PRESERVING THE MILITARY HEALTH CARE BENEFIT

NEEDED STEPS FOR REFORM

By John L. Kokulis

AEI
AMERICAN ENTERPRISE INSTITUTE

PRESERVING THE MILITARY HEALTH CARE BENEFIT

NEEDED STEPS FOR REFORM

By John L. Kokulis

October 2013

AMERICAN ENTERPRISE INSTITUTE

Foreword

As Washington struggles to deal with the national debt and the size and reach of the federal government, the defense budget has become an increasingly attractive target for savings. The Obama administration has already enacted or proposed cuts of close to $1 trillion over the next decade. These have dramatically reduced the US Department of Defense's (DoD's) capacity to modernize aging military inventories.

Such investment is critical to protecting American national interests. Yet, the current fiscal environment affords little hope for a larger defense budget, and political gridlock could put in place even more reductions. Although it remains unclear whether Congress will be able to reach a compromise to avert the remainder of sequestration's almost $500 billion in defense cuts, all indications are that even if Congress were to reach something short of a "grand bargain," defense would be expected to contribute a large share of the savings—perhaps in amounts almost totaling the original sequestration package.

Despite the threat of almost $1.5 trillion in cuts to the US military, top-line reductions are only one component of the multitude of challenges facing the Pentagon. The rising cost of personnel within the Department of Defense is squeezing the budget from within as military health care costs, the largest personnel cost driver, grow exponentially. Although the cost of military pay, allowances, and health care has risen 90 percent since fiscal year (FY) 2001, the active-duty personnel count has risen by less than 3 percent.[1]

These pay and benefits increases were created with the best of intentions in the midst of two brutal wars, but they have reached the point where they are simply unsustainable. This spending is set to rise further, threatening to crowd out crucial modernization spending and leave the United States behind the cutting edge. In the words of former defense secretary Robert Gates, "Health-care costs are eating the Defense Department alive."[2]

In FY 2013, DoD requested a total of $48.7 billion for military health care—approaching 10 percent of its base budget. Increasingly, this money is going to individuals no longer in the military, while active-duty service members are seeing a decreasing share of DoD health benefits. According to TRICARE's 2012 annual report to Congress, active-duty members make up only 15 percent of all military health care beneficiaries, while retirees of all ages and their family members make up 53 percent.[3] In less than a decade, defense health care spending increased by over $25 billion, from $17.4 billion in FY 2000 to $42.5 billion in FY 2008, a 144 percent increase.[4] At this rate, health care spending is growing faster than the Defense Department's discretionary spending.

Given demographic trends and spiraling health care costs across the wider US economy, this trend will only grow more pronounced in future years. The Congressional Budget Office (CBO) projects that military health care costs will increase to $65 billion by 2017 and $95 billion by 2030—nearly a 100 percent increase from today.[5]

Demographic trends and rising private-sector health care costs are only part of the explanation for unsustainable military health care practices. For one, as CBO notes, the "growth rates of per-person costs in the military health system over the past six years have been significantly higher than the corresponding national averages."[6] Much of this cost growth was due to generous TRICARE benefits and relatively low cost sharing. This led many enrollees in TRICARE Prime, for instance, to consume health care at a much higher rate than civilians enrolled in traditional plans. A related issue is how the military health system provides private-sector care for its beneficiaries, especially

retirees. From FY 2001 to FY 2006, costs for purchased care increased by 19.6 percent per year, while direct care costs grew by only 6.2 percent annually.[7]

These cost increases are not going unnoticed. A consensus has begun to emerge that the rising cost of military health care is unsustainable and poses a challenge as spiraling costs undermine the military's ability to train, equip, and supply America's men and women in uniform. As retired Marine Corps General Arnold Punaro has said, "I am very concerned that as current trends continue, this country will not have the strong military it needs 20 years from now, because all of the money is going to go to pay people that are no longer serving."[8]

Punaro is not alone in this concern. In fact, in 2011, the Joint Chiefs of Staff penned a 24-star letter—signed by the chairman, vice chairman, and four service chiefs, in support of modest increases in TRICARE cost-sharing requirements as a first step to getting rising spending under control.[9] The letter insisted that fee increases would not break faith with those in uniform but, rather, were necessary given increasing budgetary pressure—which has only since increased.

America's political leadership is not blind to this reality. The bipartisan 2010 Quadrennial Defense Review Independent Panel recommended a host of reforms to modernize military compensation, including reforms to health care and retirement benefits. As Stephen Hadley, former national security adviser and cochair of the independent panel, put it, "At some point the money won't be there, either for the All-Volunteer Force or for adequate force structure for modernization, and that is the train wreck we talk about."[10]

Despite this broad understanding of the problems surrounding the rapid increase in military health care costs, reform has thus far proven elusive. Congress has been understandably cautious about reducing benefits for those who have served, particularly given the past decade of war. In the FY 2013 National Defense Authorization Act, Congress overturned Pentagon-proposed TRICARE Prime enrollment fees while giving ground on small adjustments such as increasing pharmacy copays. However, fee increases are not the only kind of reform. Despite widespread congressional opposition to fee increases alone, an unclaimed space remains for modest fee increases if offered as part of a holistic approach that presents both pain and gain.

Although it is unrealistic to expect that the pressure to put off health care reform will dissipate anytime soon, it is also unrealistic to expect that the status quo can persist in a time of contracting budgets.

If programs such as TRICARE are to be preserved for veterans and their families, they must first be strengthened through common-sense and much-needed reforms. The true threat to the long-term health of these programs is inaction, and that inaction has consequences for America's military families. Sooner or later, the political process will reflect this reality. The only question is whether change comes as part of a long-term and carefully planned vision or haphazardly, when the whole system can no longer support itself.

In this paper, John Kokulis, a former deputy assistant secretary of defense for health budgets and financial policy, takes just such a long-term look at the military's escalating health care costs and offers a worthy solution to bringing costs under control. Kokulis's proposal aims to produce savings by incentivizing care for beneficiaries at Military Treatment Facilities. He lays out a compelling case for the necessity of change, along with a plausible roadmap to get costs on a more sustainable trajectory, all while minimizing the burden America's military families feel.

Although the proposals offered in this paper are not ends in and of themselves, they do represent a beginning of a much larger and more systematic conversation regarding how we compensate those in uniform. Comprehensive reform must start somewhere, and we view these proposals as an excellent and outside-the-box way to get the reform process moving in the right direction.

As Congress focuses on the way forward in 2014 and beyond, we hope that this paper contributes to the current debate over military spending and provides policymakers with a fresh look at a topic that deserves our attention and dutiful action.

—**Mackenzie Eaglen and Charles Morrison**
American Enterprise Institute

Preserving the Military Health Care Benefit: Needed Steps for Reform

The rise in military health care spending has been a primary driver of the large growth in military personnel compensation over the past decade. Left unchecked, these costs will impact the ability of the DoD's Military Health System (MHS) to support its three critical missions:

1. Readiness for deployment: Maintaining an agile, fully deployable medical force and a health care delivery system so they are capable of providing state-of-the-art health services anytime, anywhere;

2. Readiness of the fighting force: Helping commanders create and sustain the most healthy and medically prepared fighting forces anywhere; and

3. The benefits mission: Providing long-term health coaching and health care for 9.7 million DoD beneficiaries.[11]

At the center of these three missions are the DoD's Military Treatment Facilities (MTFs) and the medical professionals that work and train at them. They are an important part of the benefits mission but also an essential part of the readiness mission. Despite the more than $4 billion recently invested in new facilities and capabilities and the staff now returning from multiple Operation Enduring Freedom and Operation Iraqi Freedom deployments, these MTFs are significantly underutilized in DoD's efforts to control costs.[12] Utilizing more of this capacity and combining it with best practices now being implemented in the health care industry to enlist beneficiary support to control expenses will be important components of the solution to control rising military health care costs.

Rapid Cost Escalation

DoD's total medical costs have more than doubled, from $19 billion in fiscal year 2001 to $48.7 billion for fiscal year 2013.[13] Growing faster than DoD's overall budget, these costs now make up close to 10 percent of DoD's total budget, whereas they represented only 5.9 percent of the total back in FY 2001. (See figure 1.)

Left unchecked, the problem is forecasted to get worse. In a 2012 report, the Congressional Budget Office (CBO) estimated the military health care budget will jump to $65 billion by 2017 and to $95 billion by 2030.[14] CBO is not alone in its concern. Since 2007, the Government Accountability Office (GAO) has identified concerns regarding the sustainability of military health care benefits and recommended that Congress consider restructuring military compensation.[15]

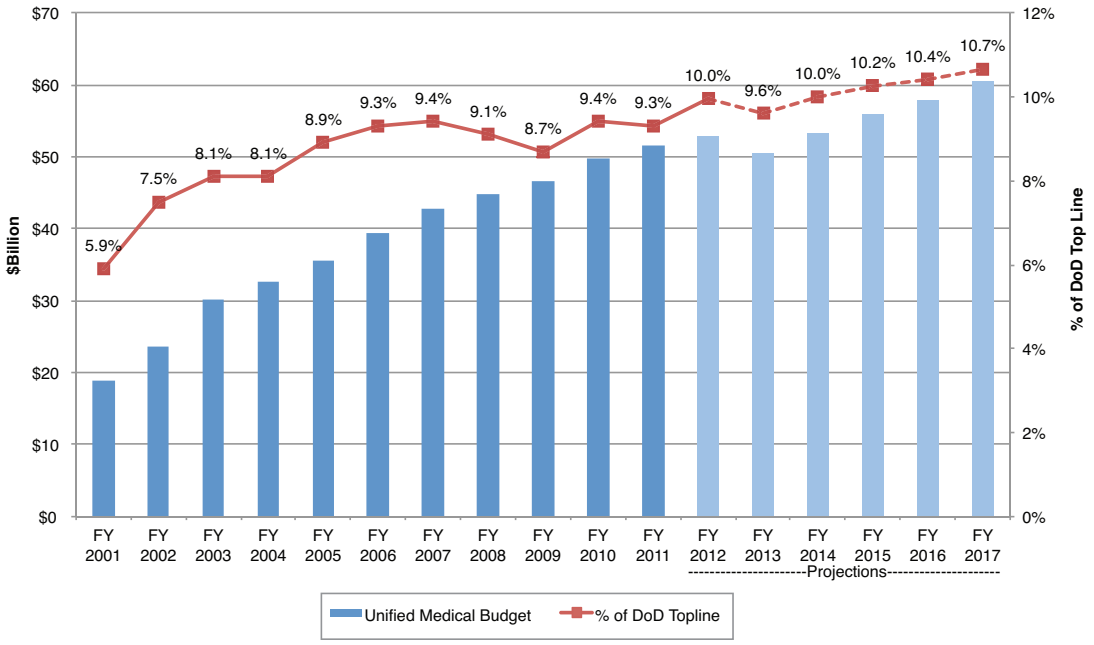
The consensus surrounding military health care reform runs even deeper. Numerous independent panels, commissions, and organizations, including the Quadrennial Review of Military Compensation, the Defense Business Board, the Quadrennial Defense Review Independent Panel, the Center for American Progress, the RAND Corporation, the Heritage Foundation, and the Center for Strategic and International Studies, have all agreed that serious reform is imperative. Although these groups and organizations are often bitterly divided on many issues, one thing they have in common is the belief that the status quo is unsustainable.

The TRICARE Benefit

The primary vehicle for delivering health care to DoD's beneficiaries is the TRICARE program, launched in 1995, which brings together the health care resources

FIGURE 1

TOTAL MEDICAL BUDGET AS A PERCENT OF DOD TOP LINE



Source: US Department of Defense Health Affairs official

of the uniformed services and supplements them with networks of civilian health care professionals, institutions, pharmacies, and suppliers to provide access to high-quality health care services while maintaining the capability to support military operations.[16]

TRICARE is not the first comprehensive military health care system. In 1956, Congress passed the Dependents' Medical Care Act, providing the initial statutory basis for the provision of medical care to active-duty members, active-duty dependents, and retirees and their dependents. Before 1956, active-duty members received first priority for health care at the military MTFs, while their dependents were eligible for care on a space-available basis. The Dependents' Medical Care Act reemphasized the priority care system for active-duty members and officially extended eligibility for medical and dental care at the MTFs on a space-available basis to active-duty dependents, retirees, retiree dependents, and survivors.[17]

In 1966, Congress expanded the program by passing the Military Medical Benefits Act, which created the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). CHAMPUS expanded military health care eligibility and covered services and was largely based on the Blue Cross/Blue Shield high-option plan provided under the Federal Employees Health Benefits Program. CHAMPUS had two major results: the program provided coverage for civilian-based health care and for retirees ineligible for Medicare Part A and their dependents. All beneficiaries, excluding active-duty members and their families below pay grade E-5, were required to pay an annual deductible of $50 for an individual or $100 for a family. After patients reached these deductibles, active-duty dependents paid 20 percent of the allowable CHAMPUS copayment amount, while retirees and their dependents paid 25 percent of the allowable amount.[18] In FY 1991, the annual deductible increased to $150 for individuals and $300 for families.

Around this time, with costs and the administrative burden of CHAMPUS growing and with beneficiary dissatisfaction on the rise, the Department of Defense

initiated a series of pilot programs in selected regions to improve on the CHAMPUS model. The result was TRICARE, which launched in 1995 and replaced CHAMPUS with three major health care plans. Dependents of active-duty personnel, as well as retirees under the age of 65 and their dependents, can choose to enroll in TRICARE Prime (managed care option), or if they choose not to enroll in Prime, can still obtain care through TRICARE Standard (fee-for-service option) or TRICARE Extra (preferred-provider option).[19]

- **TRICARE Prime** is a health maintenance organization (HMO)–style plan. Active-duty or activated National Guard or Reserve members must enroll in TRICARE Prime, while all other eligible beneficiaries have the option to enroll or to use TRICARE Standard and Extra. Under TRICARE Prime, beneficiaries must choose a primary care physician and obtain referrals and authorizations for specialty care. In return for these restrictions, beneficiaries (retirees and their families only) are responsible for comparatively small copayments for each visit. There is an annual enrollment fee for TRICARE Prime for military retirees and their family members. There is no enrollment fee for active-duty military and their family members.[20]

  As an HMO, TRICARE Prime offers fewer out-of-pocket costs than TRICARE Standard and Extra, but less freedom of choice.

- **TRICARE Standard** is a similar benefit to the original CHAMPUS program. TRICARE Standard is a fee-for-service plan available to all non-active-duty service members, retirees from the Active Component, retirees from the Reserve Component age 60 or older, and their eligible family members. Under TRICARE Standard, beneficiaries can use any civilian health care provider payable under TRICARE regulations. The beneficiary is responsible for paying an annual deductible and coinsurance and may be responsible for certain other out-of-pocket expenses. Coverage under TRICARE Standard is automatic as long as the patient's information is current in the Defense Enrollment Eligibility Reporting System.[21] Beneficiaries do not need to fill out any forms or pay any enrollment fee. They are responsible only for an annual deductible and a small copay.

  TRICARE Standard features the broadest flexibility for beneficiaries and usually does not require referrals for specialty care. The tradeoff is that beneficiaries typically pay more out of pocket on top of an annual deductible and do not have a primary care manager responsible for coordinating the totality of their health care needs. Many beneficiaries use TRICARE Standard if they have civilian health care coverage through their employer or prefer a doctor outside the TRICARE provider network.

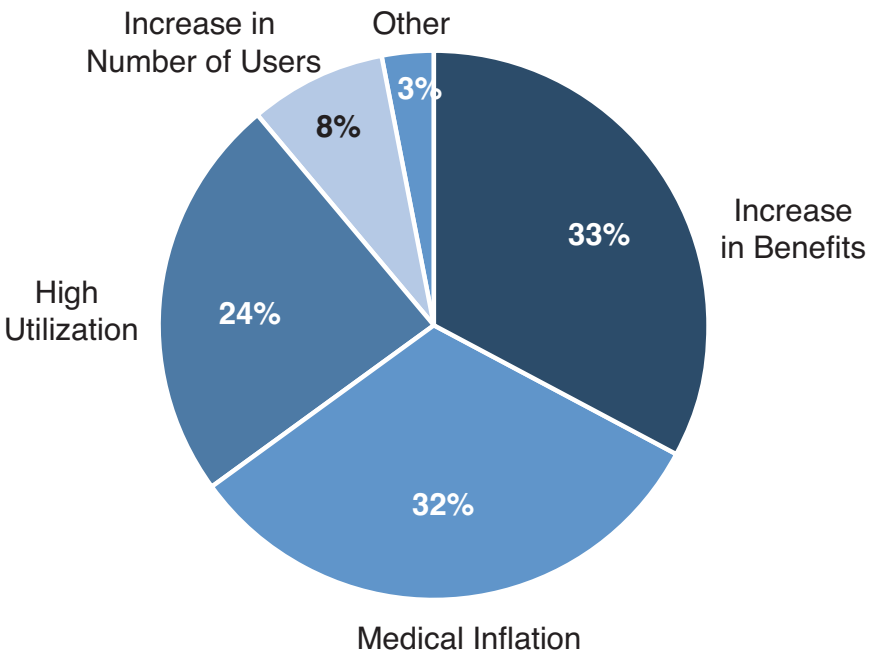
Despite the more than $4 billion recently invested in new facilities and capabilities and the staff now returning from multiple Operation Enduring Freedom and Operation Iraqi Freedom deployments, MTFs are significantly underutilized in DoD's efforts to control costs.

- **TRICARE Extra** is similar to TRICARE Standard but functions as a preferred provider organization (PPO). Because it is a PPO, patients must visit TRICARE network providers and therefore pay less out of pocket.[22] Under TRICARE Extra, copayments are generally 5 percent lower than under the Standard plan. There is no fee for use of the TRICARE Extra benefit other than the cost of coinsurance and an annual deductible.[23]

To improve TRICARE expanded coverage for retired service members age 65 and older and their families, Congress created TRICARE for Life (TFL) in 2001 to supplement Medicare by paying patient liability after Medicare payments. No enrollment is necessary for TFL, and to be eligible, members must be TRICARE and Medicare eligible and have purchased

FIGURE 2

FACTORS DRIVING INCREASE IN DOD HEALTH CARE BUDGET



Source: US Department of Defense

Medicare Part B coverage. Before TFL, these beneficiaries lost their TRICARE benefit once they turned 65 and were limited to receiving free care at the MTFs only on a space-available basis.[24]

Cost Drivers

As illustrated in figure 2, the Department of Defense cites four main factors driving cost growth: (1) an increase in benefits to plan beneficiaries; (2) medical inflation; (3) an increase in utilization; and (4) an increase in the number of beneficiaries.

Increase in Benefits. The largest contributor to this increase, representing one-third of the total increase in the military health care budget, is new benefits for beneficiaries.[25] Since establishing the TRICARE program in 1995, Congress has voted to expand the benefits and availability of the program to retirees, families of active-duty members, and active-duty and reserve members themselves by adding over 40 new benefits to the program. Key benefits are listed in appendix 1. Major additions include:

- Expanded availability (2000–2010): Over this period, the TRICARE-eligible population rose from 6.8 million to 9.7 million, nearly 85 percent of whom were not active-duty service members. This expansion represented a 43 percent real cumulative growth in the eligible population.[26]
- TRICARE Senior Pharmacy (2001): A comprehensive drug benefit not provided under traditional Medicare. For beneficiaries age 65 years and older, benefits include standardizing copayments and lowering the costs of generic medications.[27]
- Reduction of Catastrophic Cap (2001): The catastrophic cap is the maximum non-active-duty families have to pay for TRICARE-covered medical expenses. The 2001 National Defense

Authorization Act reduced this cap from $7,500 to $3,000.[28]

- TRICARE for Life (2001): TRICARE's Medicare wraparound coverage available to all Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B.[29]

- TRICARE Young Adult (2011):
  - Premium-based health care plan available for purchase by qualified adult-age dependents who have aged out of TRICARE benefits.
  - Offers TRICARE Prime or TRICARE Standard coverage worldwide.
  - Includes medical and pharmacy benefits, but excludes dental coverage.[30]

These new benefits not only have increased the DoD's health care budget, but also have altered the profile of those the military health care system serves. Of the 9.7 million beneficiaries currently eligible for TRICARE, only 15 percent are active duty.[31] Dependents and families of active-duty members represent another 21 percent, and retirees, both under the age of 65 and those Medicare eligible, along with their family members, make up 53 percent of TRICARE-eligible beneficiaries.

Medical Inflation. The second-highest contributor, representing 32 percent of the increase, is medical cost inflation.[32] While part of this growth is due to the same factors increasing costs of all public and private US health plans, the DoD's health care plan is experiencing additional increases because of its aging population's tendency to underutilize DoD "direct care."

The military's TRICARE health system consists of a combination of direct care (military hospitals and clinics) and purchased care (the civilian TRICARE network).[33] Active-duty members have priority at MTFs, followed by active-duty family members enrolled in TRICARE Prime. If an MTF is unavailable or if they choose civilian care, those families and retirees enrolled in Prime can select a civilian TRICARE provider. This increases costs, because as in the purchased care system, the DoD pays in full for every dollar of service provided to a beneficiary at a civilian clinic. If the beneficiary were to visit an MTF, however, the only cash out of pocket for the DoD would be for any variable expense from the visit, such as medicine and supplies. These kinds of variable expenses usually constitute only 10-40 percent of the visit's expenses. All other costs, such as doctors and facilities, are fixed and have already been paid for from the DoD budget, whether the facility is fully used or not. A $1,000 trip to a doctor in the purchased care system would cost the DoD a full $1,000, but that same visit to an MTF would run only anywhere from $100 to $400. Until they reach capacity, the MTFs are a lower-cost alternative to paying expenses in full to the purchased care network.

In a 2012 report, the Congressional Budget Office estimated the military health care budget for 2013 will jump to $65 billion by 2017 and to $95 billion by 2030.

More importantly, from a readiness perspective, with so many retirees now getting their care in the purchased care system—because of either convenience or lack of appointment availability at the MTFs—not only do costs go up, but the effectiveness of the MTF and those that train there is also eroded. MTFs need these "case intensive" retirees to provide the proper training to their medical staff. Of course, the kind of care retirees require does not exactly mirror the kind of care required on the battlefield. That said, many procedures common among an aging population, such as open-heart surgery, hip replacements, and chronic disease contribute a necessary—if perhaps not sufficient—role in keeping medical staff in shape and ready. This is an important issue and one that I address in the Recommendations section of this report.

High Utilization. The third-largest cost driver, making up 24 percent of the increase, is increased utilization of the health care system by its beneficiaries.[34] Part of the increase in utilization and intensity of visits to the military health system is driven, as I have mentioned, by a higher number of retirees using the system. On average, this beneficiary group requires more care per

TABLE 1

TRICARE/FEHBP BENEFIT COMPARISON, DOD MILITARY RETIREES AND FEDERAL CIVILIANS

	2013 Annual Family Premium (Enrollee Portion)	Family Deductible	Office Visit Copay (In-Network)	Retail Brand Script Copay	Catastrophic Limit per Family
FEHBP Blue Cross/ Blue Shield Standard	$5,204	$700	$20	30%	$5,000
TRICARE Standard	$0	$300	20%	$12	$3,000
FEHBP Kaiser High	$4,581	$0	$10	$30	$4,500
TRICARE Prime	$539	$0	$12	$12	$3,000*

Note: *For TRICARE Prime, today, the $520 enrollment fee counts toward the catastrophic limit.
Source: US Department of Defense

visit and thus utilizes a higher degree of health care resources than the active-duty soldiers and their families who are younger and typically healthier then the retiree beneficiaries.

The difference between TRICARE and civilian utilization can be traced in part to the much lower out-of-pocket costs TRICARE beneficiaries face as compared to their civilian counterparts.[35] Although DoD's health care spending has increased significantly over the past decade, out-of-pocket expenses paid by beneficiaries, including enrollment fees, copayments, and deductibles, have remained relatively unchanged since 1995, when TRICARE was first created.

According to DoD, retirees paid for approximately 27 percent of their overall health care costs when TRICARE was first implemented. Today, that figure has dropped to less than 11 percent.

Most other public and private health care plans have used enrollment fees, deductibles, and copays as a way to enlist beneficiaries to help manage costs. Based on best practices recognized throughout the health care industry, these plans link premium hikes to the actual cost of care and reward patients for choosing the lower-cost alternative. Unfortunately, in the military health system, with TRICARE cost shares being zero or relatively small, the TRICARE beneficiaries have little incentive to be judicious in their use of health care resources. This may help explain why retiree beneficiaries in TRICARE have a higher utilization rate than their counterparts in other public and private health plans. As the Congressional Research Service has noted, in fiscal year 2004, the outpatient utilization rate of TRICARE Prime was 44 percent higher than in civilian HMOs, while the TRICARE inpatient utilization rate was 60 percent higher.[36]

Most retired beneficiaries who are under 65 and therefore not yet eligible for TRICARE for Life currently pay an annual enrollment fee beginning at $538.56 a year, subject to an annual cost-of-living adjustment, for families covered under TRICARE Prime. TRICARE Standard, DoD's fee-for-service option, has no annual enrollment fee and has family deductibles of $300 per year, unchanged since 1995.[37] The proportion of TRICARE costs beneficiaries pay has steadily declined since the inception of the program. According to DoD, retirees paid for approximately 27 percent of their overall health care costs when TRICARE was first implemented. Today, that figure has dropped to less than 11 percent.[38] This trend is especially problematic because more and more individuals are choosing to utilize TRICARE benefits. In 2000, only 60 percent of eligible retirees took part in the TRICARE system, while DoD projects that 89 percent of retirees will utilize TRICARE by 2017.[39]

Table 1 compares these two TRICARE health plan options to similar plans offered to federal employees through the Federal Employees Health Benefit Program (FEHBP).

Impact on Beneficiaries and the MTF Readiness Mission

Aside from the effects of increasing costs on the program, these low cost shares and added benefits and the expansion of the purchased care network to give the beneficiaries more choice may have had some unintended consequences that affect the health of DoD's retired beneficiaries and the readiness mission of the MTFs.

Impact on Beneficiaries. The low cost-sharing requirements imposed on TRICARE patients, while well-intentioned, have evolved to the point where they are not only increasing the costs of the military health system but are in some cases resulting in suboptimal care for its beneficiaries. Although TRICARE Prime beneficiaries are enrolled into the system, many TRICARE Standard retiree beneficiaries are not fully enrolled and instead choose to selectively use TRICARE for its pharmacy benefits or as a "filler" comparing whichever insurance plan, private or TRICARE, is most advantageous for a particular episode of medical care. This results in poor communication between the health care professionals and the beneficiaries and, as stated earlier, ultimately in bad medicine when beneficiaries seek care from multiple sources and care is not coordinated.[40]

The military health system has embarked on implementing the Patient-Centered Medical Home (PCMH) concept at many of its MTFs, including the Walter Reed National Military Medicine Center. PCMH is a team-based model of primary care that seeks to improve health care quality and outcomes by fully coordinating and integrating the patient's health care needs using evidence-based medicine. The PCMH team, led by the patient's primary care manager, focuses on identifying, addressing, and preventing the underlying causes of disease rather than merely treating the patient on an episodic acute care basis. A recent study contracted by the US Navy's Bureau of Medicine and Surgery documented the benefits of the PCMH approach:[41]

- 23 percent average decrease in inpatient days
- 18 percent average decrease in inpatient admissions
- 14 percent average decrease in emergency room/urgent care center visits

These results are not limited to the military health system and have been documented by many private organizations. Major health plans, 42 state Medicaid programs, and industry partners are embracing the PCMH model by creating insurance plans and developing tools and resources to implement the medical homes for their patients and beneficiaries.[42]

Eligible retirees who are not fully enrolled in the TRICARE system do not get the benefit of this best-practice concept and end up with less-than-optimal coordination of their care. Additionally, since the PCMH approach has proven to lower medical costs, those who are not enrolled and do not have a coordinated care program ultimately drive up the cost of health care for the DoD.[43]

Impact on the MTF Readiness Mission. The expansion of the TRICARE purchased care network has been a necessary step in giving beneficiaries more choice and improving their access to care, especially during a time of war when some MTF professionals are deployed, leaving the MTF short-staffed. Yet the well-intentioned additions of this expansion may be harming MTF capability.

The primary mission of the MTFs within the military health system is maintaining readiness—both the physical readiness of the fighting force and the readiness of the MTF staff to provide state-of-the-art health services anytime, anywhere. MTF staff have faced multiple Operation Enduring Freedom and Operation Iraqi Freedom deployments during the last decade. This has left fewer available MTF appointments, meaning more of DoD's beneficiaries are getting care in the purchased care network at the expense of the MTFs. Most of the MHS's major MTFs are now operating at less than 50

percent capacity, with many far below 50 percent. This comes on the heels of the 2005 Base Realignment and Closure Act, through which the DoD closed down or downsized underutilized medical facilities and then invested over $4 billion to consolidate capacity and improve capabilities at the remaining facilities.

The MHS has put in programs like the Right of First Refusal to help reverse the growing popularity of the purchased care network with little success. Debates have continued between the services and the civilian DoD leadership as to the root cause of this problem and the possible corrective actions. Regardless of the cause, this trend must be reversed to maintain readiness of fully trained medical providers and bolster military graduate medical education. Without a high level of medically intensive patients (older retirees) who will challenge the skills of the MTF staff, their training and education will not be optimized—even if the medical procedures demanded by an aging population are not a perfect match for battlefield trauma.

The MTFs are, given their very low utilization rates, the lowest-cost alternative (on a variable cost basis) and, more importantly, an asset essential to the country's national security. Any solutions proposed to address the escalating military health care budget must take these two factors into account.

Previous Attempts to Address TRICARE Cost Escalation

In its FY 2007 budget request, the George W. Bush administration first proposed changes to constrain the costs of health care by focusing on care for retirees and their dependents who are not Medicare-eligible. For these beneficiaries, DOD proposed charging, for the first time, annual enrollment fees for TRICARE Standard and also significantly increased annual enrollment fees for TRICARE Prime. Annual deductibles would have also been increased. None of these proposals would have affected active-duty military and their dependents or benefits available to retirees eligible for Medicare who are covered by TFL. The proposals estimated savings of more than $11 billion over five years.[44]

In response to this proposal, Congress prohibited DOD from increasing premiums, deductibles, copayments, and other charges in both FY 2007 and FY 2008. In addition, as part of the FY 2007 National Defense Authorization Act, Congress also required the establishment of a DOD Task Force on the Future of Military Health Care, composed of military and civilian officials with experience in health care budget issues, to examine and report on efforts to improve and sustain defense health care over the long term, including the "beneficiary and Government cost-sharing structure required to sustain military health benefits."[45] The act also required that the GAO, in concert with the CBO, audit of the costs of health care for both DOD and beneficiaries between 1995 and 2005.[46]

The Task Force on the Future of Military Health Care submitted its final report in December 2007, advocating for an increase in TRICARE cost shares and recommending a phase-in of the enrollment fees and deductibles that would restore cost-sharing relationships that existed when TRICARE was created. In addition, the task force recommended that the fees and deductible amount be "tiered" based on military retirees' pay level. The CBO offered similar conclusions, finding that the DoD could save roughly $28 billion over a decade by raising TRICARE Prime enrollment fees (to $550 for individuals and $1,100 for families), establishing $30 copays for visits to civilian providers, and raising TRICARE Standard and Extra annual deductibles (to $350 for individuals and $700 for families). The CBO also proposed adding a small annual fee ($50 for single coverage and $100 for families) for TRICARE Standard and TRICARE Extra beneficiaries.[47]

For the FY 2009 budget submission, the DoD endorsed the task force's recommendations for "tiering" and "phase-in" of the cost-share increases and made them the cornerstone of its FY 2009 budget proposal. Unfortunately, Congress once again prohibited DoD from implementing these increases in FY 2009.

The 2010 budget submitted by the Obama administration did not contain legislative proposals to increase TRICARE cost shares, but Secretary Gates publicly expressed his concern about the impact of increasing TRICARE costs on the rest of the DOD budget, saying,

> Health-care costs are eating the Defense Department alive, rising from $19 billion a decade ago to roughly $50 billion. . . . In recent years the Department has attempted modest increases in premiums and co-pays to help bring costs under control, but has been met with a furious response from the Congress and veterans groups. The proposals routinely die an ignominious death on Capitol Hill.[48]

In FY 2012, the Obama administration proposed several cost-sharing increases that echoed some of the proposals presented toward the end of the Bush administration. These included a modest increase in TRICARE Prime enrollment fees and adjustments to mail-order pharmacy copays. The FY 2012 proposals represented a step in the right direction, with Congress approving the Prime enrollment fee increases (subject to an annual cost-of-living adjustment) for new retirees for the first time since the inception of the program, as well as the new pharmacy copays.

In its FY 2013 request, the Pentagon proposed an additional series of cost-share increases for TRICARE Prime, Standard, Extra, for Life, and Pharmacy, as well as a Base Realignment and Closure–style commission to examine military retirement. Their proposals were based on previous submissions, as well as input from the work of the 2007 task force, the GAO, and the CBO. Unfortunately, Congress rejected most of the proposals, with only a small exception for increased pharmacy copays. Congress also widened the mandate of the proposed Military Retirement Modernization Commission but removed its teeth by allowing the commission to offer a proposal but not requiring Congress to vote on it.

Recommendations

The recommendations in this paper for addressing these issues are not just based in budget considerations but also factor in "best practices" in the health care industry, as identified in in the 2007 Task Force on the Future of Military Health Care, among others.[49] They are rooted in three core principles:

1. Improving the military readiness of our MTFs.

2. Maintaining or improving the quality of care for all beneficiaries, including those who are not currently enrolled in TRICARE yet use the system.

3. Promoting more efficient use of health care resources and the need to maintain a fair and reasonable cost-sharing arrangement between retired beneficiaries and the DoD, while balancing the need to recognize the service of military personnel to their country with generous health care benefits.

Above all, each of these recommendations will have absolutely no additional cost-share impact on active-duty soldiers or their families and dependents. In addition, medically retired service members and survivors of members who died on active duty would also be exempt from these fee increases.

The MTFs are, given their very low utilization rates, the lowest-cost alternative (on a variable cost basis) and, more importantly, an asset essential to the country's national security.

Recommendation 1: Enroll All Beneficiaries. Many TRICARE Standard and Extra retiree beneficiaries are not fully enrolled in the system and instead choose to use TRICARE selectively for its pharmacy benefit or to choose whichever insurance plan, private or TRICARE, is most advantageous for a particular episode of medical care. This results in poor communication between the health care professionals and the beneficiaries and ultimately results in bad medicine when beneficiaries seek care from multiple sources and care is not coordinated. Achieving 100 percent enrollment of all beneficiaries would help improve medical outcomes and reduce cost.[50]

Based on the success of PCMH initiatives in the private sector and the success of MHS's own PCMH

efforts with its Prime beneficiaries, I believe that these unenrolled beneficiaries need to be fully enrolled in the TRICARE system and benefit from a coordinated care program.[51] I propose that TRICARE Standard and Extra retirees under age 65 pay a modest annual fee of $120 to commit to the program. This fee would increase every year based on an index linked to medical inflation. Additionally, I propose a modest enrollment fee for TRICARE for Life beneficiaries starting at $120 per year, also indexed to medical inflation.

Having these retirees enroll in the system will not only provide them better care but also help make the TRICARE program more efficient by reducing excess payments in the system. Based on a 2006 survey, about half of all TRICARE beneficiaries under 65 with private insurance also use TRICARE.[52] For these retirees, Congress designated TRICARE as a second payer. This presents a coordination issue: if TRICARE does not know that a retiree has private insurance, TRICARE pays first, thereby making an expenditure it should not. Having all retirees in Prime, Standard, and Extra properly enrolled in the system will help eliminate these erroneous payments.

Recommendation 2A: Create Financial Incentives to Encourage Retiree Beneficiaries under 65 to Seek Care at MTFs to Lower Cost and Enhance Readiness. Mirroring best practices most other major public and private health care plans employ, cost shares for all retiree beneficiaries should be adjusted to more adequately reflect the actual cost of care with the goal of rationalizing the use of health care resources and improving accountability.

These are not new recommendations, but rather, have been advanced by multiple budget proposals under presidents from both political parties over much of the past decade. In addition, the independent CBO and GAO have proposed these cost-share increases, and in 2010, they were endorsed by the National Committee on Fiscal Responsibility and Reform Report (commonly known as the Simpson-Bowles Commission).[53] The most independent extensive review on this issue was conducted in 2007 by the Task Force on the Future of Military Health Care, a group established by Congress in Section 711 of the National Defense Authorization Act of 2007 to make recommendations on such issues as addressing the concerns about the rising costs of the military health mission.

In advancing the need for increased cost shares, four main points of agreement stand out:

- Most cost shares should be "tiered" so that they are low for those receiving lower retired pay and higher for those receiving higher retired pay.
- Ease in the cost shares over four or five years so as to minimize effects on retirees.
- Enrollment fees should be implemented for retirees who use TRICARE Standard and Extra and TRICARE for Life.
- Any indexing of cost shares should be tied to some sort of medical inflation index.

The table in appendix 2 summaries three of the most recent of these proposals:

- DoD TRICARE fee proposal in FY 2013.[54]
- 2011 CBO report: "Reducing the Deficit: Spending and Revenue Options."[55]
- 2007 Task Force on the Future of Military Health Care final report.[56]

The three proposals are similar in their approaches and the dollar amounts they recommend for enrollment fees and deductibles. In addition, they have all undergone thorough review and analysis by independent groups, civilian DoD, and service leadership. As such, they serve as a good foundation for my recommendations on the level of increase to apply to TRICARE cost shares.

Where my approach differs with these previous ones is that, in those proposals, all three phases in the fee increases and deductibles come in at a fixed dollar amount, regardless of how much patient care can be recaptured at the MTFs. As I have stated, the MTFs within the Military Health System are underutilized

TABLE 2

PROPOSED COST SHARES FOR TRICARE RETIREES UNDER AGE 65

	Year 1		Year 2		Year 3		Year 4		Year 5	
	Min	Max	Min	Max	Min	Max	Min	Max	Min	Max
PRIME ENROLLMENT FEES:										
Tier 1	$484	$538	$508	$590	$532	$680	$556	$760	$580	$850
Tier 2	$496	$538	$532	$690	$568	$890	$604	$1,185	$640	$1,450
Tier 3	$500	$538	$548	$790	$596	$1,100	$644	$1,430	$792	$1,950
STANDARD/EXTRA ENROLLMENT FEES:										
All Tiers	–	$120	–	$120	–	$120	–	$120	–	$120
STANDARD/EXTRA ANNUAL DEDUCTIBLE:										
All Tiers	–	$320	–	$400	–	$460	–	$520	–	$580

Source: US Department of Defense

with most operating at less than half capacity. As such they are a low-cost alternative that DoD can use in its efforts to lower the growth in its health care expenditures. Based on this fact, I propose linking the phase-in to this effort by establishing a minimum and maximum range for these amounts. I recommend the following:

- If 100 percent of the recapture target has been met, then the enrollment would go up only by the minimum (Min) fee level defined below:
  - $24 ($2 a month) for Tier 1 retirees (retired pay: $0–22,589)
  - $36 ($3 a month) for Tier 2 retirees (retired pay: $22,590–45,178)
  - $48 ($4 a month) for Tier 3 retirees (retired pay: $45,180+)

- If 0 percent of the recapture target has been met, then the enrollment fee would be capped at the maximum (Max) fee level defined in table 2.

- Any amount of patient recapture below the target amount would proportionally reduce the enrollment fee. Since this exact "proportional relationship" entails a complicated formula that depends on the population profile, the type of patient cases that return to the MTF, and other factors, careful analysis by those directly involved in the TRICARE system is needed to refine this proposal. Consequently, DoD should direct its TRICARE team to create a "proportional fee formula" for this alternative.

This recommendation offers the greatest potential for savings to DoD, in addition to strengthening the capabilities of MTFs by increasing the volume of patient care. If we assume a modest 5 percent recapture of the $16 billion that is now annually being spent in the purchased care system, DoD would save $600 million annually ($16 billion x 5 percent going to MTF x 75 percent to account for MTF "sunk" fixed cost). This savings in just one year would offset the proposed fee increases on the beneficiaries. Continue the program for three years, and DoD would save close to $2 billion annually.

Recommendation 2B: Institute pharmacy copays that encourage the use of low-cost generics and promote the use of low-cost distribution options such as TRICARE Pharmacy Home Delivery. In fact, in the president's budget submission for FY 2013,[57] DoD advanced this exact concept, proposing to raise copays for brand and nonformulary refills but keep copays for generic refills through home delivery and all refills

made at the MTF free. Building on the objective to strengthen the MTFs by recapturing patient care, I propose taking this a step further by lowering the generic and brand copays for prescriptions written at an MTF or by an MTF doctor via telemedicine (seeing a doctor via electronic communication) when picked up at a retail pharmacy. This will provide incentives for retirees to seek a refill prescription through an MTF. Many visits to the purchased care network are for nothing more than a simple refill for a prescription. These visits can be reduced. Better yet, coming to the MTFs to get their scripts filled may lead these retired beneficiaries to seek more of their care at that MTF.

DoD should direct its TRICARE team to come up with a new copay formula for retail pharmacy–filled prescriptions written at an MTF and come up with a plan to expand the use of telemedicine to assist in standard prescription refills.

Recommendation 3: Once these fees and cost shares are fully phased in, index them to medical inflation. Part of the reason the MHS budget is in such crisis is that Congress has left TRICARE enrollment fees, copays, and deductibles mostly unchanged since it established the program in 1995. The FY 2012 and FY 2013 changes were a good step in this direction, but any future changes must be indexed to medical inflation—not simply a local cost-of-living adjustment.

It cannot be emphasized enough that the greatest imperative for reform is the moral obligation to preserve and strengthen care for America's men and women in uniform and their families.

Estimated Savings

If these recommendations were enacted, the DoD could expect to realize savings in the range of $12 billion to $13 billion over a five-year period:

- Estimated $3.5–4 billion in savings from increased TRICARE Prime cost shares and added enrollment fees for TRICARE Standard and Extra.
- Estimated $2 billion in savings from added enrollment fee for TRICARE for Life
- Estimated $6.5–7 billion in savings from increased pharmacy copays (including both current-year budgets for eligible retirees under 65 and annual contributions into the Medical Eligible Retiree Health Care Fund for Medicare-eligible retirees).[58]

The time to act is now both in terms of strengthening our MTFs and improving the overall budget outlook. DoD estimates that if policymakers had implemented all of the proposals from the independent 2007 task force in 2009 and continued them in subsequent years, the military's health care spending would have been reduced by $1.9 billion in 2009 and by $6 billion in 2013.[59]

Conclusions

It cannot be emphasized enough that the greatest imperative for reform is the moral obligation to preserve and strengthen care for America's men and women in uniform and their families. It is out of a sense of duty for those who have served, those who are currently serving, and those who will serve in the future that politics must adjust to the current fiscal reality.

This paper aims to chart a responsible way forward that incentivizes the use of Medical Treatment Facilities. MTFs provide DoD with facilities that reduce costs and provide valuable training to the military's medical professionals. The MTFs are a testament that world-class health care for America's military personnel is both a good investment and a moral obligation—and that it need not break the bank.

Left unchecked, military health care costs will consume an increasing portion of the defense budget, hindering the Defense Department's efforts to make

needed investments in force modernization. Despite the political sensitivity involved with altering military compensation, the Pentagon has little choice. It can sacrifice US security to meet the runaway cost of people, or it can offer up a serious and long-term vision for reform.

As I have described, previous proposals by the Bush and Obama administrations, CBO, and GAO have been remarkably similar in their suggestions and have enjoyed wide endorsement, including from the Simpson-Bowles Commission. The proposals focused on low TRICARE out-of-pocket expenses that, while well-intentioned, have evolved to the point where they are not only increasing the costs of the military health system but are, in some cases, resulting in suboptimal care for its beneficiaries.

First, achieving enrollment of all TRICARE beneficiaries would reduce cost by reducing excess payments outside the military health system and would ensure better treatment for beneficiaries by increasing good communication among health care professionals about patients. Second, out-of-pocket expenses would have to be increased by a small amount. Such cost shares would be tiered so that they would be low for those receiving lower retired pay and higher for those receiving higher retired pay. Furthermore, these cost shares would be linked to a medical inflation index. Appropriate cost-share increases from previous proposals have been independently reviewed and are provided in appendix 2.

Finally, this paper goes beyond previous proposals by suggesting that the increase in out-of-pocket fees be partially determined by the extent to which Military Treatment Facilities can reduce military health expenditures after financial incentives have encouraged beneficiaries to seek treatment at MTFs rather than more expensive private-sector options. If savings targets are met, out-of-pocket expenses would go up by a smaller amount.

The Defense Department could expect to realize savings of $12–13 billion over a five-year period that could be used to strengthen vital care for America's men and women in uniform and their families. Independently, the Defense Department has estimated that if the proposals of the 2007 task force had been adopted by 2009, the military's health care spending would have been reduced by $1.9 billion in 2009 and by $6 billion in 2013.

Enacting these recommendations would strengthen Military Treatment Facilities and simultaneously put the military health system on a more stable financial path. Simply put, the failure to reform harms the capabilities of the MTF mission and the well-being of beneficiaries. In all aspects, lack of reform is a detriment to our national security and the men and women who uphold it.

Appendix 1

Expansion of DoD Health Care Benefits
Major Additions (1993–2011)

1993 through 2000
TRICARE Managed Care legislation: Automatic enrollment for active duty
1995
TRICARE triple option benefits: Prime, Standard, and Extra
TRICARE Senior Prime Demonstration
Catastrophic cap reduced from $7,500 to $3,000 per year for non-active-duty Prime enrollees
1997
TRICARE Prime enrollment becomes portable across regions
TRICARE Selected Reserve Dental Program
National Mail-Order Pharmacy
1998
Tricare Retiree Dental Program
1999
TRICARE Prime Remote for active-duty service members
2000
Catastrophic cap reduced from $7,500 to $3,000 per year for non-active-duty beneficiaries using Standard/Extra
2001
TRICARE for Life
Eliminated copays for active-duty family members enrolled in TRICARE Prime
TRICARE Senior Pharmacy
Enhanced TRICARE Retiree Dental Program
Extension of medical and dental benefits for survivors
Entitlement for Medal of Honor recipients
TRICARE Prime travel entitlement
Chiropractic Care program
School physicals

continued on the next page

2002
TRICARE Prime Remote for active-duty family members
TRICARE Online for online appointment scheduling
TRICARE Plus Program
2004
Elimination of non-availability statements
Transitional Assistance Management Program expanded
2005
TRICARE Reserve Select
TRICARE Maternity Care options
2007
Expansion of TRICARE Reserve Select
Expanded disease management programs
2008
Wounded Warrior benefits
Establishment of Pathology Center
2009
Active-Duty Dental Program
Increase of Extended Care Health Options government liability to $36,000 for certain services
Elimination of copays for preventative services for TRICARE Standard
2010
TRICARE Overseas Program begins health care delivery
TRICARE Retired Reserve
Guard/Reserve coverage expanded for early eligibility
Transitional Assistance Management Program offered to active-duty joining select reserve
2011
TRICARE Young Adult

Appendix 2

Summary
Previous Proposals on TRICARE Cost Shares for Retirees under the Age of 65

		Year 1	Year 2	Year 3	Year 4	Year 5
PRIME ENROLLMENT FEES:						
2007 Task Force[1]	Tier 1	$460	$570	$680	$790	$900
	Tier 2	$460	$640	$830	$1,010	$1,190
	Tier 3	$460	$780	$1,110	$1,430	$1,750
2011 CBO Analysis[2]	Tier 1	$1,100	$1,100	$1,100	$1,100	$1,100
	Tier 2	$1,100	$1,100	$1,100	$1,100	$1,100
	Tier 3	$1,100	$1,100	$1,100	$1,100	$1,100
FY13 DoD Budget[3]	Tier 1	$520	$600	$680	$760	$850
	Tier 2	$520	$720	$920	$1,185	$1,450
	Tier 3	$520	$820	$1,120	$1,535	$1,950

		Year 1	Year 2	Year 3	Year 4	Year 5
STANDARD/EXTRA ENROLLMENT FEES:						
2007 Task Force[1]	Tier 1	$0	$30	$60	$90	$120
2011 CBO Analysis[2]	All Tiers	$100	$100	$100	$100	$100
FY13 DoD Budget[3]	All Tiers	$0	$140	$170	$200	$230

		Year 1	Year 2	Year 3	Year 4	Year 5
STANDARD/EXTRA ANNUAL DEDUCTIBLE:						
2007 Task Force[1]	All Tiers	$300	$350	$390	$440	$490
2011 CBO Analysis[2]	All Tiers	$700	$700	$700	$700	$700
FY13 DoD Budget[3]	All Tiers	$300	$320	$400	$460	$520

Sources:

1. Department of Defense, "Task Force on the Future of Military Health Care, Final Report," 2007, available at www.naus.org/resources/MilHealthCareTaskForceFINALREPORT12-07.pdf.

2. Congressional Budget Office, "Reducing The Deficit: Spending and Revenue Options," 2011, available at http://cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf.

3. US Department of Defense, *Overview: FY 2013 Budget Request*, February 2012, http://comptroller.defense.gov/defbudget/fy2013/FY2013_Budget_Request_Overview_Book.pdf.

Notes

1. Dinah Walker, *Trends in U.S. Military Spending*, Council on Foreign Relations, August 23, 2012, www.cfr.org/geoeconomics/trends-us-military-spending/p28855.

2. Robert M. Gates, "Eisenhower Library (Defense Spending)" (speech, Abilene, KS, May 8, 2010), www.defense.gov/speeches/speech.aspx?speechid=1467.

3. US Department of Defense, *Evaluation of the TRICARE Program: Fiscal Year 2012 Report to Congress*, February 2012, 10, www.tricare.mil/hpae/_docs/TRICARE2012_02_28v5.pdf.

4. Defense Business Board, *Focusing a Transition*, January 2009, 31, http://dbb.defense.gov/Portals/35/Documents/Reports/2008/FY09-4_Focusing_A_Transition_2009-1.pdf.

5. Congressional Budget Office, *Long-Term Implications of the 2013 Future Years Defense Program*, July 2012, 20, www.cbo.gov/publication/43428.

6. Ibid., 22.

7. Philip Lurie, "Analysis and Forecasts of TRICARE Costs," Institute for Defense Analyses, Fall 2008, 1, https://www.ida.org/upload/research%20notes/rn_fall2008_tricare.pdf.

8. "Cutting Retiree Benefits a Sore Subject for Military," NPR, December 4, 2011, www.npr.org/2011/12/04/143115964/cutting-retiree-benefits-a-sore-subject-for-military.

9. Thom Shanker, "Joint Chiefs Support Rise in Health Care Fees for Military Retirees," *New York Times*, February 14, 2011, http://atwar.blogs.nytimes.com/2011/02/14/joint-chiefs-support-rise-in-health-care-fees-for-military-retirees/.

10. US Government Printing Office, "Hearing before the Committee on Armed Services, United States Senate," Senate Hearing 111-836, August 3, 2010, www.gpo.gov/fdsys/pkg/CHRG-111shrg64136/html/CHRG-111shrg64136.htm.

11. US Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality: Fiscal Year 2012 Report to Congress*, February 28, 2012, 10, www.tricare.mil/hpae/_docs/2012eval/index.html#/a/.

12. Government Accountability Office, "Military Base Realignments and Closures: Updated Costs and Savings Estimates from BRAC 2005," June 29, 2012, 6, www.gao.gov/assets/600/592076.pdf.

13. Government Accountability Office, "DoD Health Care: Prohibition on Financial Incentives That May Influence Health Insurance Choices for Retirees and Their Dependents under Age 65," February 16, 2011, 1, www.gao.gov/assets/100/97296.pdf.

14. Congressional Budget Office, Long-Term Implications of the 2013 Future Years Defense Program, 20.

15. Government Accountability Office, *TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, but Project Savings Are Likely Overstated*, May 31, 2007, www.gao.gov/assets/270/261458.html.

16. TRICARE information available at www.tricare.mil.

17. Michelle Dolfini-Reed and Jennifer Jebo, *The Evolution of the Military Health Care System: Changes in Public Law And DoD Regulations*, Center For Naval Analysis, 2000, 1, www.cna.org/sites/default/files/research/d0000437.a3.pdf.

18. Ibid., 18, 26.

19. Congressional Budget Office, *The Effects of Proposals to Increase Cost Sharing in TRICARE*, June 2009, 2, www.cbo.gov/sites/default/files/cbofiles/ftpdocs/102xx/doc10261/tricare.pdf.

20. Ibid.

21. "TRICARE Standard and Extra," TRICARE website, www.tricare.mil/Welcome/Plans/TSE.aspx.

22. Ibid.

23. Ibid.

24. Government Accountability Office, *Medicare Subvention Demonstration*, May 1999, 3, www.tricare.mil/ocfo/_docs/GAO_HEHS_99_39.pdf.

25. US Department of Defense Health Affairs official.

26. Brittany Gregerson, "Cutting Military Health Care," *Armed Forces Journal*, (May 2012), www.armedforcesjournal.com/2012/05/10122465.

27. US Department of Defense, "DoD Implements TRICARE Senior Pharmacy Program: Fact Sheet," March 20, 2001, www.defense.gov/releases/release.aspx?releaseid=2871.

28. Peter H. Stoloff et al., *Evaluation of the TRICARE Program: FY 2002 Report to Congress* (Washington, DC: US Department of Defense, 2002), www.tricare.mil/ocfo/_docs/eval_report_fy02.pdf.

29. US Department of Defense, "TRICARE Choices: At a Glance," 4, www.humana-military.com/library/pdf/choices-at-a-glance.pdf.

30. US Department of Defense, "TRICARE Choices: At a Glance," 5.

31. US Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality: Fiscal Year 2012 Report to Congress*, 10.

32. US Department of Defense Health Affairs official.

33. US Department of Defense, *Evaluation of the TRICARE Program: Access, Cost, and Quality: Fiscal Year 2012 Report to Congress*, 9.

34. US Department of Defense Health Affairs official.

35. Congressional Budget Office, *Growth in Medical Spending by the Department of Defense*, September 2003, 27, www.cbo.gov/sites/default/files/cbofiles/ftpdocs/45xx/doc4520/09-09-dodmedical.pdf.

36. Richard A. Best Jr., *Increases in Tricare Costs: Background and Options for Congress* (Washington, DC: Congressional Research Service, July 25, 2008), 3, www.dtic.mil/cgi-bin/GetTRDoc?AD=ADA485895.

37. Don J. Jansen and Katherine Blakeley, *Military Medical Care: Questions and Answers* (Washington, DC: Congressional Research Service, July 24, 2013), 7, www.fas.org/sgp/crs/misc/RL33537.pdf.

38. Rick Maze, "Hagel Defends DoD's Call for Tricare Fee Hikes," Military Times, April 11, 2013, www.militarytimes.com/article/20130411/BENEFITS06/304110008/Hagel-defends-DoD-s-call-Tricare-fee-hikes.

39. US Department of Defense, *Section-by Section Analysis*, March 14, 2012, 70, www.dod.mil/dodgc/olc/docs/14March2012NDAASectionalAnalysis.pdf.

40. Marci Nielsen et al., *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results*, 2012 (Washington, DC: Patient-Centered Primary Care Collaborative, 2012), 1, www.pcpcc.net/sites/default/files/media/benefits_of_implementing_the_primary_care_pcmh.pdf.

41. Linda M. Pikulin, Eric W. Christensen, and CDR Jamie Lindly, *FY12 Medical Home Port Evaluation* (Washington, DC: Center for Naval Analysis, September 2012), 35, 37, 38, 40, 41, 43, 45, www.cna.org/sites/default/files/research/DRM-2012-U-001777-Final.pdf.

42. Nielsen et al., *Benefits of Implementing the Primary Care Patient-Centered Medical Home*, 2–3.

43. Ibid., 7–13.

44. Government Accountability Office, *TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending*, 15.

45. US Department of Defense, *Task Force on the Future of Military Health Care: Final Report*, December 2007, 6, www.naus.org/documents/MilHealthCareTaskForceFINALREPORT12-07.pdf.pdf.

46. Don J. Jansen, *Increases in Tricare Costs: Background and Options for Congress* (Washington, DC: Congressional Research Service, May 14, 2009), 4, http://assets.opencrs.com/rpts/RS22402_20090514.pdf.

47. Congressional Budget Office, *Reducing the Deficit: Spending and Revenue Options*, March 2011, 78–79, www.cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12085/03-10-reducingthedeficit.pdf.

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

49. US Department of Defense, *Task Force on the Future of Military Health Care*.

50. Nielsen et al., *Benefits of Implementing the Primary Care Patient-Centered Medical Home.*

51. US Department of Defense, *Military Health System Patient Centered Medical Home Guide*, June 2011, 1–4, www.tricare.mil/tma/ocmo/download/MHSPCMHGuide.pdf.

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

53. Congressional Budget Office, *Reducing the Deficit*, 19, 78–79. See also National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, 2010, 41–42, www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf.

54. US Department of Defense, *Overview: FY 2013 Budget Request*, February 2012, http://comptroller.defense.gov/defbudget/fy2013/FY2013_Budget_Request_Overview_Book.pdf.

55. CBO, *Reducing the Deficit*, 19, 80, 82.

56. US Department of Defense, *Task Force on the Future of Military Health Care*.

57. US Department of Defense, *Overview: FY 2013 Budget Request*, 5-4.

58. Cost savings estimates calculated based on the work by the DoD, Congressional Budget Office, and Government Accountability Office in their past proposals cited in this report.

59. Congressional Budget Office, *The Effects of Proposals to Increase Cost Sharing in TRICARE*, 3.

About the Author

John L. Kokulis is President/Founder of Constantine Partners LLC, a management consulting firm. Previously, he served as deputy assistant secretary of defense for health budgets and financial policy during the George W. Bush administration. Additionally, he served as the special assistant to the secretary of defense for health affairs, and as a member of the Defense Health Board. He is currently a member of the board of governors of Chapman University and an advisory board member of the school's entrepreneurial leadership program.

Acknowledgments

I would like to thank Charles Morrison, Christy Sadler, Claude Aubert, and the entire team at the American Enterprise Institute for their dedicated support in the research, editing, and publication of this document. I am especially grateful to Danielle Pletka, Joseph Antos, and Scott Gottlieb for their invaluable feedback on the many drafts of this document.