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Approaches to Reducing Federal Spending on National Defense

Presentation to the Manpower Roundtable

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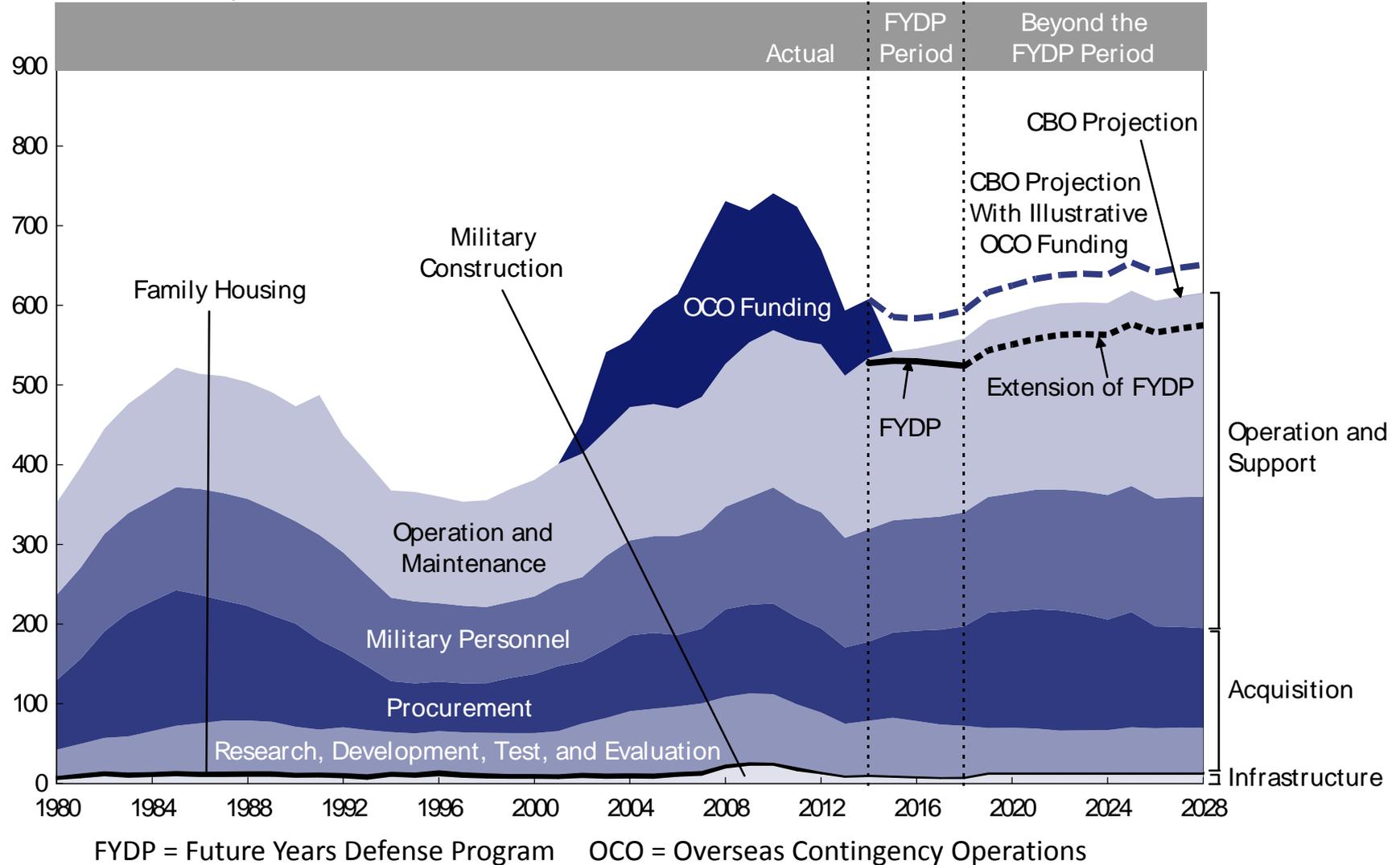
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This presentation provides information published in *Long-Term Implications of the 2014 Future Years Defense Program* (November 2013) and *Options for Reducing the Deficit: 2014 to 2023* (November 2013).

See www.cbo.gov/publication/44683 and www.cbo.gov/budget-options/2013/44687.

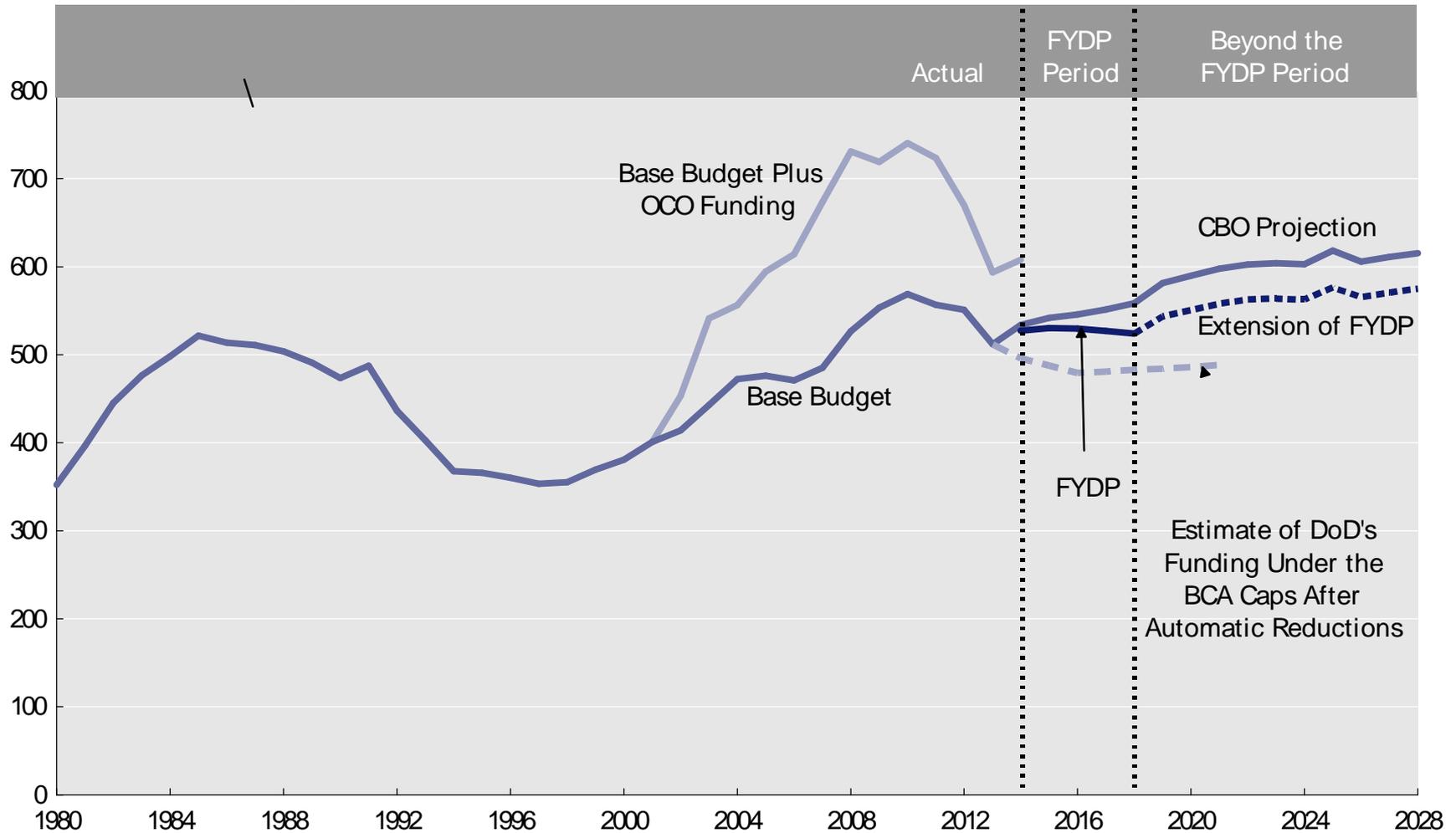
Cost of DoD's Plans, by Appropriation Category

(Billions of 2014 dollars)



Cost of DoD's Plans Compared with Funding Caps

(Billions of 2014 dollars)



FYDP = Future Years Defense Program OCO = Overseas Contingency Operations BCA = Budget Control Act

Reduce the Size of the Military to Satisfy Caps Under the Budget Control Act

(Billions of dollars)	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	Total		
											2014-2018	2014-2023	
Change in Spending													
Budget authority	0	-28	-39	-49	-45	-66	-73	-80	-86	-86		-161	-552
Outlays	0	-18	-31	-42	-43	-57	-67	-75	-81	-83		-133	-495

This option would take effect in October 2014. Amounts do not reflect changes to caps in 2015 made by the Bipartisan Budget Act.

- This option would reduce the size of the military so that, by 2017, DoD’s budget would comply with the cap for that year. It would not fully comply with the caps for 2014-2016.
- If the reductions were spread evenly across the four military services and among all active, guard, and reserve personnel, those reductions could eliminate
 - 10 Army brigade combat teams (out of 66 planned in 2017);
 - 34 major warships (out of 244 in 2017);
 - 2 Marine regiments (out of 11 in 2017);
 - 170 Air Force fighters (out of 1,100 in combat squadrons in 2017).

Other Options to Reduce Spending

Option	Reductions in Outlays, 2014–2023
1. Cap Increases in Basic Pay for Military Service Members	\$25 billion
2. Replace Some Military Personnel With Civilian Employees	\$20 billion
3. Increase TRICARE Cost Sharing for Working-Age Retirees	\$19 billion–\$71 billion
4. Increase Cost Sharing for TRICARE for Life members	\$31 billion
5. Six Procurement Options Examined by CBO	\$10 billion–\$37 billion each [relative to FYDP extended]

Option 1: Cap Increases in Basic Pay for Military Service Members

(Billions of dollars)	Total	
	2014–2018	2014–2023
Change in Spending		
Budget authority	-4.7	-24.9
Outlays	-4.6	-24.6

This option would take effect in January 2015.

- *An argument for:* Average cash compensation for military personnel exceeds that of 80 percent of comparable civilians.
- *An argument against:* Recruiting and retention could be compromised.

Option 2: Replace Some Military Personnel With Civilian Employees

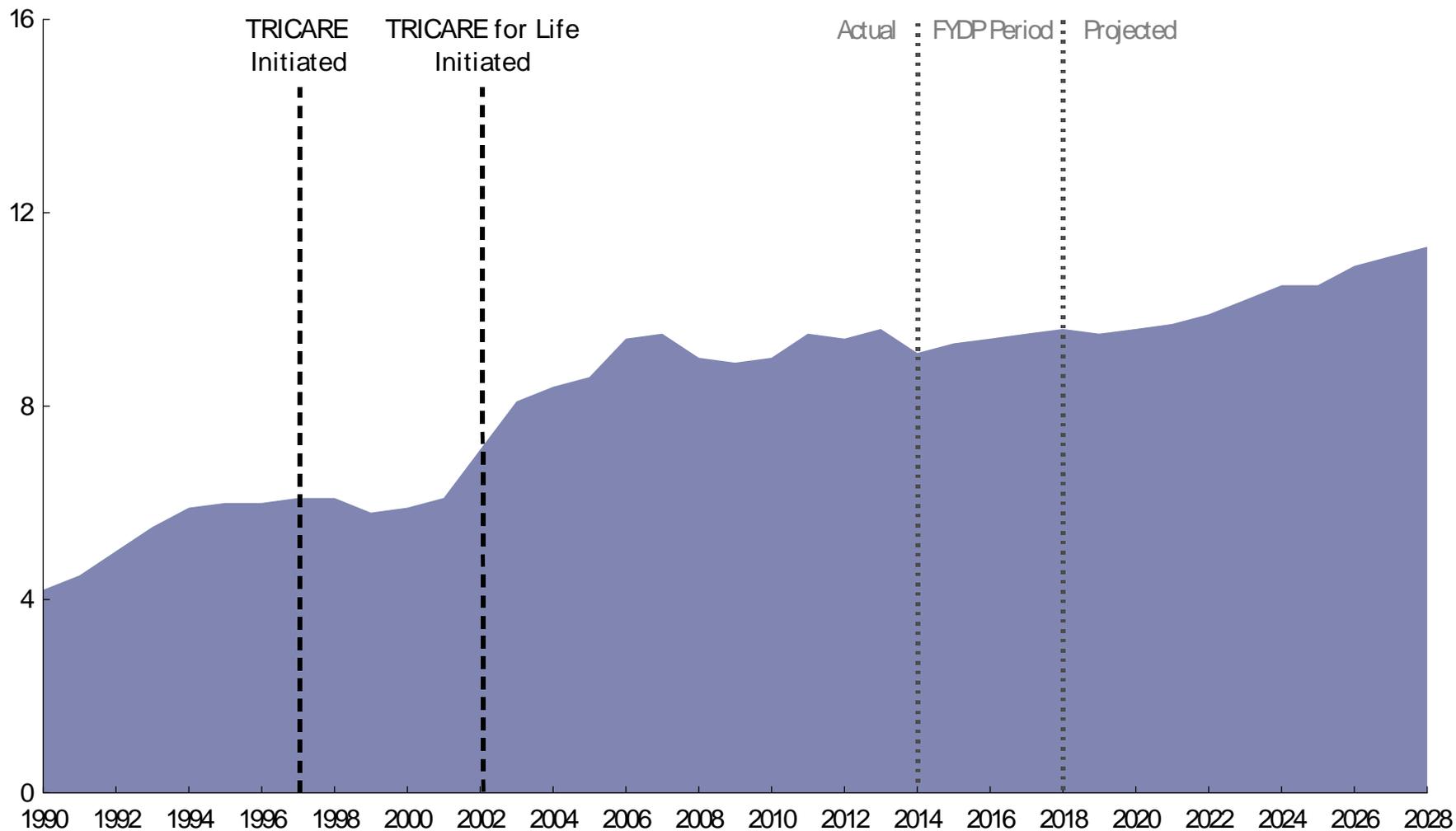
(Billions of dollars)	Total	
	2014–2018	2014–2023
Change in Spending		
Budget authority	-5.0	-20.2
Outlays	-4.6	-19.4

This option would take effect in October 2014.

- *An argument for:* Civilians require less job-specific training and are not subject to the frequent transfers that military personnel are.
- *An argument against:* It could reduce the number of trained military personnel able to deploy in an emergency.

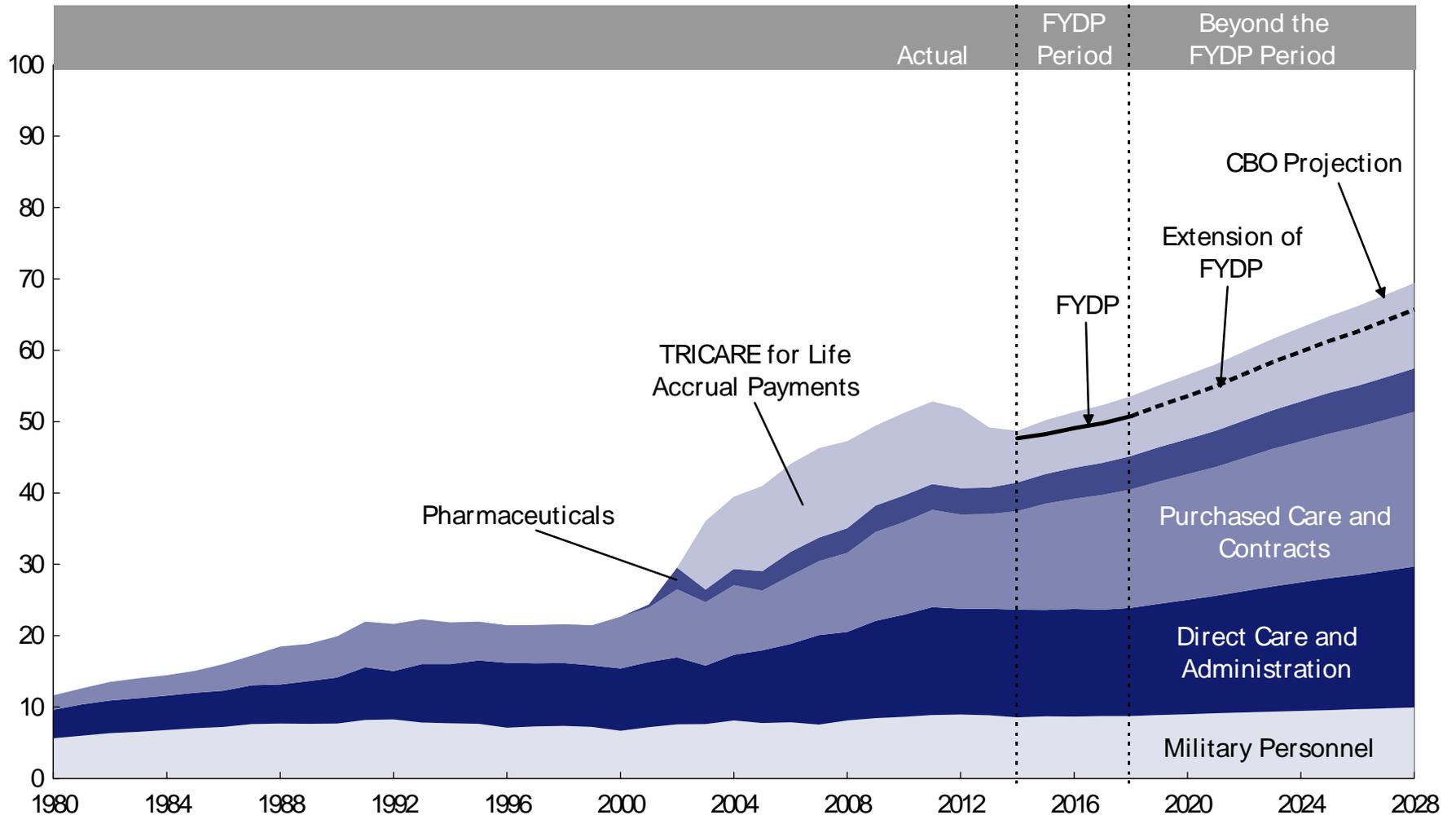
Actual and Projected Costs for Military Health Care as a Share of DoD's Base Budget, 1990 to 2028

(Percent)



Costs of DoD's Plans for Its Military Health System

(Billions of 2014 dollars)



TRICARE Beneficiaries Generally Pay Less Out-of-Pocket for Their Health Care Than Their Civilian Counterparts

- The share of health care costs paid by a military retiree family of working age (<65) has fallen.
 - 27 percent of the total cost of care when TRICARE was first fully implemented
 - 11 percent in 2012
- In 2012, on average, retiree families paid less than one-fifth as much for their care as civilian counterparts with employment-based insurance.

Average Annual Costs for Military Retiree Families Under TRICARE Plans and for Civilian Counterparts with Employment-Based Insurance, 2012

(Dollars)

	Premium or Enrollment Fee	Deductibles and Copayments	Total Annual Out-of-Pocket Costs
TRICARE Prime	520	445	965
Civilian HMO	5,080	1,000	6,080
TRICARE as a Percentage of the Civilian HMO Plan			16%
TRICARE Standard or Extra	0	1,035	1,035
Civilian PPO	4,270	1,295	5,565
TRICARE as a Percentage of the Civilian PPO Plan			19%

Some Options for Slowing the Growth of Health Care Costs

■ Cost-sharing Options

- Increase fees, copayments, and deductibles for working-age military retirees and families
- Prevent working-age military retirees and families from enrolling in Prime but allow access to Standard/Extra for an annual fee
- Introduce minimum out-of-pocket costs to Tricare for Life for Medicare-eligible retirees and families

■ Other Approaches

- Expand disease management programs
- Expand scholarships and close the Uniformed Services University of the Health Sciences (USUHS)
- Hire additional auditors to combat fraud
- Combine the military departments' medical establishments

Option 3a: Modify TRICARE Enrollment Fees, Deductibles and Copayments for Working-Age Military Retirees

(Billions of dollars)	Total	
	2014–2018	2014–2023
Change in Mandatory Outlays	-0.1	-0.3
Change in Revenues	-0.4	-1.6
Change in Discretionary Spending		
Budget authority	-6.8	-21.0
Outlays	-6.1	-19.7

This option would take effect in October 2014.

Option 3b: Make Working-Age Retirees Ineligible for TRICARE Prime

(Billions of dollars)	Total	
	2014–2018	2014–2023
Change in Mandatory Outlays	0.1	0.5
Change in Revenues	-3.0	-10.5
Change in Discretionary Spending		
Budget authority	-25.5	-75.4
Outlays	-23.1	-71.0

This option would take effect in October 2014.

Option 4: Introduce Minimum Out-of-Pocket Requirements Under TRICARE for Life

(Billions of dollars)	Total	
	2014–2018	2014–2023
Change in Mandatory Outlays		
MERHCF	-8.0	-22.2
Medicare	-2.6	-8.6
Total	-10.6	-30.7

This option would take effect in January 2015.

MERHCF = Department of Defense Medicare-Eligible Retiree Health Care Fund

The Pros and Cons of Changing TRICARE Fees for Retirees

■ Arguments For

- DoD-provided care was not meant to replace health insurance offered by postservice employers.
- The benefit is available only to those who served a full career; most veterans will never receive it.
- Would encourage a more disciplined use of medical resources and discourage the use of low-value health care.

■ Arguments Against

- Would impose costs on those who chose to remain in the military for a full career.
- Would discourage some current members from remaining.
- Higher copayments could cause some people to delay treatment, and their health could suffer.

Potential for Savings in the Other Approaches

- Expand disease management programs
 - Studies of DoD’s existing program find small to nonexistent savings.
- Expand the use of scholarships and close USUHS
 - In 2012, USUHS funding was \$190 million for operations and maintenance and \$35 million for military personnel
 - Transferring functions would mean continuing some funding.
- Hire additional auditors
 - Would have known costs and reduce deficits by unknown but probably small amounts.
- Combine military medical establishments
 - Defense Health Agency established on October 1, 2013
 - DoD estimated that savings from implementing the Defense Health Agency could equal \$46.5 million per year
 - GAO’s assessment was that savings would be lower.

An Example of a Procurement Option: Replace the Joint Strike Fighter Program With F-16s and F/A-18s

(Billions of dollars)	Total	
	2014–2018	2014–2023
Change in Spending		
Budget authority	-23.3	-48.5
Outlays	-11.9	-37.1

This option would take effect in October 2014. Savings are measured relative to CBO's extension of DoD's FYDP.

- *An argument for:* New F-16s and F/A-18s would be sufficiently advanced to meet anticipated threats.
- *An argument against:* F-16s and F/A-18s lack the stealth design features found on the F-35s.