaches CBO considered in this analysis might not reduce health care spending on their own, they would improve the visibility of costs, which would allow decisionmakers to make more informed choices about allocating defense resources for health care.

For this report, CBO examined three broad approaches to making fundamental changes on the supply side:

- Focusing the direct care system on operational readiness,
- Paying fixed amounts per person to private insurers for TRICARE, and
- Changing how DoD finances health care.

Each approach has the potential to address all or some of policymakers' aims—to improve readiness, increase the quality of care, or reduce spending for military health care—but each has drawbacks as well. CBO examined ways that the alternatives could be implemented and identified whether they would address one or more of the concerns policymakers and analysts have expressed about military health care.

Approach 1: Focus the Direct Care System on Operational Readiness

For several reasons, policymakers might choose to reduce the size of the direct care system to focus it more on the types of care needed by the active-duty force, while shifting more peacetime care to the private sector:

- The medical conditions encountered most often at MTFs are similar to those seen in civilian facilities rather than those encountered by active-duty members, particularly in combat zones. Although deployed service members need routine care, the peacetime MTF workload may not be ideal for preparing military clinicians for deployment duties, and many military physicians serving in a combat

1. See Congressional Budget Office, *Approaches to Reducing Federal Spending on Military Health Care* (January 2014), www.cbo.gov/publication/44993.

theater often have no formal training in emergency medicine or trauma resuscitation.[2]

- The geographic distribution of patients is uneven, resulting in long waits at some MTFs and insufficient patient load at other MTFs.

- The number of retirees is projected to decline in the coming decades, and contracted care can be reduced more easily to match decreases in the beneficiary population.

Focusing on operational readiness in the direct care system would require that the clinicians who provide care during deployments undertake more of their training in civilian trauma centers. Routine medical care would be provided by the private sector much more often than it is now. For the military services, the number of uniformed medical personnel would shrink, potentially allowing the services to increase end strength in other areas. (End strength is the number of active-duty service members on the last day of the fiscal year.) Training fewer medical staff at MTFs would constitute a considerable change, however, and some families of military personnel would probably prefer not to receive routine care from the private sector.

Such changes could be implemented in a number of ways. Although it is not possible to envision precisely how changing one part of the current system would affect other aspects of military health care, CBO examined in detail three issues that would need to be addressed to focus the direct care system on operational readiness: the provision of combat care, the extent of care provided at MTFs, and the staffing of MTFs.

Who Would Provide Combat Care and How Would They Be Trained?

Under this approach, medical care provided during military operations overseas could be delivered either by active-duty military clinicians or by reservists, but in either case, most of their training would be conducted in civilian hospitals. (Salaries for those military physicians would be paid from the services' military personnel appropriations, as they are now.) Currently, a little less than half (44 percent) of the military medical corps is made up of reservists, who usually have full-time clinical jobs in the civilian sector and can be activated when needed. Greater reliance on them would reduce DoD's expenditures in general (because reservists cost as much as active-duty personnel only when they are activated). However, pulling more doctors and nurses from the civilian sector could also impose some costs on civilians, adversely affecting their care. If more reservists were used, the services would probably still choose to retain some active-duty physicians and nurses to ensure rapid mobilization and deployment as needed.

The main rationale for shifting training to civilian hospitals is that much of the knowledge gained by military clinicians at MTFs—where they primarily treat families and retirees—is not applicable to medicine delivered during deployment. For example, childbirth and newborn care are the highest volume inpatient services provided at MTFs.[3] Those health care needs are not the ones clinicians typically address when they deploy to combat zones, a misalignment that is well documented.[4]

The military could place greater emphasis on training its clinicians—including physicians, nurses, and other professionals who provide medical care—to treat acute injuries by placing them in civilian trauma centers.[5]

2. See Robert L. Mabry, "Challenges to Improving Combat Casualty Survivability on the Battlefield," *Joint Force Quarterly,* no. 76 (First Quarter 2015), pp. 78–84, http://dtic.mil/doctrine/jfq/jfq-76.pdf (3.44 MB); and Melony E. Sorbero and others, *Improving the Deployment of Army Health Care Professionals: An Evaluation of PROFIS* (RAND Corporation, 2013), www.rand.org/pubs/technical_reports/TR1227.html.

3. See Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress* (February 2016), p. 89, https://go.usa.gov/x9hDN.

4. See the testimony of John E. Whitley, Senior Fellow at the Institute for Defense Analyses, before the Subcommittee on Personnel of the Senate Committee on Armed Services, *TRICARE Reform* (February 23, 2016), www.armed-services.senate.gov/hearings/16-02-23-defense-health-care-reform.

5. See Christine Eibner, *Maintaining Military Medical Skills During Peacetime: Outlining and Assessing a New Approach* (RAND Corporation, 2008), www.rand.org/pubs/monographs/MG638.html. In that report, the RAND Corporation explored how DoD might maintain the operational readiness of military personnel by stationing some of them in civilian hospitals. It also presented steps that DoD could take to institute a pilot study on the practice. A separate study recommended an integrated network of military and civilian trauma centers for improving such care. See National Academies of Sciences, Engineering, and Medicine, *A National Trauma Care System: Integrating Military and Civilian Trauma Systems to Achieve Zero Preventable Deaths After Injury* (National Academies Press, June 2016), http://tinyurl.com/n4r298m.

Although combat injuries from blasts, fire, and military-grade small arms are more complex than most injuries seen in emergency rooms (those that result from falls, car accidents, and gunshots, for instance), the expertise needed for those conditions is more in line with that required on the battlefield.[6] Outside of combat operations, the only way most military clinicians are exposed to emergency medicine is through simulation training and by briefly working in civilian hospitals. Emergency rooms and trauma centers in urban areas often have large numbers of patients, which strengthens health care providers' skills. Because clinicians working in emergency rooms also treat many routine medical conditions, they retain those skills as well.

If military clinicians learned and maintained their skills mainly by working in civilian hospitals, MTFs could be restructured or closed, depending on their workload. The services could, however, decide to continue training some military clinicians in a few military hospitals that specialize in mental health and in rehabilitation of particular deployment-related injuries (such as burns and amputations) and that offer residencies for medical students and new physicians (that is, graduate medical education).

What Care Would Be Provided at MTFs?

Focusing the direct care system on operational readiness could emphasize the training of people who provide combat care while leaving the types of care provided and the populations served at MTFs unchanged (although the volume of services would be reduced); or it could make fundamental changes in the MTFs. Many beneficiaries feel strongly about having access to MTFs, and leaving the types of care provided at such facilities unchanged (but at a lower volume) could preserve some of that access, but not as much as under the current system.

Alternatively, under this approach, all care for non-active-duty patients could be moved out of the MTFs and directed to private providers, shrinking the size of the direct care system substantially. Going further, small clinics on military bases could provide routine care for active-duty members, but major procedures could be performed in outside facilities. One possible disadvantage of such changes would be the loss of some medical positions at MTFs in the United States that provide a rotation base for military personnel who are returning from deployments overseas or that provide opportunities for promotion. Also, because large reductions in active-duty medical positions would result in heavy reliance on reservists, the military could end up short of its clinical manpower requirements, particularly for specialists.

Who Would Provide Care at MTFs?

Under this approach, civilians would provide at least some health care in MTFs unless the direct care system became much smaller. Most peacetime medical care could be furnished by federal civilians, or by contractors, who would work in MTFs. The medical communities in the three military departments have classified between 43 percent and 82 percent of their ambulatory care occupations as commercial in nature, which means those functions may be carried out by either federal civilians or contractors. Those commercial occupations include surgeons and other physicians, nurses and dentists, as well as administrators, pharmacists, and technicians. Patients might notice little change or even improvement if civilians provided more care because civilians tend to remain in their jobs longer than military personnel, who must periodically change jobs and locations.

What Would Be the Budgetary Consequences of Such Changes?

Depending on how the contracts were negotiated, moving health care delivery from MTFs to private providers could result in substantial savings or additional costs. DoD reports that, even within the current Prime plan, the average annual cost to the government of patients who use civilian providers is much less for inpatient and outpatient care than for patients who use MTFs for most of their care.[7] Civilian insurers could implement different models—such as value-based contracts—that are not feasible in the current structure but have the potential to reduce costs. One reason that civilian providers are less costly, however, is that their reimbursement rates under TRICARE are tied to Medicare rates. If contracted providers were paid rates that were comparable to those paid by private insurers, which are much higher than Medicare's rates, on average, switching care to civilian providers could be more costly, not less. Because DoD has not put forth any plans for moving most care out of

6. An exception is Brooke Army Medical Center in San Antonio, Texas, which is a Level I Trauma Center.

7. See Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress* (February 2016), pp. 88 and 93, https://go.usa.gov/x9hDN.

the MTFs, CBO could not evaluate whether other contract mechanisms could reduce costs sufficiently to offset higher non-Medicare rates.

Regarding the budgetary effects of using more civilians at MTFs, CBO estimates that replacing one military member with one civilian could save about $24,000 per year, on average, assuming that the relative costs of military and civilian medical personnel did not change. Not all of those savings would accrue to DoD, however, as many of the costs of military personnel are associated with their veterans' benefits. If fewer civilians were required to replace a given number of military personnel, as has been found in other areas of DoD, then additional savings would be realized within the department. For example, if three military personnel could be replaced with only two civilians, CBO estimates, the annual savings could approach $36,000 per position replaced.[8] To attain budgetary savings, however, DoD would need to reduce military end strength.

Approach 2: Pay Fixed Amounts per Person to TRICARE Contractors

TRICARE uses private-sector doctors, hospitals, and contractors to supplement care that is not provided at MTFs. Administration of that private-sector health care within the United States is currently split into three geographic regions—North, South, and West—with one contractor each.[9] Those contractors develop and maintain the private network of health care providers and oversee management tasks such as enrollment of patients, claims processing, specialty care referrals, customer service, and recordkeeping.

Under most TRICARE contracts, doctors and hospitals are paid on a fee-for-service basis, which largely puts the burden of implementing cost-control measures on DoD. Although many large employers use the same approach—contracting with an insurer to manage provider networks and process claims and paying those claims as they are incurred—many health insurers outside of TRICARE have instituted or are currently experimenting with various reforms to counteract rising costs and possible overutilization of services associated with fee-for-service plans.[10] Some employers pay insurers a fixed fee per enrollee for coverage. Under those arrangements, the insurer bears the financial risk that costs will exceed expectations and therefore has stronger incentives to control those costs. Taking those considerations into account, CBO examined how TRICARE could adopt an approach using fixed payments per person for health care services.

How Do TRICARE Contracts Currently Work?

TRICARE contracts must adhere to certain standards, and the regional contractors have discretion about how to meet performance objectives. However, the contractors have no authority to control costs, and the prices they pay to private providers are governed by statute. Federal law mandates that TRICARE adopt Medicare's reimbursement rules when practicable.[11]

TRICARE uses a prospective payment system for inpatient stays and for hospital outpatient services, similar to that used by Medicare. Under that system, the payment amount for the hospital is predetermined for the type of medical encounter or the type of procedure performed, even though the amount of care that each patient receives may vary significantly.[12] For other

8. The general methodology used in this estimate is based on earlier work by CBO. See Congressional Budget Office, *Replacing Military Personnel in Support Positions With Civilian Employees* (December 2015), www.cbo.gov/publication/51012. The range of potential savings in this estimate represents either one civilian replacing one service member or two civilians replacing three service members. The estimate that three military personnel could be replaced with two civilians is based on the observed military-civilian substitution ratio across both medical and nonmedical occupations. Military personnel require more training and perform more ancillary duties than civilian personnel. The military system also requires more people in a given occupation to provide jobs for those returning from deployments and to ensure opportunities for promotion. Much of the federal savings would arise because civilian employees are ineligible for VA benefits. Also, civilian employees receive a much larger share of their income in a taxable form than do active-duty personnel, which increases tax revenues paid by civilian employees relative to military personnel.

9. Beginning January 1, 2018, the three regions will be merged into two (East and West), each having one Managed Care Support Contractor.

10. For an overview of recent reforms in civilian health plans and alternative approaches, see Susan D. Hosek and others, *Introducing Value-Based Purchasing Into TRICARE Reform* (RAND Corporation, 2016), www.rand.org/pubs/perspectives/PE195.html.

11. 10 U.S.C. §1079(h) (2012 & Supp.). Major exceptions are obstetrics and pediatrics, which generally do not apply to the population using Medicare.

12. Sometimes the payment is adjusted for extremely long stays. Payments are also adjusted for complications that may arise or for other conditions the patient may have (known as comorbidities).

types of outpatient care, such as routine office visits, TRICARE uses a fee-for-service payment system. Unlike prospective payment, fee-for-service is a model where services are unbundled and paid for separately. With that type of payment system, health care providers may prescribe more treatments and procedures than are necessary because payment is dependent on the volume and complexity of care rather than quality of care or the medical outcome. (Some of those incentives to overtreat are also present under prospective payment systems.)

How Do Fixed Payments per Person Work in the Private Sector?

One arrangement used in the private sector to counteract incentives to overtreat is capitation. Capitation can take many forms, but in essence the provider—either the insurance firm or, less commonly, the clinical practice—is paid a fixed amount for each enrollee to provide certain types of care for a specified period (typically one year); that amount may be adjusted for risk on the basis of the characteristics of each enrollee. Under full capitation, providers are paid a flat fee for their assigned patient population, regardless of how little or how much care those patients use. With other variations of capitation, only certain types or categories of services are paid for on a capitated basis, depending on which services are excluded (also known as carved out).

How Would Capitated Payments for TRICARE Work?

Like private-sector plans, TRICARE could also move toward some form of capitated payment system that holds the regional contractors responsible for both the cost and quality of care. Currently, contractors pass claims from private health care providers through to the Defense Health Agency, and bills are paid from a dedicated account.[13] Alternatively, DHA could establish a system in which TRICARE contractors are paid on a capitated basis to cover the provision of services to enrollees in their regions. The capitated amount per patient would be adjusted for risk.

One way in which DHA could institute capitated payments would be to select contractors through a competitive bidding process based largely on the capitation payments that those contractors would be willing to accept. Each contractor would have to meet quality and access standards set by DoD but would have broad latitude about how to construct its provider networks and structure the benefits. That feature would allow contractors to move away from fee-for-service payment structures and implement alternative structures sometimes seen in the civilian market. MTFs, which receive appropriated funds, have their own patients and would not be part of the contract network; rather, beneficiaries' use of MTFs would be part of the calculation when setting contractors' capitated rates. Details would be determined by the contractors, but additional contract features could include changes in how medical providers are reimbursed and in patients' cost sharing.

An advantage of that approach might be more predictable costs for DoD once the payment formulas were constructed. Because contractors in a capitated system would have a profit incentive to minimize costs, the resulting savings would initially accrue to them. However, competition among bidders would tend to convey at least some of those savings to DoD over time. Alternatively, contracts could be constructed so that savings were shared between contractors and DoD from the outset, but that deviation from capitated payments would also weaken the incentive for TRICARE contractors to generate savings in the first place. To the extent that firms bear some of the risk for cost variation that is now borne by DoD, however, the added costs of doing so would be reflected in their bids.

Although the cost per beneficiary would be more apparent, it is not clear that this approach would reduce federal spending. The bidding process might not be competitive because a single regional incumbent that already has an established network of providers in place could have a large advantage over other potential bidders. In addition, most of the capitated contracts seen in the private sector involve substantially higher cost sharing for beneficiaries. If DoD wanted to keep the current out-of-pocket costs about the same for its enrollees, then measurable savings might not accrue. One additional concern involves the incentives to provide health care: Although fee-for-service contracts encourage overtreatment, some researchers have argued that capitated contracts encourage undertreatment.

Approach 3: Change the Way That Military Departments Pay for Health Care

Altering internal budgeting practices to change the way the Army, Air Force, and Navy pay for health care would create pressure within DoD to change the way care is

13. All medical claims are processed by two subcontractors, PGBA, LLC, and Wisconsin Physicians Service Insurance Corporation.

supplied in the Military Health System (and the direct care system in particular)—with the aim of making the system more efficient or more effective (or both). CBO examined two variants of this approach. One would provide fixed payments to the MTFs for the health care they provide beneficiaries. The other would have the departments purchase health care on a fee-for-service basis through an accounting mechanism known as a working capital fund (WCF), which would make the cost of that care more apparent to the services and provide the MHS with some additional flexibility in the way it provides care.

How Might DHA Use a Capitated Budget to Operate Military Treatment Facilities?

Just as TRICARE's regional contractors could receive capitated payments (that is, a fixed amount per enrollee per year) for the care of patients, such a system could be implemented for military treatment facilities. That approach has been tried by DoD before, most recently in 2005. However, the department encountered a number of difficulties when conducting those experiments, including the following: forecasting the number of patients seeking care in a system that did not require beneficiaries to enroll; calculating reimbursement rates that accurately reflected the costs of treating patients; adjusting for risk (particularly for high-cost patients); and enforcing spending caps. When DHA begins to operate the MTFs as a single health care system, as directed by the 2017 NDAA, capitated payments for the MTFs may be more feasible than they were in the past, especially given recent improvements in DoD's method of collecting data at the patient level. Nevertheless, implementing such an approach could still prove difficult.

Currently, DHA provides each military service with funding designated for providing health care. The services then distribute funds to their respective surgeons general, who in turn allocate funds to the MTFs.[14] Some of that funding is used to provide medical care to beneficiaries, and the rest is used for other activities, including graduate medical education, training, and readiness. The funding for all those purposes is intermingled, which would make its disentanglement challenging. The details of the new structure are being developed by DoD, but the most recent plan grants DHA budgetary responsibilities for the MTFs, while service components will oversee the readiness of military physicians, nurses, and other health care providers.[15]

With capitated payments, DHA would provide funds only for medical care of enrolled populations. (That approach would use capitation funding for direct care provided at the MTFs; the previous section examined an approach that would use capitation funding only for care provided by contractors outside of the MTFs.) Once DHA developed a per-beneficiary formula, each MTF would receive funding based on that formula and the number of beneficiaries.

Payments for reimbursing private providers when patients are referred by MTF clinicians to outside providers for care or for the few patients with significantly higher costs than average could be defrayed by DHA using a management reserve fund solely for those purposes: Because government budgeting generally does not allow funds to be used beyond one fiscal year, unless specifically designated otherwise in an appropriation act, some health care funds would have to be designated as multiyear funding.[16] To the extent that health care funding under capitation was insufficient to maintain the MTFs, DHA, along with the military departments, would have to use a different funding source to cover the difference or reduce costs.

Transitioning to a system in which DHA funded only medical care, as opposed to also funding ancillary activities as happens now, would take some time. One transitional mechanism would be for DoD to initially distribute to the Army, Navy, and Air Force amounts equal to the difference between each department's current total funding and the amount that the MTFs could claim as reimbursement for providing health care under capitation. That amount would then decline over time. The military departments could choose to pass all of that transitional funding through to the MTFs; DHA and the military departments could demand greater efficiency from the MTFs by passing through smaller amounts and reallocating the difference to other purposes; or they could close some MTFs if they identified higher priority uses for those funds.

14. DHA currently operates and funds two MTFs: Walter Reed National Medical Center and Fort Belvoir Community Hospital, both in the Washington, D.C., area.

15. See Department of Defense, *Plan to Implement Section 1073c of Title 10, United States Code, Second Interim Report* (June 2017) www.health.mil/Reference-Center/Reports?query=Reform.

16. Most funding in the operation and maintenance appropriation is for one year: It must be obligated within the fiscal year for which it was appropriated. Multiyear funding can be obligated over more than one year.

Using capitation funding would help DoD identify the costs of providing health care to beneficiaries in the MTFs, which could promote more efficient or more effective resource allocation, or both. Employing this approach would present significant challenges, however. Foremost, closing or realigning facilities that are not sustainable in the new capitated environment would probably be viewed as a reduction in benefits both by military families and by those retirees located near MTFs because those people would lose access to free care. In addition, DHA would need a policy for providing additional funding to individual MTFs that were exposed to large financial risk because some patients were extremely expensive to treat. Also, although DoD now has the data necessary to develop a suitable method for determining per-patient expenses, past efforts to implement capitated payments were unsuccessful. Even if those obstacles could be overcome, the new system would be complex, and implementing it would probably take years and result in additional administrative costs that might partially offset potential savings or other benefits, such as cost transparency, that capitation would bring.

How Could Military Health Care Be Funded Through a Working Capital Fund?

Over the years, several large organizations within the Department of Defense have adopted a system in which DoD "customers" (meaning, generally, the deployable elements of the armed forces) purchase services from a DoD supplier, using a set of internal prices. The goal is for customers that require services or commodities to be aware of their cost so that they use them more efficiently. Military paychecks, for instance, are processed by the Defense Finance and Accounting Service (DFAS) for the military departments, which pay DFAS for that service. Similarly, the U.S. Transportation Command (TRANSCOM) provides global transportation of passengers and cargo by air, land, and sea to the military departments and other customers, in peacetime and in wartime, and charges for those services according to a set fee schedule. For instance, the Army can send troops and equipment overseas using TRANSCOM but must pay for that service and thus take its costs into account. Agencies funded in that way can take on work outside of DoD as well. U.S.-based nongovernmental organizations can ship humanitarian supplies using TRANSCOM, for example.

Under this approach, DHA would join those and a few other defense agencies that receive their funding through a WCF, instead of through direct appropriations. With this model, funds would be appropriated by the Congress to defense customers (in this case, the military services). Those customers would place orders with DHA for health care provision and obligate appropriations to pay for those services. DHA would provide health care to beneficiaries (either at MTFs or through civilian providers), incurring costs for labor, materials, and contracts, and adding a surcharge to cover administrative expenses and other overhead costs.

DHA's prices would be set to reflect the expected average costs for health care services. Prices would need to be set at least a year in advance so that the military departments could factor them into their annual budget requests. DHA, in conjunction with its customers, would project how much and what types of health care would be needed, and the costs they would incur. Costs would be allocated across DHA's health care services. The price of each health care service or product would be set as the total expected costs for providing the service divided by the quantity that DHA expected to provide. (Because the provision of health care often involves substantial fixed costs, at least in the short run, allocating costs across services to set prices appropriately could be particularly challenging.)

One advantage of pricing health care in that way is that the cost of providing that care would become more visible. Participating in an agency financed through a WCF could provide greater managerial flexibility as well. For example, WCF agencies can meet increased demand without requesting additional appropriations (although they would draw more appropriated funds from their customers) and can continue to operate during a temporary government shutdown. They also can take on more work for other federal agencies, which the MHS generally does not do.[17] One disadvantage of this approach is that WCF organizations must develop cost-accounting tools to attribute costs to specific outputs, and the current tools used by the MHS might not be sufficient, although it might be able to adopt similar tools that exist in the private sector or that are used by other defense agencies. Pursuing this approach might also require realigning the responsibilities between DHA and the military surgeons general.

17. Some patients of the Veterans Health Administration currently receive selected medical procedures at MTFs.

CHAPTER

3

Specific Options for Changing the Military Health System

CBO has estimated the budgetary effects of two options that have been proposed to change the Military Health System. Option 1—increase cost sharing for most beneficiaries who use TRICARE—is based on changes authorized by the Congress in 2016 and is intended to affect primarily the demand for military health care. The expectation is that higher enrollment fees, copayments, and other costs would cause beneficiaries to reduce the amount of health care services they use or switch to other coverage.[1] In its examination of the first option, CBO found that appreciable reductions in federal spending would be possible within the current structure of the MHS.

Option 2—replace TRICARE with a choice of commercial insurance plans for most beneficiaries—is intended to affect both demand and supply. It is largely based on a proposal made by the Military Compensation and Retirement Modernization Commission (MCRMC).[2] The proposal would affect the demand for medical care because most beneficiaries would see their share of costs increase. It would affect the supply of medical care because, the commissioners believed, commercial insurers could bring innovations seen in the civilian insurance market to the MHS. Such changes could increase the value of health care—that is, they could increase the quality of health care while reducing costs.[3]

Under Option 2, military treatment facilities would operate like any other preferred provider in a commercial network. Thus, they would be reimbursed for care provided under the contracts set with the commercial insurer. For example, the military hospital located in San Diego would become an in-network provider and be reimbursed for care in the same way as the civilian hospital nearby. Consequently, the size and scope of that military hospital would be determined by beneficiaries' demand for its services. If those beneficiaries preferred to go to a civilian hospital, the military hospital would not receive enough funding to retain its current capacity.

Because the supply-side initiatives would bring unprecedented changes to the way MTFs are funded and operated, and because the nature of the new civilian-based market is unknown, a high degree of uncertainty is associated with the estimate of Option 2's budgetary effects. (Details of CBO's estimate and model can be found in the supplemental material that is posted with this report on the agency's website, www.cbo.gov/publication/53137.)

Option 1 could be implemented relatively quickly, but the full effects of Option 2 could take several years. To allow for a more straightforward comparison of the budgetary effects of the two options, CBO estimated the impact on federal costs in three particular years: 2021 (the first full fiscal year in which both options would be implemented), 2026 (5 years later), and 2031 (10 years later). Estimates are provided in constant 2017 dollars.[4]

Option 1 would make no changes to the way health care is supplied, so it would not measurably improve medical readiness or the quality of health care provided. It would, however, reduce federal spending on military health care. Under Option 2, beneficiaries would have more plans from which to choose, with different provider networks and different cost-sharing requirements. Beneficiaries

1. See Willard Manning and others, "Health Insurance and the Demand for Medical Care: Evidence From a Randomized Experiment," *American Economic Review*, vol. 77, no. 3 (1987) www.jstor.org/stable/1804094; and Katherine Swartz, *Cost-Sharing: Effects on Spending and Outcomes,* Research Synthesis Report 20 (Robert Wood Johnson Foundation, December 2010), http://tinyurl.com/oyle4s8 (PDF, 369 KB).

2. See Alphonso Maldon Jr. and others, *Final Report of the Military Compensation and Retirement Modernization Commission* (January 2015), pp. 79–119, www.dtic.mil/docs/citations/ADA625626.

3. For a discussion of value-based initiatives, see Susan D. Hosek and others, *Introducing Value-Based Purchasing Into TRICARE Reform* (RAND Corporation, 2016), www.rand.org/pubs/perspectives/PE195.html.

4. Although general price inflation is removed from the estimates, they incorporate projected cost growth in health care that exceeds the general rate of inflation.

might view those expanded choices as improvements over the TRICARE program. Also, the need to compete with private facilities for patients could increase the quality of care provided at MTFs. CBO did not measure those effects, but the potential for improvement could be relevant for policymakers.

Option 1: Increase Cost Sharing for Most Beneficiaries Who Use TRICARE

This option would modify the changes to the TRICARE program that were authorized in the National Defense Authorization Act for Fiscal Year 2017 (see Box 1-1 on page 12). It would retain a managed care option (Prime) and a preferred-provider health plan (Select), but it would eliminate the two distinct schedules of enrollment fees, copayments, and deductibles—thus requiring that people who entered service before January 1, 2018, and those who enter service after that date to incur the same cost-sharing payments. Under the option, enrollment fees for working-age retirees would be substantially higher than those specified in the 2017 NDAA. In addition, enrollment fees, copayments, and other out-of-pocket costs would be indexed to the future growth in nationwide per capita spending for health care, rather than the cost-of-living index specified in the NDAA.[5]

The Prime and Select plans would both allow users to manage their own care and to see either in-network or out-of-network providers. As is currently the case, beneficiaries who seek care from in-network providers would pay lower out-of-pocket costs than those seeing out-of-network providers. The two TRICARE plans would be offered to the family members of active-duty personnel and to military retirees who are not yet eligible for Medicare and their families. Active-duty members would continue to have their health care provided by the MHS for free, and Medicare-eligible retirees could continue to use TRICARE for Life.

How the Option Would Work

Under this option, beginning in January 2020, active-duty personnel could enroll their family members in either TRICARE Prime (as they can now) or in Select at no cost. Those who enrolled in Select would be subject to an annual deductible, as well as copayments or coinsurance for each visit, depending on whether they saw in-network or out-of-network providers. CBO expects that this part of the option would result in very small changes in either government spending or utilization of health care by the families of active-duty personnel.

Working-age military retirees who wished to enroll in Prime could do so by paying a $650 annual fee for individual coverage or $1,300 for family coverage. The fees would be approximately equivalent to those instituted when TRICARE began providing benefits in 1995—$230 for individual coverage or $460 per family—after adjusting for growth in nationwide per capita health care spending.[6] (The enrollment fees would be approximately double those authorized in the 2017 NDAA, but all other out-of-pocket costs would be the same as those stipulated by that legislation.)

Retirees (or surviving spouses) who wanted coverage from TRICARE's preferred provider plan (Select)—which would include both in-network and out-of-network coverage—could enroll and pay an annual fee of $450 for individual coverage or $900 for family coverage. For visits to civilian providers, beneficiaries would pay copayments that matched the new amounts

5. CBO recently published a cost estimate for S. 1519, the National Defense Authorization Act for Fiscal Year 2018. Section 707 of that bill would apply the higher out-of-pocket costs enacted in the National Defense Authorization Act for Fiscal Year 2017 (P.L. 114-328) to almost all working-age retirees, even those who began their service before 2018. See Congressional Budget Office, cost estimate for S. 1519, the National Defense Authorization Act for Fiscal Year 2018 (August 3, 2017), www.cbo.gov/publication/52991. The savings from Option 1 would be greater than the savings from S. 1519 because Option 1 would impose higher enrollment fees, and out-of-pocket costs would increase each year with the rate of growth of medical inflation. CBO also has previously estimated the effects of increasing out-of-pocket costs for working-age retirees in its biennial volume on options for reducing the deficit. For instance, see Congressional Budget Office, "Health Option 15: Modify TRICARE Enrollment Fees and Cost Sharing for Working-Age Military Retirees," *Options for Reducing the Deficit: 2017–2026 (*December 2016), pp. 263–264, www.cbo.gov/publication/52142. The estimates for Option 1 are similar to the estimates in that volume. Differences are attributable to the effects of recently enacted legislation, updated economic inputs, and differences in the out-of-pocket costs postulated for the estimates.

6. As a point of comparison, the least expensive health maintenance organization available to federal civilians in the Mid-Atlantic region (where most federal civilians reside) costs the employee $1,450 per year for individual coverage and $3,400 per year for family coverage. See Kaiser Permanente, *2017 Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.,* RI 73-047 (October 2016), p. 102, http://tinyurl.com/y7atqukl (PDF, 463 KB).

authorized by the Congress in the 2017 NDAA, while treatment at MTFs would continue to be free. Retirees also would have an annual deductible of $150 per individual or a family deductible of $300 for in-network care, and deductibles of $300 per individual and $600 per family for out-of-network care.

Effects of the Option

CBO finds that increasing the share of health care costs paid by most TRICARE beneficiaries, beginning in January 2020, could reduce federal discretionary spending by about $2.9 billion in 2031. There is some uncertainty associated with the estimate because of the possibility that the Department of Defense would retain capacity in the MTFs that exceeded the amount required for the care of beneficiaries. There would also be a small reduction ($0.4 billion) in revenues collected annually by the federal government, as some beneficiaries would switch from TRICARE to health care plans offered by their civilian employers. Thus, the net effect of Option 1 would be to reduce the deficit by $2.5 billion in 2031, if the Congress reduced discretionary spending accordingly.

Effects on Discretionary Costs. The increased out-of-pocket expenses for beneficiaries would reduce DoD's discretionary costs for the TRICARE program, both directly, as enrollees used fewer services, and indirectly, as Prime members switched to Select or to civilian care provided by their current employers or some other source.[7] As the amount of care provided by some MTFs decreased, the direct care system would have excess capacity if DoD did not adjust its size. However, DoD might be unable to eliminate some of that capacity because of training needs or for other reasons. Paying to maintain some or all of that excess capacity would limit the savings associated with higher fees and copayments.

According to CBO's estimates, if TRICARE fees, copayments, and deductibles were modified as specified in Option 1, and if DoD could only decrease excess capacity by about half, discretionary costs for DoD's TRICARE program would be reduced, on net, by $1.6 billion in 2021 (in 2017 dollars). Savings in 2031, when the benefit changes were fully implemented and any capacity reductions had been made, would equal about $3.2 billion (see Table 3-1). Because the initial enrollment fees for working-age retirees would be higher than those specified in the 2017 NDAA and because this option would index out-of-pocket costs to medical inflation (rather than to the cost-of-living adjustment for retiree pensions, which is equal to the annual increase in the consumer price index), the option would produce estimated savings larger than those expected under the NDAA for all future years.

Discretionary spending outside of DoD would increase slightly under the option. Some eligible retirees would switch to other discretionary federal programs—such as the Federal Employees Health Benefits (FEHB) program (if the person or his or her spouse was employed as a civilian by the federal government) or the Veterans Health Administration—increasing the costs of those programs. Some of those increases would be offset by reductions in spending on health care for current members of the uniformed services outside of DoD (specifically, the Coast Guard, and commissioned officers in the Public Health Service and the National Oceanic and Atmospheric Administration). On net, about $0.3 billion in additional spending would be needed for those programs in 2031, CBO projects, so the overall reduction in discretionary costs would be $2.9 billion in that year.

Effects on Mandatory Spending and Revenues. Some low-income people would switch to Medicaid, thereby increasing mandatory spending. However, those increases in mandatory spending would be roughly offset by reduced mandatory spending on the TRICARE-related health care costs of retired members of the non-DoD uniformed services—the net effect being that the change in mandatory spending would be close to zero in 2031.[8]

The changes in TRICARE fees also would cause some current users to shift to health care plans sponsored by their employers in the private sector. Because premiums paid by employers for employment-based health insurance are not subject to federal income tax, the change would lead to a shift in overall compensation from taxable wages to nontaxable fringe benefits. CBO and the staff of the Joint Committee on Taxation estimate that

7. In this chapter, CBO uses the word "costs" to describe the changes in discretionary funding that would need to be appropriated by the Congress.

8. Health care costs for retired uniformed members of the Coast Guard, the Public Health Service, and the National Oceanic and Atmospheric Administration are paid from mandatory spending accounts. By contrast, DoD pays for the health care of its retirees who are not yet eligible for Medicare out of its annual discretionary appropriation.

Table 3-1.

Estimated Budgetary Effects of Option 1: Increasing Cost Sharing for Most Beneficiaries Under TRICARE

Billions of 2017 Dollars

	2021	2026	2031
Changes in Discretionary Budget Authority [a]			
Department of Defense	-1.6	-2.3	-3.2
VHA, FEHB program, and other uniformed services	0.1	0.2	0.3
Net Impact on Discretionary Budget Authority	-1.5	-2.1	-2.9
Other Budgetary Effects			
Change in mandatory outlays[b]	*	*	*
Change in revenues[c]	-0.3	-0.3	-0.4

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would increase the annual enrollment fee for retirees who use TRICARE Prime to $650 for individuals and $1,300 for families. It also would create an enrollment fee for TRICARE Select of $450 for individuals and $900 for families and would have separate deductibles for in-network and out-of-network care. In addition, it would increase copayments. All fees and deductibles would increase each year at the rate of per capita medical inflation. This estimate is based on the assumption that the change would become effective in calendar year 2020.

FEHB = Federal Employees Health Benefits; VHA = Veterans Health Administration; * = between -$50 million and $50 million.

a. For the discretionary effects of the option, changes in outlays would approximately equal the changes in budget authority.

b. Mandatory spending would increase because some retirees would rely more heavily on certain mandatory federal programs, such as Medicaid (if they have low incomes) or the FEHB program (if they have retired from the federal civil service). However, mandatory spending would decline for retirees associated with the Coast Guard, the Commissioned Officer Corps of the National Oceanic and Atmospheric Administration, and the uniformed corps of the Public Health Service. The combined effect is shown on the table.

c. Negative numbers represent a loss of revenues. About 28 percent of the estimated revenues for each year (about $0.1 billion in 2031) would come from Social Security payroll taxes and so would be classified as off-budget. Revenues would decrease because many working-age retirees would increase their use of employment-based health plans, which would reduce taxable income.

this shift would result in a reduction of about $0.4 billion in federal revenues in 2031 (in 2017 dollars).[9]

Option 2: Replace the TRICARE Health Plans With a Choice of Commercial Insurance Plans for Most Beneficiaries

Beginning in January 2020, this option, based on the one proposed by the Military Compensation and Retirement Modernization Commission, would:

- Eliminate the TRICARE health plans and contracts and establish a system of private insurance plans from which families of active-duty personnel and working-age retirees could choose;
- Provide an allowance to the families of active-duty personnel to cover their median health insurance plan premiums and average out-of-pocket costs (the private insurers would specify what the new cost-sharing requirements would be); and
- Require most MTFs to become in-network providers in commercial health plans and be reimbursed for care.

How the Option Would Work

Under this option, active-duty personnel would still receive care at MTFs, and Medicare-eligible beneficiaries could continue to use TFL. (Thus, MTFs would continue to receive appropriated funds for the care of active-duty personnel and reimbursement from the Medicare-Eligible Retiree Health Care Fund for the care of Medicare-eligible retirees.) Service members who wished to purchase health insurance for their families would pay 28 percent of the premium for the plan they chose. Those service members would receive a tax-free allowance to offset average costs for family premiums and other out-of-pocket expenses. Service members could keep any part of the allowance that was unspent at

9. Of the estimated $445 million reduction in revenues that would result in 2031, about $125 million would come from Social Security payroll taxes and would be classified as off-budget.

the end of the year.[10] Working-age retirees who wished to purchase health insurance for themselves or their families would pay 20 percent of their chosen plan's premium but would receive no allowances to offset those higher expenses.

Family members of active-duty personnel and working-age retirees and their families would be subject to the copayments or coinsurance costs established by their chosen plan and would have to pay for care obtained from MTFs rather than receiving that care for free. For this estimate, CBO assumed that TRICARE reimbursement rates to civilian providers would no longer be tied to Medicare rates, as they are currently, so that reimbursement costs would be higher under the option than under current law.[11]

Effects of the Option

CBO finds that changing the TRICARE program in the way the MCRMC proposes would have small budgetary effects once it was phased in, but the estimates are highly uncertain. Two factors—the provision of allowances to families of active-duty members and the possibility that DoD would retain capacity in the MTFs that exceeded the amount required for beneficiaries—would offset the budgetary savings that would result if retiree families paid higher premiums and copayments.

Effects on Discretionary Costs. In CBO's estimation, the effects on the demand for health care would be larger under this option than those seen in Option 1 because beneficiaries' cost-sharing requirements in the new system would be greater, on average, than those under Option 1. Despite the reductions in demand that would result from those higher out-of-pocket expenses, discretionary costs for DoD would increase by about $2.7 billion in 2021, CBO estimates (see Table 3-2). Costs for DoD would increase in part because of the higher reimbursement rates paid to providers, but also because of the new allowances and the likelihood that DoD would retain excess capacity in its direct care system—all of which would more than offset the potential savings for DoD from reduced demand. By 2031, if the excess capacity in the system was reduced by about half, DoD could see a small reduction in costs (of about $0.4 billion per year, in 2017 dollars). The estimated budgetary effects are very sensitive to that judgment about the reduction in excess capacity.

Discretionary costs for the Veterans Health Administration, FEHB program, and the other uniformed services would increase by an additional $0.2 billion in that year, largely because of military retirees' leaving TRICARE and relying more on the care provided by VHA. Thus, under Option 2, discretionary costs for the federal government as a whole would decrease by about $0.2 billion in 2031 (in 2017 dollars), CBO estimates.

Comparison With the MCRMC's Estimate. The MCRMC estimated that implementing its proposal could reduce DoD's spending for health care by about $3.2 billion per year (which represents about 6 percent of MHS's annual spending).[12] According to the Commissioners' findings, about two-thirds of the savings ($2.2 billion annually) would come from higher cost sharing paid by beneficiaries. In the Commissioners' estimation, private-sector health plans would offer better management of beneficiaries' health care usage and outcomes and would be able to reduce the program's overhead and management expenses—thus accounting for the remainder of the savings. They based their conclusions on the expectation that the MTFs—as in-network providers in a commercial system—could provide sufficient care to cover their operating costs, perhaps by charging patients lower out-of-pocket costs than other providers. They also assumed that MTFs could treat other populations, including veterans or local civilians. But if MTFs could not attract enough business to cover

10. Families that faced catastrophic illness would be able to apply for relief under a program that DoD would establish specifically for that purpose.

11. Recent reports show that commercial insurance payments to physicians are about 25 percent higher than similar payments from Medicare and that payments to hospitals are, on average, about 75 percent higher under commercial insurance plans. See Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy* (March 2016), pp. 82 and 94, https://go.usa.gov/xncBB (PDF, 5.6 MB). Also see Thomas M. Selden and others, "DATAWATCH: The Growing Difference Between Public and Private Payment Rates for Inpatient Hospital Care," *Health Affairs*, vol. 34, no. 12 (December 2015), pp. 2147–2150, http://doi.org/10.1377/hlthaff.2015.0706; and Jared Lane Maeda and Lyle Nelson, *An Analysis of Private-Sector Prices for Hospital Admissions*, Working Paper 2017-02 (Congressional Budget Office, April 2017), www.cbo.gov/publication/52567.

12. For an analysis of the estimated savings, see Sarah K. Burns, Philip M. Lurie, and Stanley A. Horowitz, *Analyses of the Military Healthcare Benefit Design and Delivery: Study in Support of the Military Compensation and Retirement Modernization Commission,* IDA Paper P-5213 (Institute for Defense Analyses, January 2015), www.dtic.mil/docs/citations/ADA617159.

Table 3-2.

Estimated Budgetary Effects of Option 2: Replacing TRICARE With a Choice of Commercial Insurance Plans for Most Beneficiaries

Billions of 2017 Dollars

	2021	2026	2031
Changes in Discretionary Budget Authority [a]			
Department of Defense	2.7	1.3	-0.4
VHA, FEHB program, and other uniformed services	0.2	0.2	0.2
Net Impact on Discretionary Budget Authority	3.0	1.5	-0.2
Other Budgetary Effects			
Change in mandatory outlays[b]	*	*	*
Change in revenues[c]	-0.6	-0.8	-0.9

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would replace TRICARE with a choice of private insurance plans from which family members of active-duty personnel and working-age retirees could choose. Average deductibles and copayments would increase, but families of active-duty service members would receive an allowance to offset those costs. MTFs could become preferred providers in the private networks and be reimbursed for care. Reductions in excess capacity of the MTFs would be phased in over 10 years. This estimate is based on the assumption that the change would become effective for all beneficiaries beginning in calendar year 2020.

FEHB = Federal Employees Health Benefits; MTFs = military treatment facilities; VHA = Veterans Health Administration;

* = between -$50 million and $50 million.

a. For the discretionary effects of the option, changes in outlays would approximately equal the changes in budget authority.

b. Mandatory spending would increase because some retirees would rely more heavily on certain mandatory federal programs, such as Medicaid (if they have low incomes) or the FEHB program (if they have retired from the federal civil service). However, mandatory spending would decline for retirees associated with the Coast Guard, the Commissioned Officer Corps of the National Oceanic and Atmospheric Administration, and the uniformed corps of the Public Health Service. The combined effect is shown on the table.

c. Negative numbers represent a loss of revenues. About 28 percent of the estimated revenues for each year (about $0.2 billion in 2031) would come from Social Security payroll taxes and so would be classified as off-budget. Revenues would decrease because many retirees would increase their use of employment-based health plans, which would reduce taxable income.

their costs, their excess capacity could be eliminated by DoD, in their estimation. Because some of the new plans could offer greater choice to consumers than is currently offered by TRICARE, the Commissioners argued, the overall quality of health care would increase as well.

CBO's estimate differs from the MCRMC's plan in two significant ways. First, the MCRMC proposed phasing in the higher premiums over 15 years to help retirees adjust to the new plan. However, to examine the full effect of the proposal, CBO based its estimate on the assumption that the new premiums and other cost-sharing requirements would take effect in 2020. Second, and of greater importance in assessing the long-term effects, the MCRMC assumed that the direct care system—that is, the MTFs—could be part of the commercial plan network, much like any other private provider, and could adjust its capacity to reflect the demand for its services. By contrast, CBO considered the likelihood that the direct care system would have excess capacity that DoD would retain through subsidies.

The MCRMC proposal also would change how a portion of military health care is funded: It would fund the benefit for younger retirees in the same way the TFL program is financed, so that health care for *all* retirees (not just those who are eligible for Medicare) would be funded through accrual charges. Under an accrual budget, DoD pays for the future benefits of people who are currently providing military service. By contrast, with a cash system, the current year's defense budget reflects the cost of pensions or health care benefits provided now

to retirees who ceased contributing to national security years earlier. The accounting effects of switching to an accrual fund, however, would make it hard to observe the budgetary effects of altering the TRICARE benefit. For this portion of the analysis, CBO therefore estimated the effects of changes in benefits under a cash-accounting system—that is, when DoD pays for the health benefits of retirees as they are incurred—and explored the effects of accrual funding separately (see Box 3-1). Although accrual funding would affect DoD's budget, it would not affect the federal budget deficit or surplus.

Uncertainty About Discretionary Costs. Under this option, the effects on DoD's costs are substantially more uncertain than in Option 1 because the program would be significantly different from the current TRICARE program. In particular, CBO had to consider two related variables when estimating the effects of Option 2:

- The extent to which beneficiaries would leave MTFs in favor of private providers, and
- The ability of DoD to reduce the excess capacity in MTFs if the direct care system was not able to fully cover its costs by providing health care.

For the purposes of this estimate, CBO took the midpoint of the distributions for both key variables. In CBO's view, it is likely that some patients would switch from MTFs to private-sector care because they would face cost sharing for services from MTFs. In addition, some MTFs might not be part of the providers' networks. Those changes would leave excess capacity in the direct care system. If DoD maintained all of the excess capacity—for readiness or other reasons—subsidies to the affected MTFs might be required, and discretionary costs would increase. If DoD could reduce all of the excess capacity, then the direct care system would be fully funded for the health care it provided, and no discretionary spending would be required to subsidize it.[13] CBO estimated that the workload in the direct care system would be reduced by about half and that DoD would choose to retain that capacity through subsidies. Small variations in those factors could cause large changes in the estimates. Evaluated at the midpoint of the ranges, discretionary costs would decrease by about $200 million per year, CBO estimates, but costs could fall in a likely range from about $3.7 billion in annual savings to about $3.2 billion in annual costs.

An additional source of uncertainty about the effects of this option relates to the integration of MTFs into the provider networks of commercial health plans, a process that could be quite difficult. The MTFs would have to shift from their current financing through DoD's budget to arrangements in which they received much of their funding from those health plans. And they would still need to provide and budget for their care of active-duty personnel. The commercial health plans would have to determine their premium bids despite substantial uncertainty about the pricing and use of care at MTFs. Because those facilities are generally located close to military families and represent their usual source of care, health plans that did not include MTFs in their networks might have trouble attracting enrollees. Private hospitals might view military facilities as competitors and raise concerns with insurers about including military hospitals in civilian networks. Much would depend on local conditions, but the operational challenges of implementing such a shift would be substantial and it could take much longer than anticipated by the MCRMC or by CBO.

Effects on Mandatory Spending and Revenues. Like Option 1, this option also would affect mandatory spending and tax revenues. Mandatory spending would decrease slightly, CBO estimates, by about $15 million annually (in 2017 dollars), primarily because of reduced spending for retirees who served in the Coast Guard and for uniformed members of the Public Health Corps.

The changes in TRICARE fees also would cause some working-age retirees to shift to health care plans sponsored by their current employers in the private sector. Because employment-based health insurance premiums are not subject to federal income tax, the change would lead to a shift in overall compensation from taxable wages to nontaxable benefits. CBO and the staff of the Joint Committee on Taxation estimate this shift would

13. Under Option 2, MTFs potentially would receive funding from several sources. They would receive appropriated funds related to the care of active-duty personnel, plus any funding related to excess capacity. They would receive funding from the MERHCF for those retirees who are eligible for TFL. And they would receive funding from private health plans for care provided as part of the network. It could be more difficult to identify the cost of operating an MTF under the option than it is under the current system.

Box 3-1.

The Effects of Implementing Accrual Funding for Working-Age Retirees Under Option 2

The Department of Defense (DoD) currently uses a cash-accounting system to record payments for the health care benefits of working-age retirees—that is, costs are recorded as they are incurred. Consequently, decisionmakers may be more likely to determine the size and composition of the force with little regard for the implications of the costs of retirees' future health care coverage. By contrast, under an accrual system, the cost of those future benefits would be reflected in DoD's current budget through accrual charges, potentially giving the department and policymakers a better picture of the full costs of military personnel. The accrual payments from DoD represent an intragovernmental transfer and do not affect the federal budget as a whole. Both military retirement pay and the TRICARE for Life (TFL) program are funded from accrual accounts.

The Congressional Budget Office examined a proposal made by the Military Compensation and Retirement Modernization Commission that would expand the accrual fund currently used to pay for the health care of Medicare-eligible enrollees in TFL in several steps to include the health care costs of working-age retirees (and their families). Under that proposal, discretionary spending by DoD for the care that is currently provided to retirees and their family members would be eliminated, except for the accrual charge. That reduction, net of the added cost of new allowances for active-duty families and reservists, would total about $16.8 billion annually in the steady state (as represented in 2031), CBO estimates (see the table).[1]

DoD would not be responsible for funding the cost of benefits attributable to military service before 2020. The Treasury would make payments into the fund to cover that liability for past service. Because that transaction would be a mandatory outlay with a corresponding mandatory receipt, there would be no budgetary implications for DoD or the federal government as a whole (hence, they are not described in the table.)

To add the health care costs of younger retired beneficiaries to the existing fund for older retirees, however, DoD and the other uniformed services (the Coast Guard, the Public Health Service, and the National Oceanic and Atmospheric Administration) would pay an additional accrual charge into the fund each year for the future health care benefits that are earned in that year. Those payments would be determined by DoD's Board of Actuaries so that the contributions, together with the interest, would fund the expected future medical benefits. Using the most recent economic assumptions approved by the board, CBO estimates that those new accrual payments would amount to about $13 billion per year in steady state (in 2031, expressed in 2017 dollars).

Under current law, DoD's accrual payments for the TFL program are uniform regardless of the branch of service or rank, so CBO's estimates of the effects of Option 2—replace TRICARE with a choice of commercial insurance plans for most beneficiaries—are similarly uniform.[2] According to information obtained from DoD's Office of the Actuary, in 2016, the most recent year for which published data are available, that office used an inflation rate of 2.75 percent, a nominal discount rate of 5.5 percent, and an expected nominal rate of growth for medical expenditures of 5.5 percent.[3]

The overall reduction in discretionary costs across the federal budget in 2031 would equal about $3.2 billion. DoD would receive payments from the fund for the care it provides to those beneficiaries. Payments from the accrual fund would be considered mandatory spending and would equal about $16 billion per year (in 2017 dollars), CBO estimates.

1. Estimated annual costs are shown in the "steady state"—that is, when the benefit changes would be fully implemented and any capacity reductions would have been made, which CBO projects would happen by 2031.

2. The only distinction in the payments is between those for full-time service members and those for part-time reservists. Because part-time reservists are less likely to reach retirement, the accrual charges for them are lower than the charges for full-time personnel. Even reservists who do retire cannot draw health benefits until they start receiving an annuity (at roughly age 60).

3. See Department of Defense, Office of the Actuary, *Valuation of the Medicare-Eligible Retiree Health Care Fund* (December 2016), pp. D-2–D-3, https://go.usa.gov/xX3JV (PDF, 2.27 MB).

Continued

Box 3-1. Continued

The Effects of Implementing Accrual Funding for Working-Age Retirees Under Option 2

Estimated Budgetary Effects of Replacing TRICARE With Private Insurance and Using Accrual Funding

Billions of 2017 Dollars

	2021	2026	2031
Changes in Discretionary Budget Authority[a]			
Department of Defense			
Defense Health Program	-10.8	-13.5	-16.8
New accrual payments	9.6	11.4	13.4
VHA, FEHB program, and other uniformed services	0.2	0.2	0.2
Net Impact on Discretionary Budget Authority	-1.0	-1.8	-3.2
Other Budgetary Effects			
Change in mandatory outlays[b]	13.5	14.7	16.2
Change in revenues[c]	-0.6	-0.8	-0.9
Receipt of accrual payments (nonscorable)[d]	-9.6	-11.4	-13.4

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would replace TRICARE with a choice of private insurance plans from which family members of active-duty personnel and working-age retirees could choose. DoD would pay the estimated future costs of the current force for retiree health care into an accrual fund. Average deductibles and copayments would increase, but families of active-duty service members would receive an allowance to offset those costs. MTFs would become preferred providers in the private networks and be reimbursed for care. Reductions in excess capacity at MTFs would be phased in over 10 years. This estimate reflects the assumption that the change would become effective for all beneficiaries beginning in calendar year 2020.

FEHB = Federal Employees Health Benefits; MTFs = military treatment facilities; VHA = Veterans Health Administration.

a. For the discretionary effects of the option, changes in outlays would approximately equal the changes in budget authority.

b. Under accrual accounting, the health care costs of working-age retirees would be paid from a mandatory account, so the change in mandatory outlays in this table is larger than the comparable change in Table 3-2. To crosswalk the estimates in this table with those in Table 3-2, one would eliminate the payment and receipt of the accrual payments and add together the lines for "Defense Health Program" and "Change in Mandatory Outlays," which would approximately equal the line for "Department of Defense" in Table 3-2. Any differences are due to rounding. Although accrual accounting would affect DoD's budget and mandatory spending, it would not affect the budget deficit or surplus.

c. Negative numbers represent reductions in budget authority or a loss of revenues. About 28 percent of the estimated revenues for each year would come from Social Security payroll taxes and so would be classified as off-budget. Revenues would decrease because many retirees would increase their use of employment-based health care plans, which would reduce taxable compensation.

d. New accrual payments would be offset one-for-one by the receipt of those payments into the accrual fund. However, for budget-enforcement purposes, the receipt of those payments could not be used to offset mandatory outlays.

Table 3-3.

Detailed Estimates of the Cost of Health Care for an Average Family Using TRICARE in 2031

2017 Dollars

	Working-Age Retirees and Their Families[a]			Families of Active-Duty Personnel[b]		
	Current Program	Option 1	Option 2	Current Program	Option 1	Option 2
Health Care Costs for a Family						
Paid by the government	24,100	21,900	21,000	24,300	24,200	14,800
Paid by a family	1,900	3,300	7,500	300	300	7,900
Total cost per family	26,000	25,300	28,500	24,600	24,500	22,700
Costs to the Government						
Health care costs for a family	24,100	21,900	21,000	24,300	24,200	14,800
Allowance paid to a family	n.a.	n.a.	n.a.	n.a.	n.a.	7,900
Additional subsidy to retain capacity at MTFs[c]	n.a.	200	2,500	n.a.	0	4,400
Total cost per family	24,100	22,100	23,500	24,300	24,200	27,100
Costs to a Family						
Health care costs paid out of pocket	1,900	3,300	7,500	300	300	7,900
Allowance received from the government	n.a.	n.a.	n.a.	n.a.	n.a.	-7,900
Total cost per family	1,900	3,300	7,500	300	300	0

Source: Congressional Budget Office.

A family is defined as a household that relies on TRICARE for 100 percent of its health care.

Estimated annual costs are shown in the "steady state"—that is, when the benefit changes would be fully implemented and any capacity reductions would have been made, which CBO projects would happen by 2031.

MTFs = military treatment facilities; n.a. = not applicable.

a. The average retiree family consists of three people, including the retiree sponsor who is not yet eligible for Medicare.

b. The average active-duty family consists of three people, not including the sponsor.

c. The potential subsidies required to retain capacity at MTFs under the options are uncertain. CBO estimates that the likely range of possible outcomes varies from zero to $400 per retiree family in Option 1, from zero to $4,900 per retiree family under Option 2, and from zero to $8,700 per active-duty family under Option 2.

result in a reduction of about $900 million in federal revenues in 2031.[14]

Comparing the Estimated Average Costs per Family of Each of the Two Options

Each of the options would have different implications for the government and for families of both active-duty service members and military retirees (see Table 3-3).

Costs for Retiree Families. In 2031, under current law, the average retiree family is expected to cost the federal government about $24,000 (in 2017 dollars), and that family's out-of-pocket costs are expected to amount to about $2,000.[15] Both options would reduce the government's costs for the average retiree family, CBO estimates, largely by increasing beneficiaries' premiums, fees, or other out-of-pocket costs.

Under Option 1, retiree families would see their costs rise by about $1,400 annually. Under Option 2, retiree families could see their out-of-pocket costs rise by about $5,600 per year, growing to about four times their share under the current program. (Cost-sharing requirements would not be specified under Option 2, so estimating

14. Of the estimated $0.9 billion reduction in revenues that would result in 2031, about $0.2 billion would come from Social Security payroll taxes and would be classified as off-budget.

15. The per-family calculations are composites and have been weighted by the proportion of families using the different TRICARE plans.

what enrollees would pay in premiums and what cost sharing they would incur is difficult. CBO judged that the new cost-sharing and provider reimbursement rates would be comparable to those seen in the civilian sector, particularly in the FEHB program, because the new system would resemble that program in some respects.)[16]

Costs for Active-Duty Families. For the average active-duty family, the total cost to the government would be similar under current law and under Option 1, equaling a little more than $24,000 annually in either case. However, the government's cost per family would rise under Option 2, to more than $27,000, because DoD would be paying for the health care of those families as well as the costs required to retain excess capacity at MTFs. Nevertheless, the quantity of care used by active-duty families and retirees would decline, CBO projects, because increased out-of-pocket expenses would reduce their use of health care.[17]

Effects of Excess Capacity on the Government's Costs. The net effects of Option 2 (and to a lesser extent Option 1) for both retiree and active-duty families would depend on the extent to which DoD retained all of the current capacity in the direct care system. Under Option 2, the annual cost to the government per active-duty family to maintain about half the excess capacity at MTFs would be $4,350, with a likely range of zero to $8,700 per family per year. The comparable amount for a retiree's family would be about $2,460 per year, ranging between zero and $4,920 per year. Because active-duty families tend to use the direct care system more intensively than retiree families, the financial effect on MTFs would be larger if more of those families switched to civilian network providers under the options.

16. Utilization is currently higher among TRICARE Prime enrollees than users of civilian plans. See Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality, Fiscal Year 2016 Report to Congress* (February 2016), pp. 85 and 90, https://go.usa.gov/x9hDN.

17. Because active-duty families would no longer have health care as an in-kind benefit but would instead receive allowances to offset the higher average premiums under Option 2, CBO estimates that their use of health care would probably decrease by about 18 percent.

Appendix: Cost Sharing in TRICARE Under Current Law

The deductibles, copayments, and other fees that TRICARE users face depend on several factors: whether the beneficiary is serving on active duty, is a family member or surviving spouse of an active-duty service member, or is retired from the military. Other considerations are the type of TRICARE plan the beneficiary qualifies for and uses—Prime, Extra, or Standard—and whether the individual receives care in a military treatment facility or from a civilian provider.

This appendix provides an overview of the various fees that certain TRICARE users pay. The accompanying tables provide a more detailed breakdown of those costs.

- Active-duty members and their families who use Prime (a managed care option similar to a health maintenance organization, or HMO) pay no out-of-pocket costs (see Table A-1). Family members can use Extra or Standard (a preferred provider network, known as a PPO in the civilian sector), both of which allow more choice of providers but require a deductible and some cost sharing.

- Retirees and their families who are not yet eligible for Medicare (sometimes called working-age retirees) pay nothing if they rely on military treatment facilities for their care. If they choose to use civilian providers within the Prime network, they face lower costs than those who rely on the Extra network or pay Standard out-of-network charges (see Table A-2). They pay a larger share of costs than family members of people on active duty.

Table A-1.

Costs Incurred by Active-Duty Service Members and Their Families Under TRICARE in 2017

	Prime (HMO)[a]	Extra (PPO, in network)[b]	Standard (PPO, out of network)
Annual Enrollment Fee	0	0	0
Annual Deductible for Civilian Care[b]	0	$50 single/$100 family for E-4 and below; $150/$300 for E-5 and above	$50 single/$100 family for E-4 and below; $150/$300 for E-5 and above
Outpatient Visit	0	15% of negotiated charge	20% of allowed charges for covered service
Emergency Services	0	15% of negotiated charge	20% of allowed charges for covered service
Mental Health Visit	0	15% of negotiated charge	20% of allowed charges for covered service
Inpatient Hospitalization	0	$18 per day ($25 minimum charge)	$18 per day ($25 minimum charge)
Catastrophic Cap[c]	$1,000	$1,000	$1,000

Source: Department of Defense, Office of Health Affairs.

E-4 and E-5 denote military pay grades.

HMO = health maintenance organization; PPO = preferred provider organization.

a. Beneficiaries participating in Prime receive priority treatment when they make appointments at military treatment facilities. Those participants can see specialty providers without a referral under a "point-of-service" (POS) alternative. The POS alternative has a deductible that ranges from $300 (for individual coverage) to $600 (for family coverage) and 50 percent cost sharing.

b. Cost sharing begins after the outpatient deductible is met.

c. The catastrophic cap is the annual maximum a family would have to pay for TRICARE-covered services. Some costs do not count toward that cap.

Table A-2.

Costs Incurred by Working-Age Retirees and Their Families Under TRICARE in 2017

	Prime (HMO)[a]	Extra (PPO, in network)[b]	Standard (PPO, out of network)
Annual Enrollment Fee	$282.60 single/ $565.20 family	0	0
Annual Deductible for Civilian Care[b]	0	$150 single/$300 family	$150 single/$300 family
Outpatient Visit	$12	20% of negotiated charge	25% of allowed charges
Emergency Services	$30	20% of negotiated charge	25% of allowed charges
Mental Health Visit	$12	20% of negotiated charge	25% of allowed charges
Inpatient Hospitalization	$11/day ($25 minimum)	In Network: $250/day or 25% for hospital services (whichever is less) plus 20% for separately billed professional charges	$848 per day or 25% of institutional services (whichever is less) plus 25% for separately billed professional charges
Catastrophic Cap[c]	$3,000	$3,000	$3,000

Source: Department of Defense, Office of Health Affairs.

HMO = health maintenance organization; PPO = preferred provider organization.

a. Beneficiaries participating in Prime receive priority treatment when they make appointments at military treatment facilities. Those participants can see specialty providers without a referral under a "point-of-service" (POS) alternative. The POS alternative has a deductible that ranges from $300 (for individuall coverage) and $600 (for family coverage) and 50 percent cost sharing.

b. Cost sharing begins after the outpatient deductible is met.

c. The catastrophic cap is the annual maximum a family will have to pay for TRICARE-covered services. Some costs do not count toward this cap.

List of Tables and Figures

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About This Document

This Congressional Budget Office report was prepared at the request of the Chairman of the House Budget Committee in the 114th Congress. In keeping with CBO's mandate to provide objective, impartial analysis, the report makes no recommendations.

The report was prepared by Carla Tighe Murray and Elizabeth Bass, with guidance from Matthew Goldberg (formerly of CBO) and David Mosher. Matthew Schmit prepared the cost estimates. Phil Ellis (formerly of CBO), Allison Percy, Matthew Schmit, and David Weaver provided useful comments, as did Sarah Burns of the Institute for Defense Analyses, Susan Hosek of the RAND Corporation, and Laura Junor of the National Defense University. (The assistance of external reviewers implies no responsibility for the final product, which rests solely with CBO.)

Jeffrey Kling, John Skeen, and Robert Sunshine reviewed the report, Loretta Lettner edited it, and Jorge Salazar prepared it for publication. An electronic version and supplemental material are available on CBO's website (www.cbo.gov/publication/53137).

Keith Hall
Director
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