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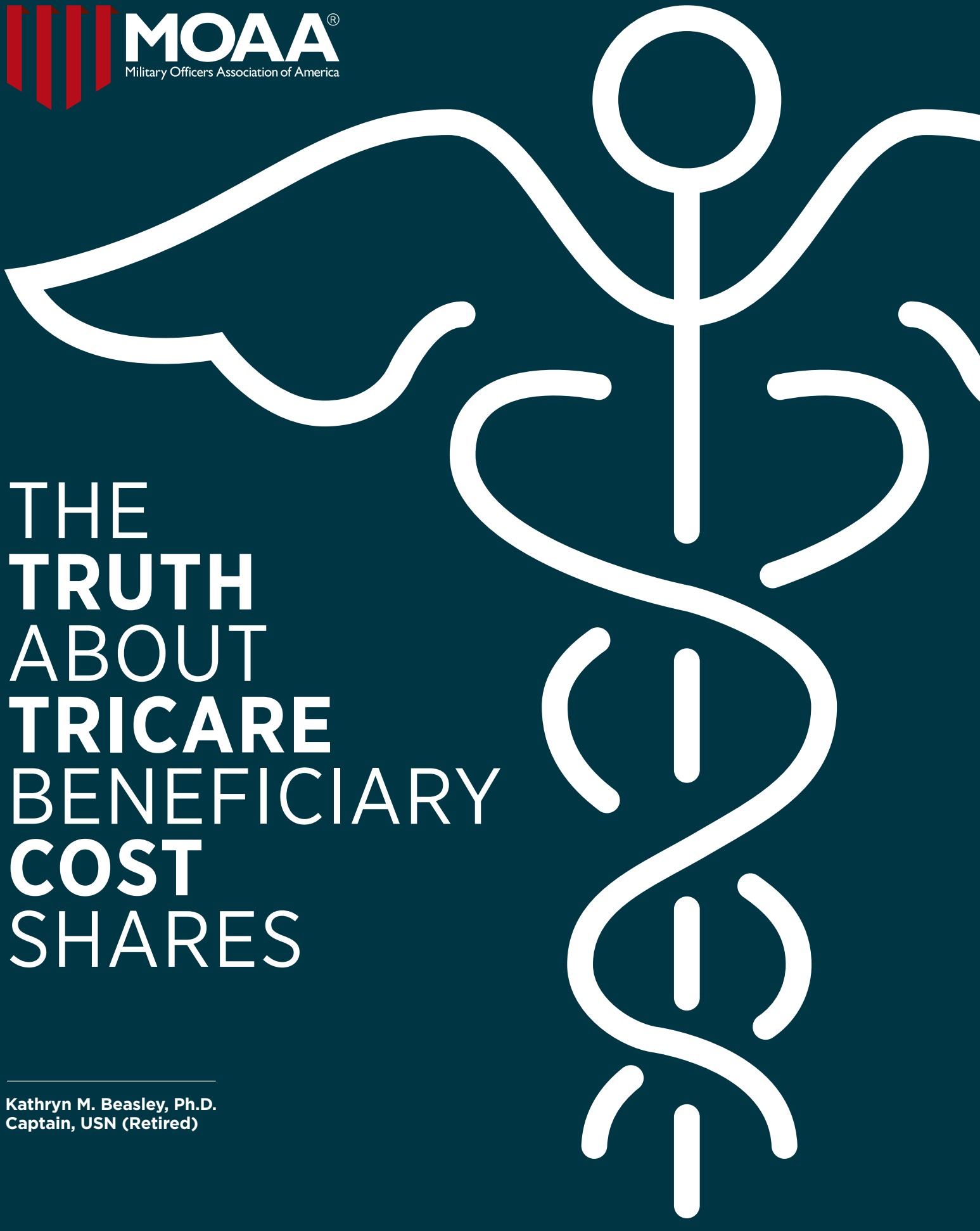
Military Officers Association of America



THE **TRUTH** ABOUT **TRICARE** BENEFICIARY **COST** SHARES

Kathryn M. Beasley, Ph.D.
Captain, USN (Retired)

Executive Summary

The military retirees' service-earned health care benefit is a top priority of the Military Officer Association of America (MOAA). The benefit is continually attacked and remains under a near-constant threat of further erosion — in part because decision-makers have been operating absent a complete picture of today's military retiree, the history of the TRICARE program, and the service and sacrifice military personnel (and their families) have paid up front for their benefits.

Today's retirement-eligible servicemember likely has deployed to a war zone multiple times, disrupting all aspects of life for themselves and their family. It is not fully known how these decades of multiple deployments will translate into their health care needs in retirement. Several factors are known, but more unknowns remain.

Meanwhile, years of scaling down budgets, system reforms, increasing fees, and a false narrative of what beneficiaries pay have left the TRICARE benefit fractured. Despite this, it remains the target of additional cost-saving measures. The facts are these:

- TRICARE is one part of the Military Health System, one of the largest, most complex systems in the world.
- DoD uses fiscal year 2000 as a data point in budget discussions. This is dangerous because it was prior to 9/11. It also was the end of years of decreased budget cuts.
- In the past 37 years, DoD has consistently spent about 33 percent of its budget on personnel and health care. This represents stability in budgeting and distribution.
- In 2012, Congress instituted an annual premium increase for TRICARE beneficiaries. The increase was tied to the annual cost-of-living adjustment (COLA).
- In 2018, the Defense Health Agency restructured fee tables, greatly increasing beneficiary cost shares which affect working-age retirees the most.
- Prescription costs for beneficiaries are on track to rise significantly between 2017 and 2027.
- Today's working-age TRICARE retiree's cost shares are now more closely aligned with the average civilian's cost shares than in previous years, and increasingly in proportion with the civilian employer's cost of coverage. In fact, in many typical scenarios, there is only a 4 percent difference between the average civilian family's share of health care costs and the average military family's share.

As the economy has become robust and recruitment and retention issues continue to rise, the vitality of the health care benefit, very likely, will be a determining factor for recruitment and more so for retaining those currently serving and their families.

ABOUT THE AUTHOR
Capt. Kathryn Beasley, Ph.D. USN (Ret) has been the director of Government Relations for Health Affairs at the Military Officers Association of America since 2009. Contact her via email at KathyB@moaa.org

The Truth About TRICARE Beneficiary Cost Shares

Introduction

Service-earned benefits are a top priority for the Military Officers Association of America (MOAA). One of these benefits, earned through a career of service and sacrifice, is health care coverage through the TRICARE program.

Yet, that benefit, and those who have earned it, seem to continually come under siege by Department of Defense (DoD) officials and by some members of Congress. On an annual basis, or even more frequently, military retirees' health care benefits are targeted as a resource for DoD's readiness accounts.

Today's working-age TRICARE retiree's cost shares are now closely aligned with the average civilian's cost shares, and in proportion with the civilian employer's cost of coverage. This is the result of several years of TRICARE fee increases. Importantly, retirees age 65 and over continue to pay some of the highest costs of all. The impact of accumulated program changes, including new benefits, has greatly altered the original TRICARE program.

DoD should correct the misperception that military retirees do not pay as much for health care as civilians do. First, any comparison between military retirees' earned benefits and their civilian counterparts' employee benefits is an apples-to-oranges notion. Second, the true costs borne by those who have served, and their families, show the significant price they pay.

Necessary historical context will reveal the military retiree of today pays their fair share in the cost of their health care. However, there is no explanation for the diminishing premium for their decades of service and sacrifice.

Today's Military Retiree

The health care benefit a military member becomes eligible for when they retire is earned through a career of service and sacrifice. That period of service might be 20 years, 30 years, or more, and might include times of war or peace. To understand who the 21st-century military retiree is, it is important to consider key aspects, such as age, finances, and family culture. Additional consideration must be given to deployment effects on service-members' health and family — given the past two decades of war in Iraq and Afghanistan. Military families in particular have experienced the real costs of war with lost family income stemming from frequent moves, the effects of repeated deployments, and long-term issues which impact their and their children's health status.

General Retirement Data

According to the 2018 Congressional Research Service (CRS) report, *Military Retirement: Background and Recent Developments*, in 2017, there were more than 2 million military retirees in the U.S. DoD paid retirees $53.5 billion

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that year. Military retirement pay is funded entirely by the government into the military retirement system. In its report, CRS highlights that this benefit is considered a significant retention tool for maintaining a career force. The system includes a defined payment for all retirees as well as nonmonetary benefits, which include TRICARE coverage.

The CRS report also notes, "In FY2017, the average active duty non-disability enlisted retiree is 42 years old and has 21 years of service at retirement; the average officer is 46 years old and has about 23 years of service at retirement."

A Career History of Deployment

The newest generation of servicemembers retiring or considering retirement in the next few years represents a cohort who have served the duration of their careers during wartime conflicts, post-Sept. 11, 2001. Of course generations of servicemembers, veterans, and retirees have endured tremendous sacrifices during their service to the nation — but serving in the military during the recent 20-year span unquestionably has affected servicemembers and their families in ways not yet fully understood. One thing is certain, servicemembers and their families have carried and continue to carry a tremendous burden in the service to our nation.

In its 2018 report, *Examination of Recent Deployment Experience Across the Services and Components*, RAND Corp. notes, "Deployment history is a key aspect of new military retirees' service, especially in the post-9/11 era. Deployments have also been linked to the well-being of servicemembers and their families. Aspects such as the number of deployments and the cumulative time spent deployed are associated with a wide variety of relevant outcomes; examples include the retiring servicemembers' physical and mental health, the post-deployment earnings of reservists, well-being and academic performance of the servicemembers' children, the quality of marital relationships, and spouses' labor force participation to name a few."

The report also references an earlier RAND analysis, *The Deployment Life Study: Longitudinal Analysis of Military Families Across the Deployment Cycle*, which found deployments pose a significant disruption and are associated with numerous servicemember and family health care needs. The 2018 report states, "spouses of deployed servicemembers reported their children experienced behavioral and peer-related problems during deployments (Meadows et al., 2016)." Additionally, the annual *Military Family Lifestyle Survey* by Blue Star Families ranked, in 2017 and 2018, time away from family, followed by pay and benefits, as a top concern for both servicemembers and their spouses.

According to the 2018 RAND study, "All of the services have contributed substantially to the 3.1 million troop-years of deployments since September 2001," with the Army leading. It also notes, "Previous studies have shown the correlations between deployments and servicemember and family well-being," so it is important to understand the servicemembers who deployed during their careers. Of those who deployed, most were active duty, enlisted, and, the study states, "Most servicemembers who deployed were married at the time; nearly half had children."

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Regarding mental health and well-being, a 2011 survey by the Pew Research Center, *The Difficult Transition from Military to Civilian Life*, found that "veterans who served after Sept. 11, 2001, have experienced difficulties readjusting to civilian life. The model [Pew used] predicts that a veteran who served in the post-9/11 era is 15 percentage points less likely than veterans of other eras to have an easy time readjusting to life after the military (62% vs. 77%)." Additionally, Pew found "two other factors significantly shaped the re-entry experiences of post-9/11 veterans but appear to have had little impact on those who served in previous eras. Post-9/11 veterans who were married while they served had a significantly more difficult time readjusting than did married veterans of past eras or single people regardless of when they served."

The Pew analysis also identified significant emotional issues in a service-member's transition to civilian life. For instance, the Pew study states, "Serious injuries and exposure to emotionally traumatic events are relatively common in the military. Nearly a third (32 percent) of all veterans say they had a military-related experience while serving that they found to be 'emotionally traumatic or distressing' — a proportion which increases to 43 percent among those who had served since the Sept. 11, 2001, terrorist attacks."

Health Status of Those Who Have Served

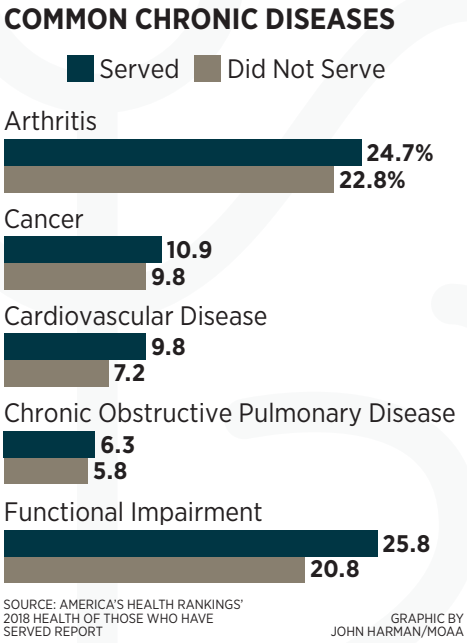
It is not often thought of, or even recognized, that those who have served for any amount of time in uniform, much less a full-service career, would have a difference in their health status from civilians who have never served. MOAA, in partnership with the United Health Foundation, examined these differences across a number of domains measured by the Centers for Disease Control and Prevention surveys from 2011 through 2016. The most recent iteration of this study was published in 2018, *America's Health Rankings 2018® Health of Those Who Have Served Report*. It was the first year health trends were available. The findings are segmented by sub-populations and age cohorts, so the health characteristics and behaviors of age-related cohorts of retirees can be observed.

Overall, individuals who have served reported their general health status was better than reported by their civilian counterparts. However, the report notes, "Despite generally reporting better health, those who have served still have higher rates of chronic disease and behavioral health concerns, and little-to-no improvements have been made on many important markers of good health." There are noted differences in chronic diseases between those who have served and their civilian counterparts.

Many chronic disease rates for those who have served indicate significant differences (Figure 1), especially among the over-50-year-old demographic who have served, whose rates are even more divergent.

The report draws attention to mental health outcomes, with a focus on data that indicate both men and women who have served have higher rates of depression, anxiety, and frequent mental distress when compared to both civilian men and women (Figure 2). And it states a disturbing fact: "The rate of depression among those who have served has increased 9 percent overall and as much as 32 percent among those who have served aged 26-34 since the first time MOAA and United Health Foundation examined this in

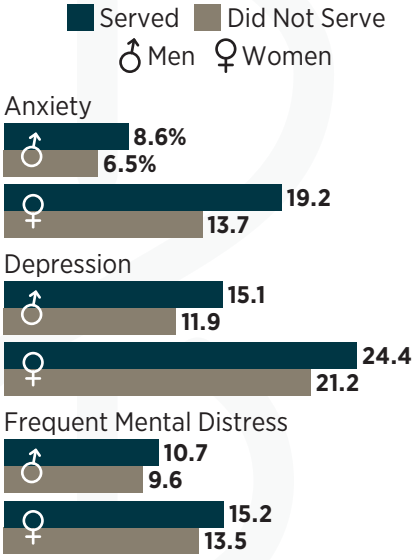
Figure 1



SOURCE: AMERICA'S HEALTH RANKINGS' 2018 HEALTH OF THOSE WHO HAVE SERVED REPORT

GRAPHIC BY JOHN HARMAN/MOAA

Figure 2



SOURCE: AMERICA'S HEALTH RANKINGS® 2018 HEALTH OF THOSE WHO HAVE SERVED REPORT

GRAPHIC BY JOHN HARMAN/MOAA

2011-12." Further, it notes that "during this time, little improvement has been observed in rates of anxiety and frequent mental distress among those who have served."

"These new markers of health provide a more holistic picture of the health of those who have served," the report states. They also provide for greater quantitative awareness into the strengths and challenges associated with the health and well-being of those who have served. The findings also add helpful insight into the health status of today's military retiree.

Putting the Cost of Military Health Care in Context

To understand the actual monetary costs of TRICARE, it is important to first take a macro view of the Military Health System (MHS), of which the TRICARE program is only one part.

As a health care organization, the MHS is one of the largest and most complex in the world. It supports health care needs for 9.5 million beneficiaries globally, to include the reserve components. The MHS has two main missions. First, its primary mission is to maintain operational readiness of servicemembers in preparation for conflict, and for casualty care during and resulting from conflict. This role has expanded over time to include missions other than war, for example peace-keeping and humanitarian missions. Second, it is charged with providing peacetime health care for families of servicemembers and retirees and their family members and survivors. This dual mission requirement is performed through multifaceted global organizational entities, requiring a budget of commensurate size. In the FY 2019 budget, the Defense Health Program (DHP) was appropriated $51 billion.

The myth DoD and others frequently utilize is a narrative that misrepresents the costs associated with providing health care to eligible beneficiaries. For the past decade, numerous reports and official public comments, including the Institute for Defense Analyses' 2016 report, *Comparing the Cost of Military Treatment Facilities with Private Sector Care*, have claimed DoD's personnel costs are skyrocketing, "driven largely by health care costs." Even though the government has been spending record amounts on defense, the report claims, "DoD's budget is being squeezed by rising health care costs that have increasingly crowded out funding for weapon systems, training, and other operational needs."

Adding context to the facts provides the reality of DoD's health care costs and personnel budgets. When describing the trend in personnel cost growth, the DoD frequently reverts to the year 2000 as the starting point. Costs surely have grown since then — for all things. Using 2000 as a baseline for estimating health care and personnel spending, without reflection on the historical context, is misleading and amounts to cherry-picking the data to make it look as dramatic as possible.

From a budget perspective, 2000 was the culmination of years of budget cuts, depressed military pay, slashed retirement value (by 25 percent for post-1986 entrants), and retirees over age 65 forced completely out of the MHS. As a result, retention suffered. To prevent a readiness crisis, over the course of the next decade, Congress enacted numerous legislative provisions aimed at benefit improvements and pay comparability. One of these was

Using 2000 as a baseline for estimating health care and personnel spending, without reflection on the historical context, is misleading and amounts to cherry-picking the data to make it look as dramatic as possible.

named TRICARE For Life (TFL), and restored promised health care coverage for military retirees over age 65. These and other investments were required to retain a career force.

Expanding the historical budget of DoD's personnel and health care costs deeper into the past, a different picture emerges. Military personnel and health care costs have continued to consume the same portion of DoD's budget — approximately one-third — for the past 37 years (Figure 3).

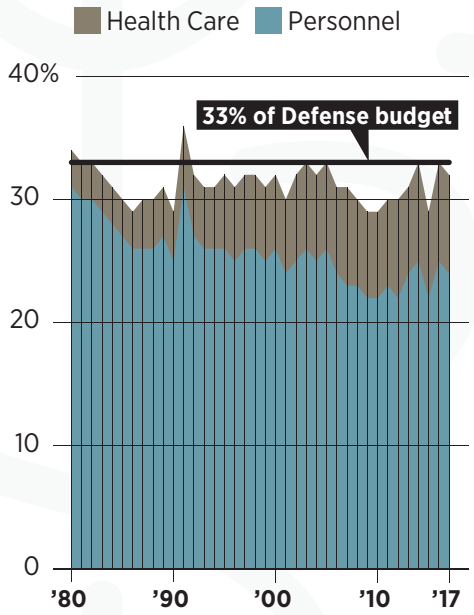
Military health care costs also have decreased and leveled off since 2010 (Figure 4). The Defense Health Agency (DHA) has even reprogrammed funds from year-end savings in health care back into DoD to be used for readiness. In 2018 alone, and by admission, the DHA reallocated $870 million. That money was used for night-vision goggles and the DoD working capital fund. It was not invested back into the health care program nor provided to beneficiaries to lower their costs.

Improving the transparency of readiness funding and effectively controlling the costs of providing care should be the goal of DoD. Separating the costs of providing care to 9.5 million beneficiaries from the costs of ensuring readiness is difficult because they overlap. Thus, the true cost of providing the health care benefit is uncertain, and determining how to lower those costs is challenging. To senior leadership, it appears easier and more expedient to raise revenue through fee increases. As a result, in recent years DoD has succeeded in its efforts to raise TRICARE fees across all categories of beneficiaries, including active duty families. However, the main target for increased funding continues to be retired beneficiaries. For the past two decades, the TRICARE benefit has remained a focus area for DoD.

Figure 3

MILITARY PERSONNEL COSTS ARE NOT EXPLODING

About one-third of the defense budget goes to military personnel and health care costs — the same share it has been for more than 30 years. That's no more unaffordable now than in the past.



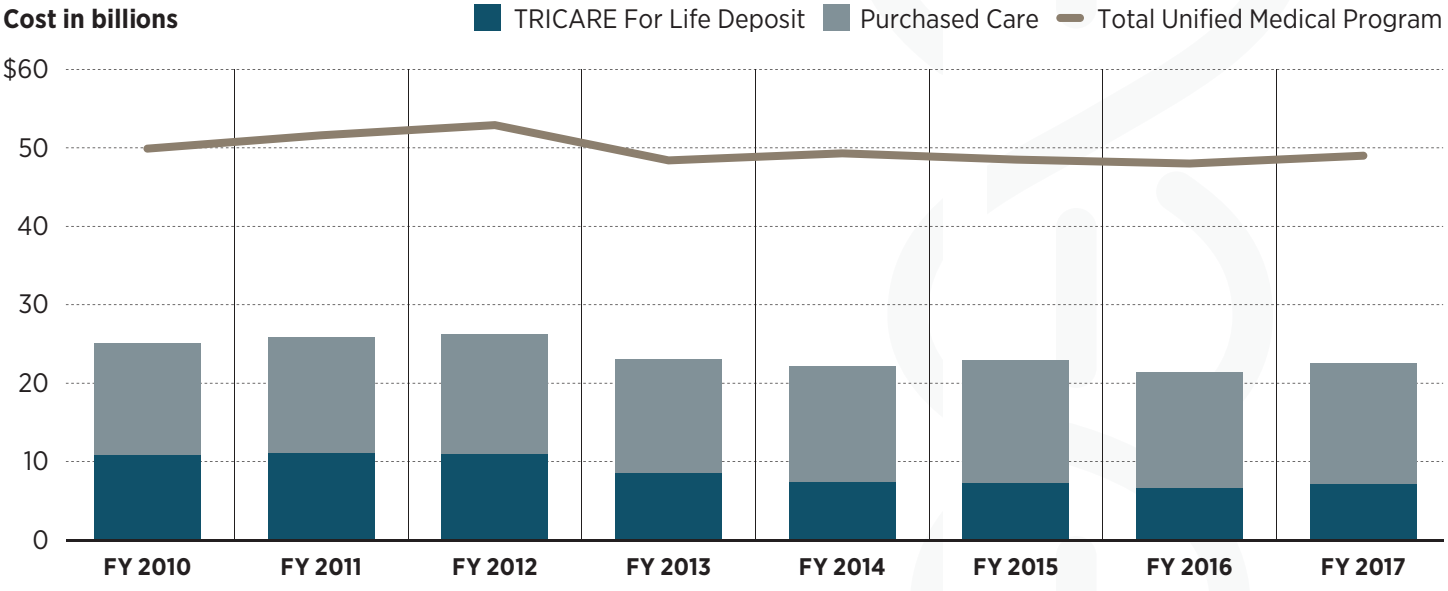
SOURCE: OMB HISTORICAL TABLES: 1980-2017

GRAPHIC BY JOHN HARMAN/MOAA

Figure 4

DOD HEALTH CARE COSTS CONTINUE TO DECLINE

Officals claim health care costs are "eating the department alive," but the numbers don't back that up.



SOURCE: DOD REPORTS TO CONGRESS: MHS WORLDWIDE SUMMARY: POPULATION, WORKLOAD, AND COSTS

GRAPHIC BY JOHN HARMAN/MOAA

Background and History of the TRICARE program

To understand today's TRICARE health benefit, it is necessary to review how health care for military beneficiaries has developed over time. To a great extent, the evolution of military health care mirrors how health care changed in the U.S. A historical review by the Center for Naval Analyses (CNA), *The Evolution of the Military Health Care System: Changes in Public Law and DOD Regulations*, finds that decades ago, "the 1956 Dependents' Medical Care Act officially established the availability of health care services to active duty dependents, retirees, and their dependents at military treatment facilities (MTFs). It also authorized the Secretary of Defense to contract with civilian health care providers for active duty dependents' medical care."

Since 1956, the MHS has experienced changes in size and scope, mission complexities, technological advancements, and expanded beneficiary populations, and these have been staggering. The following chronological list of legislative changes, from CNA's historical review, represents the most significant impacts on the health care benefit itself, prior to the advent of the TRICARE program in 1996, through to the present day:

- 1956, authorized the offering of civilian health care coverage to active duty dependents
- 1960, required nonavailability statement for nonemergent inpatient care and set coverage limits on care from civilian providers
- 1966, adopted the Military Medical Benefits Amendments
  - Formally established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), including coverage for retirees and their dependents
  - Expanded MTF and civilian provider coverage
- 1976, introduced the 40-mile radius catchment area rule and defined excluded services under CHAMPUS
- 1983, authorized CHAMPUS as secondary payer
- 1986, created the Dependents' Dental Program
- 1987, made changes to provider reimbursement methods
  - Implemented CHAMPUS Diagnosis-Related Group (DRGs)
  - Authorized MTF third-party billing for inpatient care
- 1988-89, established a catastrophic cap
- 1996, changed to TRICARE.

TRICARE reimburses civilian providers under Medicare rules. Additionally, MOAA notes the following recent changes:

- 2000 Established TRICARE For Life for over-age-65 beneficiaries
- 2017 NDAA reformed the TRICARE program and restructured the MHS

Over the past two decades, the three separate military medical departments implemented the TRICARE program, with a centralized TRICARE organizational structure providing oversight and management of the managed care support contractors. Administration of the benefit and services' readiness requirements were accomplished through a constellation of MTFs, clinics, and civilian providers. Generally, beneficiaries could move freely among these systems — from fee-for-service in the TRICARE Standard option to a managed HMO-style program such as TRICARE Prime — and into and out of the MTFs.

Since 1956, the MHS has experienced changes in size and scope, mission complexities, technological advancements, and expanded beneficiary populations, and these have been staggering.

The Current TRICARE Program — and TRICARE Reform

Over the years, the TRICARE program was adjusted in terms of managed care contractor changes, regional office configurations, and where TRICARE Prime would or would not be offered. However, most recently, as a result of the 2017 NDAA, the TRICARE program has experienced its greatest reforms since its inception. For example, TRICARE beneficiaries are required to declare their TRICARE health care option during mandated open-enrollment periods, as is commonly done in civilian health plans.

Importantly, major structural changes have occurred in the MHS simultaneously with TRICARE benefit changes. TRICARE contract oversight, as well as control of the three services' MTFs, will now be completely executed under the DHA's authorities, as was legislatively mandated in the 2017 NDAA. The DHA believes it can better prepare for future budget strategies by consolidating enterprise-wide functions, such as pharmacy and information technology. The objective is to reduce duplication and create greater savings and efficiencies across the system. The beginnings of those savings (which include increases in pharmacy and TRICARE cost shares paid by beneficiaries) are being realized by DoD and, as of FY 2017, they remain ahead of schedule (Figure 5).

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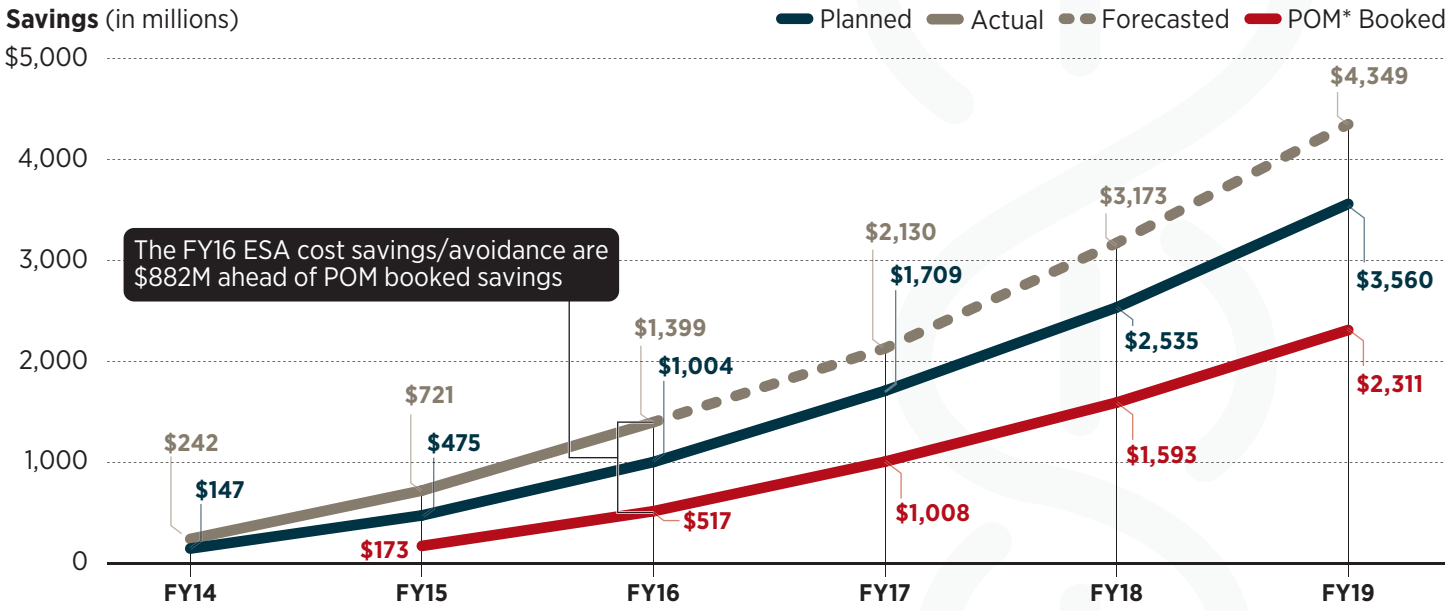
The Establishment of the TRICARE Fee Structure

Before TRICARE was established in 1996, MHS beneficiaries paid varying out-of-pocket costs based on where and from whom they received treatment. CNA's review notes, "Under what was considered the traditional

Figure 5

ENTERPRISE SUPPORT ACTIVITIES (ESAs)

DoD's health care savings have increased ahead of plan.



*Program Objective Memorandum (POM) booked savings are formal projections of estimated savings to DoD.

SOURCE: DEFENSE HEALTH AGENCY

GRAPHIC BY JOHN HARMAN/MOAA

GETTYIMAGES/HERO IMAGES

military health care benefit, beneficiaries did not pay a monthly premium — as was more often the case in the civilian, employer-based, health insurance market — for medical coverage regardless of whether they received their care in a military facility or from a civilian provider."

However, in the National Defense Authorization Act (NDAA) of 1994, when TRICARE was legislatively established, a fee structure was put into place requiring beneficiaries (not including the active duty component) to pay out-of-pocket cost shares and premiums for their health care for the first time. The original premiums for the HMO-model TRICARE Prime required under-age-65 retirees enrolling to pay a yearly fee of $230 for an individual and $460 for a family. MOAA and a handful of other military service organizations, in collaboration with DoD officials at the time, agreed to these cost shares. There were no civilian baseline comparisons or benchmarks used in reaching the decision. The only guidance was in the 1994 NDAA, directing DoD to establish "reduced out-of-pocket costs and a benefit structure that is as uniform as possible throughout the United States."

The creation of an insurance wrap-around to Medicare for TRICARE beneficiaries was legislated in the 2001 NDAA. This expanded eligibility for TRICARE coverage for Medicare-eligible military retirees age 65 or over. To receive this new coverage, military retirees were required to enroll in Medicare Part B. The new benefit was termed TRICARE For Life (TFL). The program was structured financially with Medicare as the primary payer and TRICARE as the secondary payer for Medicare-covered services. Additionally, TRICARE covers all Medicare cost-sharing by beneficiaries, including Medicare deductibles and coinsurance, and also includes a pharmacy benefit.

After they were established, TRICARE premiums remained unchanged until 2012, when Congress legislated an annual premium increase tied to the annual cost-of-living adjustment (COLA). DoD and others often contrasted TRICARE premiums and cost shares with the higher cost shares paid by

"TRICARE For Life is excellent. If it isn't broke, don't fix it."

MOAA survey respondent

civilians for their health care. For instance, the 2015 Report of the Military Compensation and Retirement Modernization Commission Final Report notes, "In 1999, military retiree premiums for TRICARE Prime represented 31 percent of the civilian HMO average; by 2014, this had fallen to only 10 percent." However, the fiscal year (FY) 2012, FY 2013, and FY 2015 defense bills increased fees by 16 percent, including large pharmacy copayments; indexed future Prime and pharmacy fee increases to military retired pay growth; and instituted mandatory home delivery of medications — all of which have made a significant contribution to slowing the growth of health care costs for DoD.

The Current TRICARE Fee Structure

In addition to the fee increases mentioned above, in 2018, the TRICARE fee structure was radically changed, to the detriment of beneficiaries. Unexpected increases in TRICARE fees spanned almost every beneficiary category, except TRICARE For Life, with retirees under age 65 suffering the greatest impact. The increases resulted from DoD's unilateral decision — made without congressional approval — to change its fee schedules from a percent-of-cost model to flat-rate fees. These structural fee changes disregard the intention of the 2017 NDAA, which prescribed current military members and their families were to be grandfathered from health care cost-share increases.

Key fee increases:

- **Retiree TRICARE Prime copayments.** Copayments range from 67 percent to 173 percent higher than 2017 Prime retiree copayments in select categories.
- **Active duty family and retiree TRICARE Select copayments.** DoD used a provision in the policy to restructure the former TRICARE Standard/Extra cost shares into what it described as an improved flat-rate copayment structure, touted as being more predictable for beneficiaries. The result is increased out-of-pocket costs that are inconsistent with private-sector PPOs and have been detrimental to many military families and retirees who rely on TRICARE Select for coverage.
- **Mental health visits considered specialty care.** This change generates significantly higher out-of-pocket costs — higher than many civilian plans — than previous TRICARE Extra coverage. These TRICARE Select costs create barriers to mental health care access.
- **TRICARE pharmacy copayments.** These copayments have doubled or tripled. For some, a $7 increase from $0 for a generic prescription can be tolerated; however, for those on a fixed income receiving several generics and other specialty medications, it is costly — and costs will increase at rates beyond the COLA in the future (Figure 6).

DoD readily asserts health care is too expensive, and these fee increases are needed to satisfy readiness costs. However, what is frequently not stated is that a large portion of the cost of health care is attributed to readiness. It is particularly disturbing that, for the first time, DoD raised TRICARE fees without the consent of the Congress. This is akin to the fox guarding the henhouse.

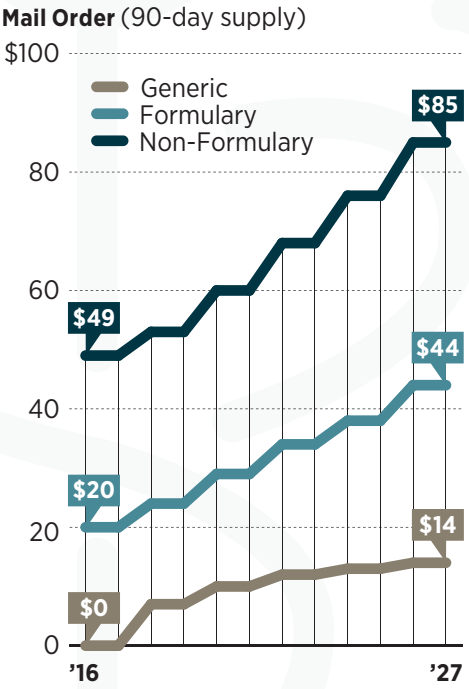
What Military Personnel Pay for Health Care and Earned Benefits

In the civilian economy, approximately three out of four full-time employees participate in employer-sponsored group health plans. According to the

Figure 6

PRESCRIPTION COSTS ON THE RISE

Mail-order generic prescriptions have already leapt from $0 to $7 since last year and are expected to double to $14 over the next 10 years. Over this same period, mail-order formularies will increase 120%, and non-formularies will increase by 73%.



SOURCE: 2018 NATIONAL DEFENSE AUTHORIZATION ACT

GRAPHIC BY JOHN HARMAN/MOAA

Kaiser Family Foundation Employer survey, the typical employee paid about 29 percent of the company's total premium cost for family coverage in 2018; the employer paid the rest. Premiums for employer-sponsored health plans (i.e., other health insurance, or OHI) vary mostly by the type of coverage (individual or family). Cost shares (including pharmacy costs) for military retirees under age 65 are becoming much more closely aligned with OHI premiums and out-of-pocket expenses for the average civilian family than they were, for example, 5 to 8 years ago (Figure 7).

The cost share data assumptions for military retirees are based on typical and conservative health care utilization patterns of today's military retiree (under age 65) and their family. The employer (DoD) portion is based on a 2018 Congressional Budget Office (CBO) estimate. These scenarios are derived from extensive experience working with transitioning military members and their families, as well as feedback from MOAA's own health care survey data and from members of The Military Coalition (a consortium of 32 member organizations representing 5.2 million military members and veterans).

Regarding "typical" health care utilization: It is understood beneficiaries use varying amounts of health care. Some might require a great deal of health care for themselves or their families, while others need much less. DoD would definitely use different data. However, MOAA's intent is to approximate realistic usage for an average military retiree and their family. It's important to acknowledge the MHS is undergoing rapid change and some downsizing of MTFs. For example, the Air Force is forcing all TRICARE Prime military retirees out of MTFs and into purchased care networks, resulting in increased out-of-pocket cost shares for beneficiaries. Also, the MHS is in the process of reducing approximately 18,000 medical personnel billets, which will result in more beneficiaries being forced into the purchased care networks. Assumption details can be found in Appendix A.

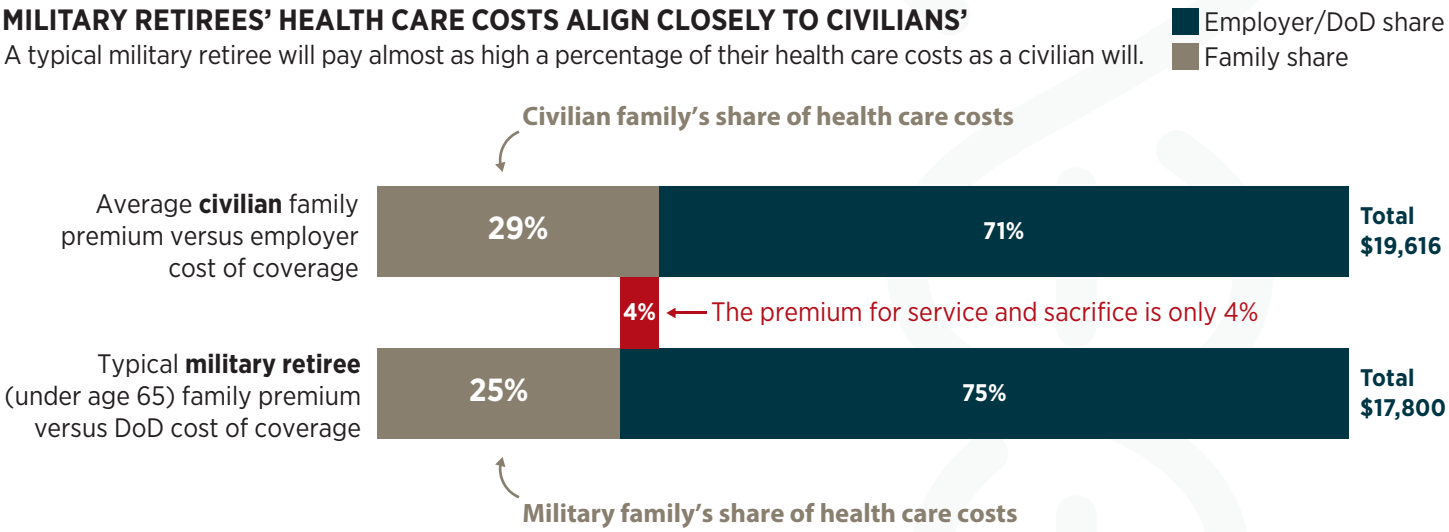
"The $41 cost for any specialty referral is too high and prohibits me from making MANY necessary appointments."

MOAA survey respondent

Figure 7

MILITARY RETIREES' HEALTH CARE COSTS ALIGN CLOSELY TO CIVILIANS'

A typical military retiree will pay almost as high a percentage of their health care costs as a civilian will.



SOURCE: KAISER EMPLOYER SURVEY, OCTOBER 2018

GRAPHIC BY JOHN HARMAN/MOAA

As retiree cost shares have increased, MOAA's survey data indicate the impact these fee increases are having on beneficiaries. Survey findings reveal TRICARE beneficiaries are increasingly dissatisfied with certain aspects of the program, such as cost of care and cost of medications, and due to this their overall satisfaction has decreased (Appendix B).

It should be noted TFL beneficiaries are not included in Figure 7. This group of beneficiaries pay some of the highest health care costs, through their Medicare Part B cost shares, and they have been especially hard hit by TRICARE pharmacy increases. These progressive year-over-year increases in pharmacy copayments are depicted in Figure 6. TFL beneficiaries will see steady increases in their cost shares across all medication tiers, which will save DoD more than $2.1 billion by 2022 and fund improvements in military readiness as well as the Supplemental Survivor Indemnity Allowance, a monthly payment to help offset the Survivor Benefit Plan-Dependency and Indemnity Compensation (SBP-DIC) offset, widows tax.

If the objective is to drive beneficiaries out of using their earned TRICARE health benefits through increased costs, imposing additional cost shares and the new TRICARE fee structure will certainly help to do that. Any additional fee increases will further erode this benefit and increase pressure on beneficiaries to delay, deny, or flat-out stop using their health care benefit, as the CBO has predicted.

Conclusion

MOAA and other military service organizations have consistently debunked the premise that military retiree health care cost shares should be compared with civilian cost shares. However, in a robust economic environment, where employers are competing for the best and the brightest, compensation packages will expand to better attract employees. If military benefits and compensation differ only marginally from those available in the civilian sector, it should come as no surprise potential military recruits will conclude the risks of military service outweigh the benefits. Who would want to sign up for the riskiest profession in the world without adequate compensation for their long-term health care?

Those who serve pay their share of their health care premiums up front with decades of service and sacrifice. Congress has been fairly consistent in supporting the principle that military retirees — by virtue of their service — should be recognized with some level of health care premium support, but the precise level of support has always been vague and not well-defined. The military health care benefit has become ripe for erosion, and we're already seeing evidence of that erosion in the costs military retirees are paying now and will pay into the future.

Those who have served have paid their share of their health care premiums up front with their decades of service and sacrifice.

TYPICAL RETIREE FAMILY OF FOUR

The sponsor of this family is typically a retiree whose rank can be either an O-5 with 22 years in service or an E-7 retiring at 20 years in service. Below is a conservative example of their annual health care utilization:

GENERAL HEALTH CARE EXPENSES	TRICARE SELECT*	TRICARE PRIME**
Annual Deductible	$300	$0
Primary Care Outpatient Visits (6)	$174	$60 (3 MTF, 3 Network 3*20)
Specialty Care Outpatient Visits (4 initial) (8 follow up)	$492	$300 (4 initial visits – 2 MTF & 2 network) (8 network follow-up visits 30*10)
ER Visits (1)	$111	$0 (MTF visit)
Urgent Care Visits (3)	$87	$90
1 Child Enrolled in TRICARE Young Adult (TYA)	$2,568 (annual premiums do not count against the catestrophic cap of $3,000).	$2,568
Enrollment fee	$0	$594
PHARMACY EXPENSES		
	90-day supply	Uses MTF for all medications
Generic Medications (3)	$84	$0
Brand-name Medications (2)	$192	$0
Non-formulary Medications (1)	$212	$0
Total:	**$4,220**	**$3,882**

*The family may or may not live near a military treatment facility (MTF).

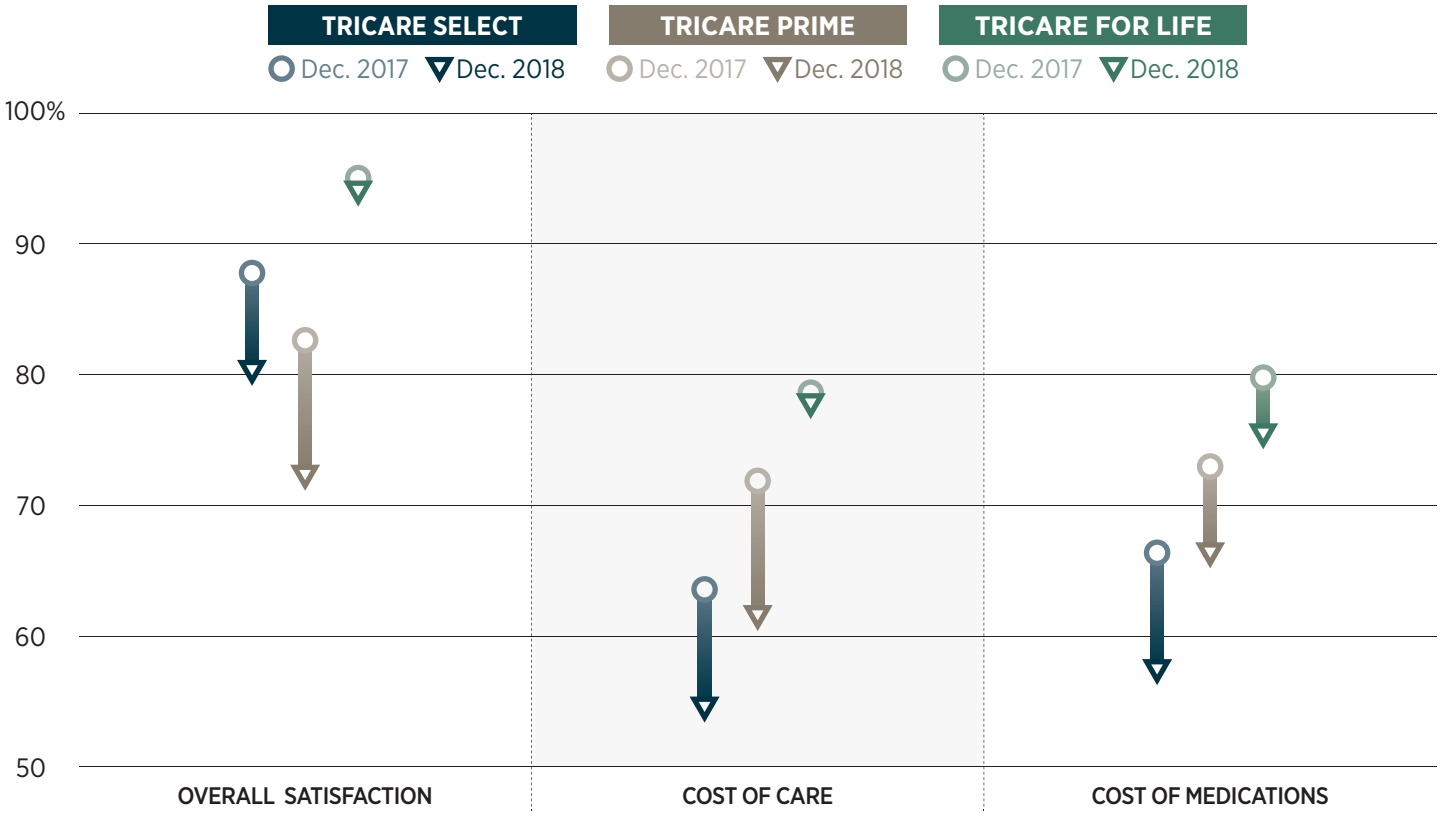
**The family lives near a military treatment facility in a Prime Service area. The family is enrolled in TRICARE Prime as their health care option. They use a mix of MTF and network care.

SOURCE: MOAA; TRICARE COSTS AND FEES FOR 2019

GRAPHIC BY JOHN HARMAN/MOAA

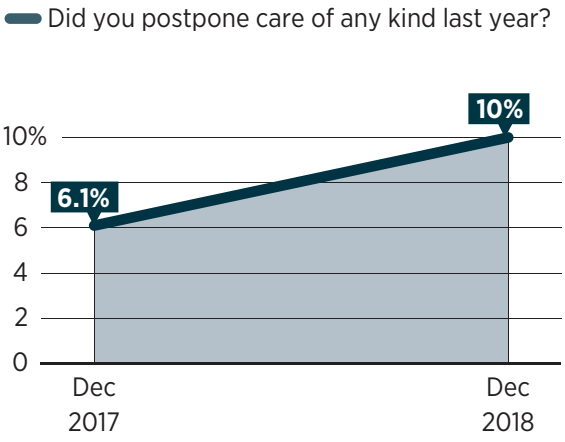
TRENDS NOTED IN HEALTH CARE SURVEY INDICATE BENEFICIARIES DISSATISFIED

Survey findings indicate TRICARE beneficiaries are increasingly dissatisfied with certain aspects of the TRICARE program. Beneficiaries using TRICARE Select and TRICARE Prime are dissatisfied the most with the cost of care, the cost of their medications and their overall satisfaction with the program trending down. Those beneficiaries using TRICARE for Life are highly satisfied with the program.



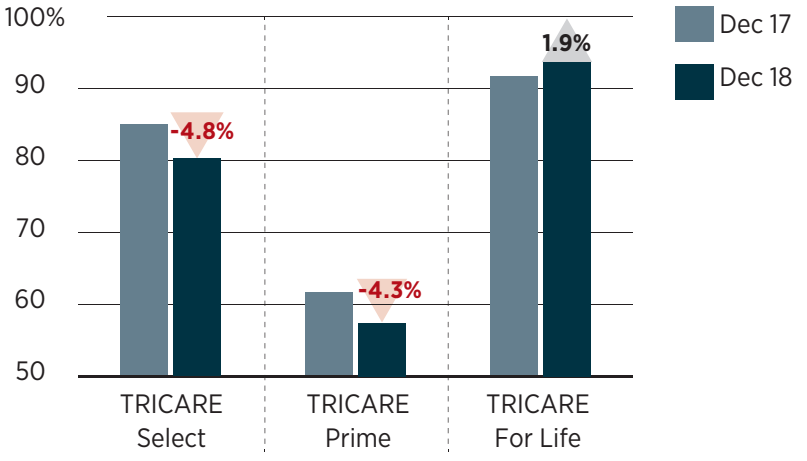
BENEFICIARIES DELAYING CARE AND THE HIGH COSTS OF MEDICATIONS

Survey respondents report increased dissatisfaction with the cost of their medications and are deferring care due to increased cost shares.



SATISFACTION WITH CHOICE OF PROVIDERS

While TRICARE For Life beneficiaries report very high satisfaction with their choice of providers, those in the TRICARE Prime and Select programs report being slightly dissatisfied with their choice of providers.



SOURCE: MOAA TRICARE BENEFICIARY SURVEY

GRAPHIC BY JOHN HARMAN/MOAA

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Military Officers Association of America
201 N. Washington St., Alexandria, VA 22314
(800) 234-MOAA (6622)
www.MOAA.org

Edited by Mariah Walters Orose | Designed by John Harman