

DOD's 21st Century Health Care Spending Challenges

**Presentation for the Task Force on the
Future of Military Health Care**

April 18, 2007

**By David M. Walker
Comptroller General of the United States**

Our Current Federal Fiscal Obligations are Unsustainable for the Long-term

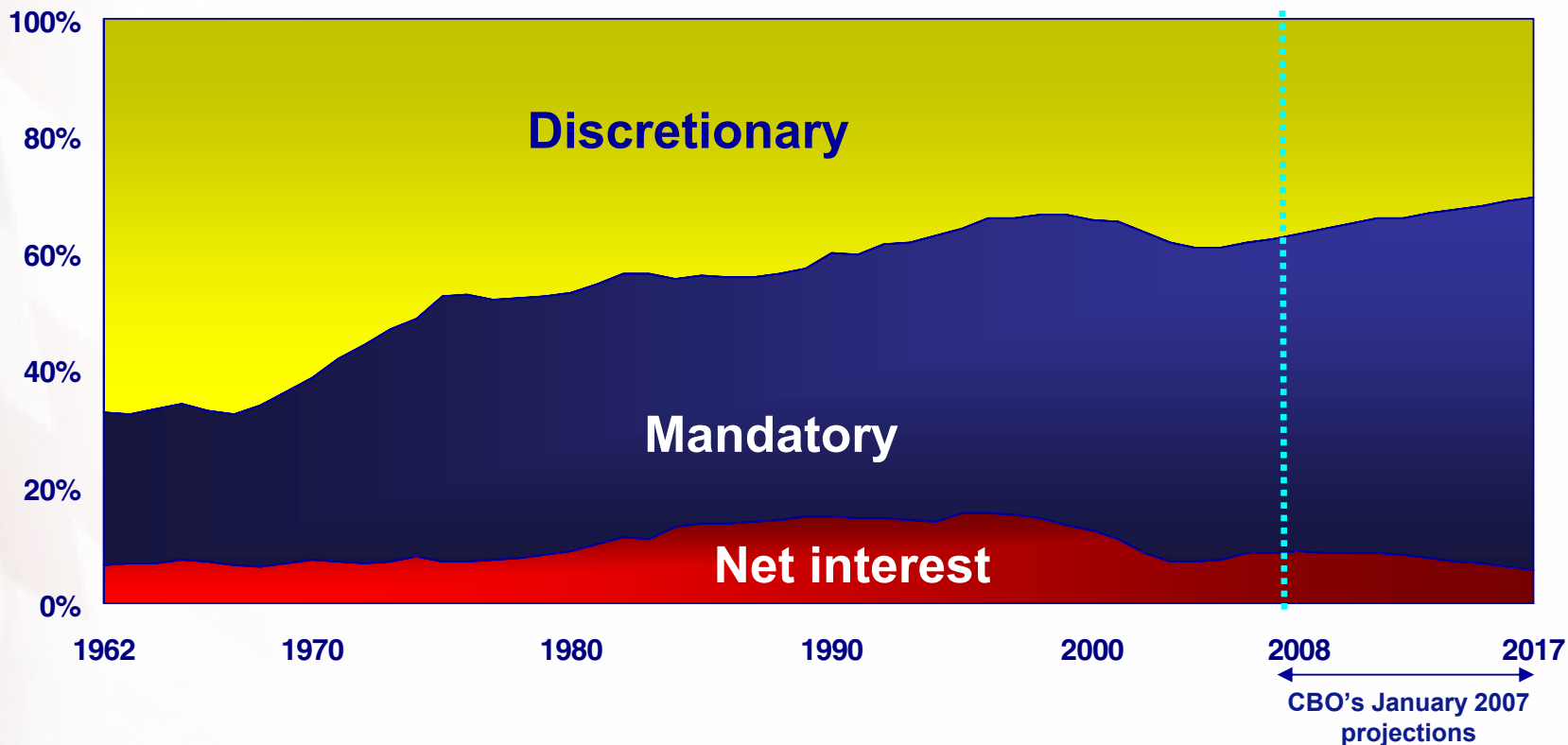
Major Fiscal Exposures(\$ trillions)	2000	2006	% Increase
<ul style="list-style-type: none"> • Explicit liabilities <ul style="list-style-type: none"> • Publicly held debt • Military & civilian pensions & retiree health • Other 	\$6.9	\$10.4	52
<ul style="list-style-type: none"> • Commitments & contingencies <ul style="list-style-type: none"> • E.g., PBGC, undelivered orders 	0.5	1.3	140
<ul style="list-style-type: none"> • Implicit exposures <ul style="list-style-type: none"> • Future Social Security benefits • Future Medicare Part A benefits • Future Medicare Part B benefits • Future Medicare Part D benefits 	13.0	38.8	197
Total	\$20.4	\$50.5	147

Source: 2000 and 2006 Financial Report of the United States Government.

Note: Totals and percent increases may not add due to rounding. Estimates for Social Security and Medicare are at present value as of January 1 of each year and all other data are as of September 30.

Federal Spending for Mandatory Programs Crowds Out Spending for Discretionary Programs

Percent of total outlays

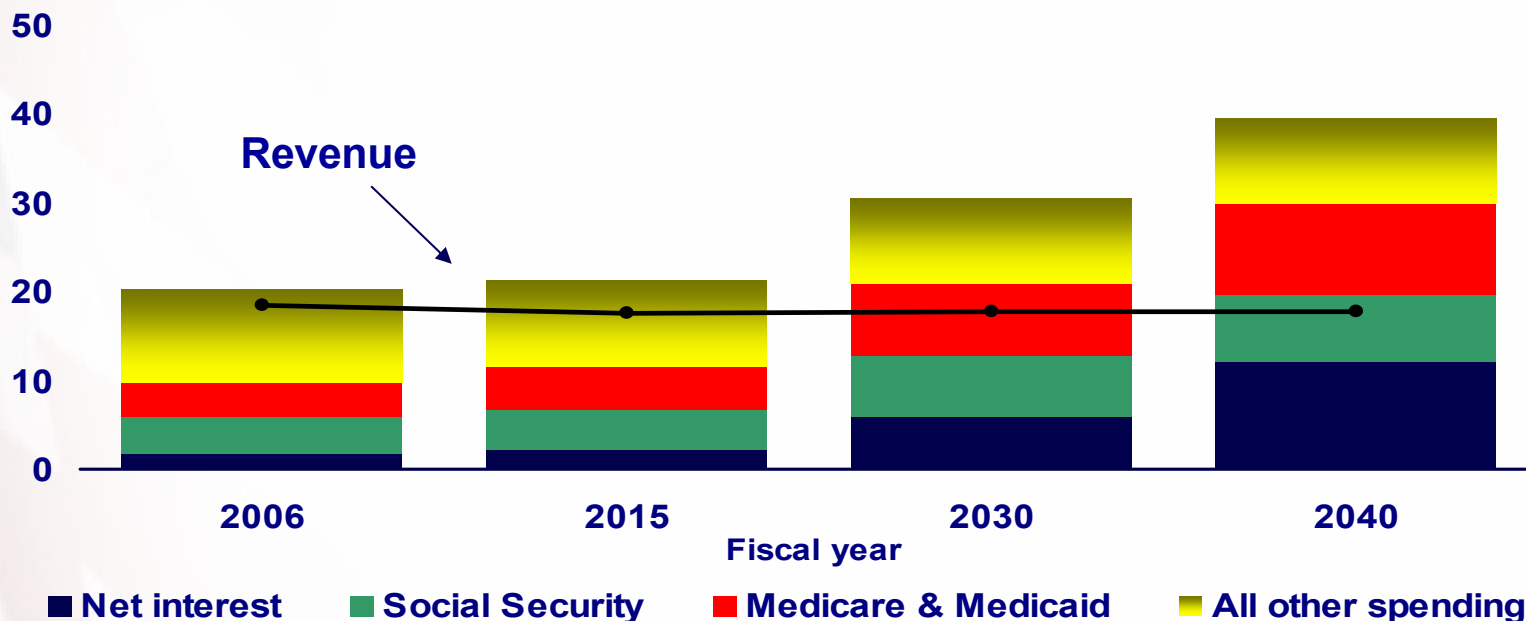


Sources: Office of Management and Budget and the Congressional Budget Office.

Potential Fiscal Outcomes

Simulation—Discretionary Spending Grows with GDP and Expiring Tax Provisions Extended (January 2007) *Revenues and Composition of Spending as a Share of GDP*

Percentage of GDP



Source: GAO’s January 2007 analysis.

Notes: AMT exemption amount is retained at the 2006 level through 2017 and expiring tax provisions are extended. After 2017, revenue as a share of GDP is held constant—implicitly assuming that action is taken to offset increased revenue from real bracket creep, the AMT, and tax-deferred retirement accounts.

What is to be done?

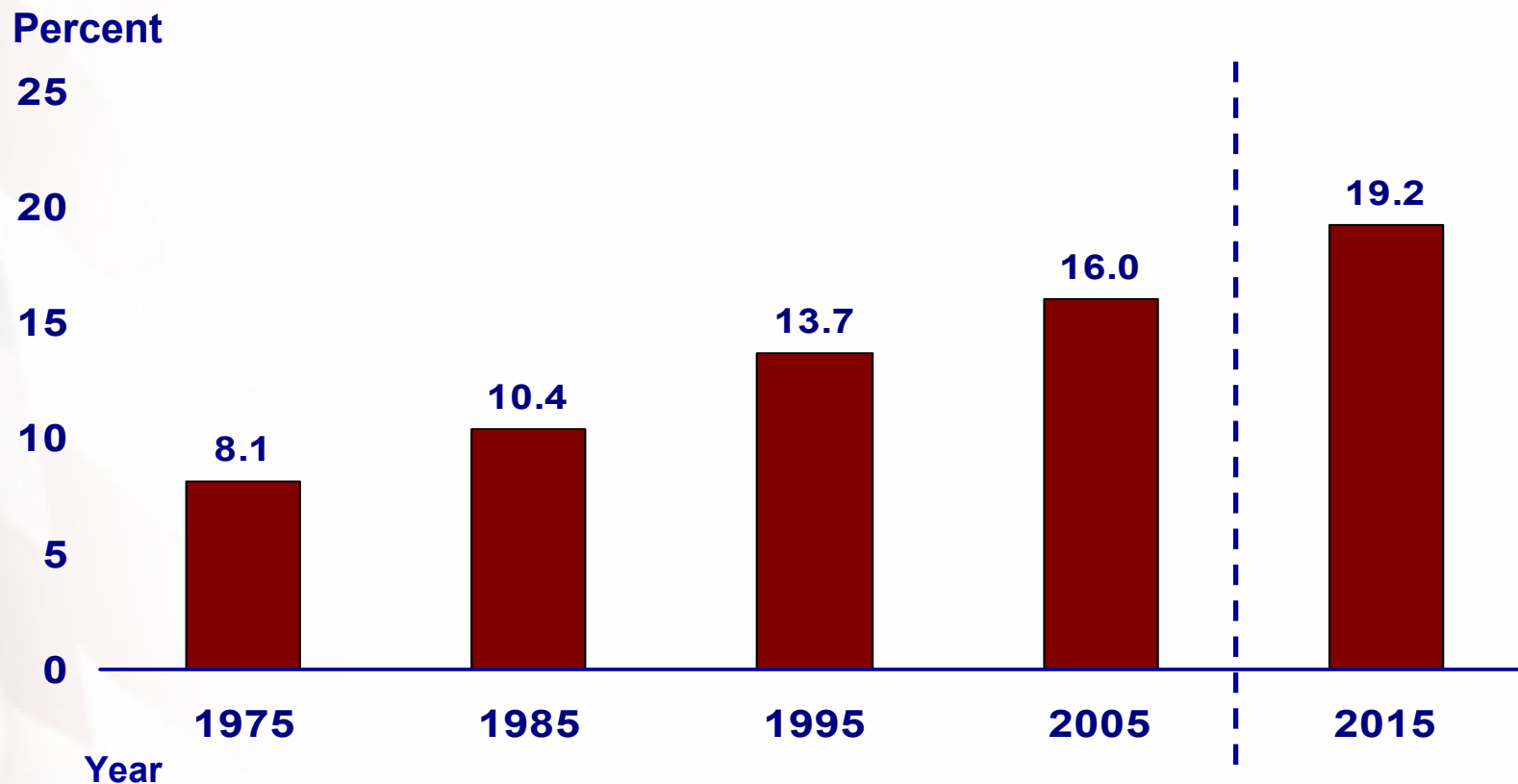
• The “Status Quo” is Not an Option

- We face large and growing structural deficits largely due to known demographic trends and rising health care costs
- GAO’s simulations show that balancing the budget in 2040 could require actions as large as
 - Cutting total federal spending by 60 percent or
 - Raising federal taxes to 2 times today's level

• Faster Economic Growth Can Help, but It Cannot Solve the Problem

- Closing the current long-term fiscal gap based on reasonable assumptions would require real average annual economic growth in the double digit range every year for the next 75 years
- During the 1990s, the economy grew at an average 3.2 percent per year
- As a result, we cannot simply grow our way out of this problem. Tough choices will be required

Growth in Health Care Spending: Health Care Spending as a Percentage of GDP

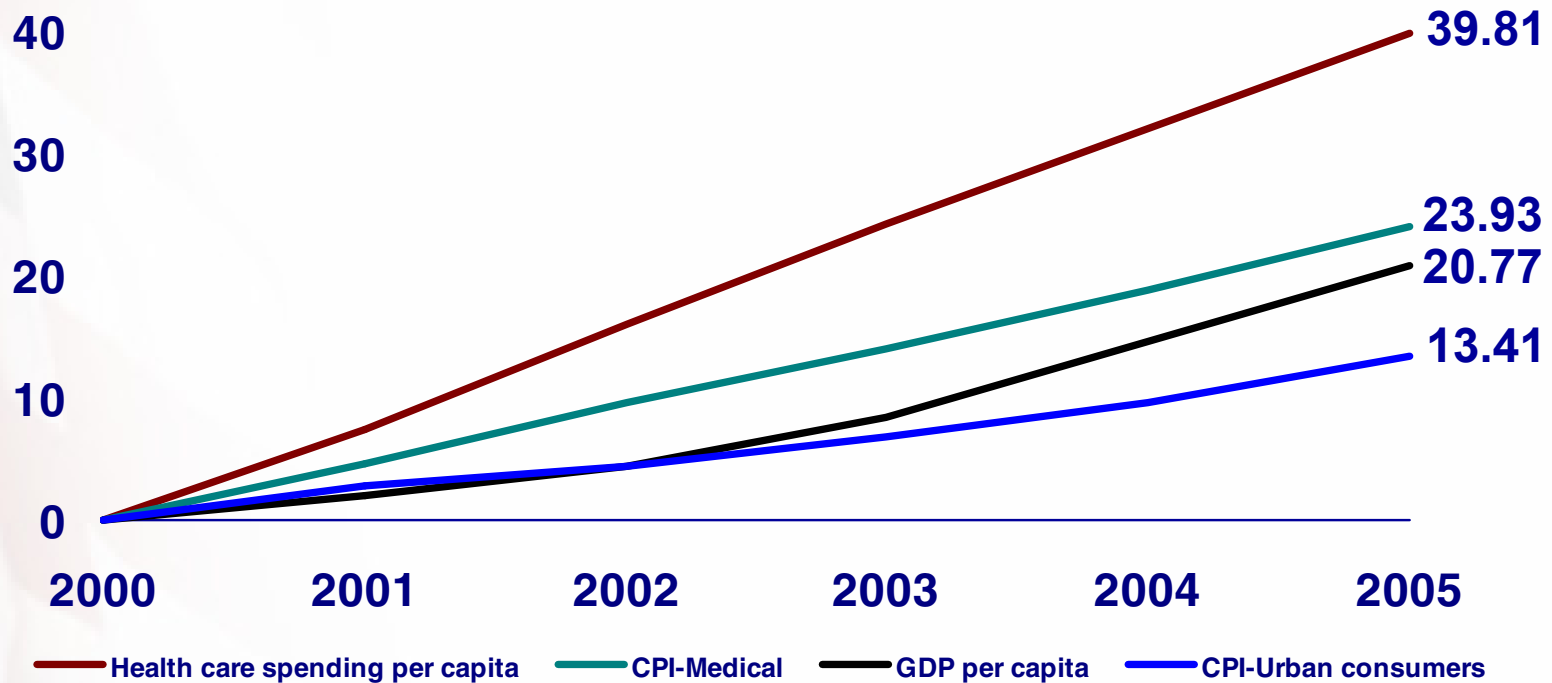


Source: The Centers for Medicare & Medicaid Services, Office of the Actuary.

Note: The most current data available on health care spending as a percentage of GDP are for 2005. The figure for 2015 is projected.

Cumulative Growth in Health Care Spending Per Capita, Medical Inflation, GDP Per Capita, and General Inflation, 2000-2005

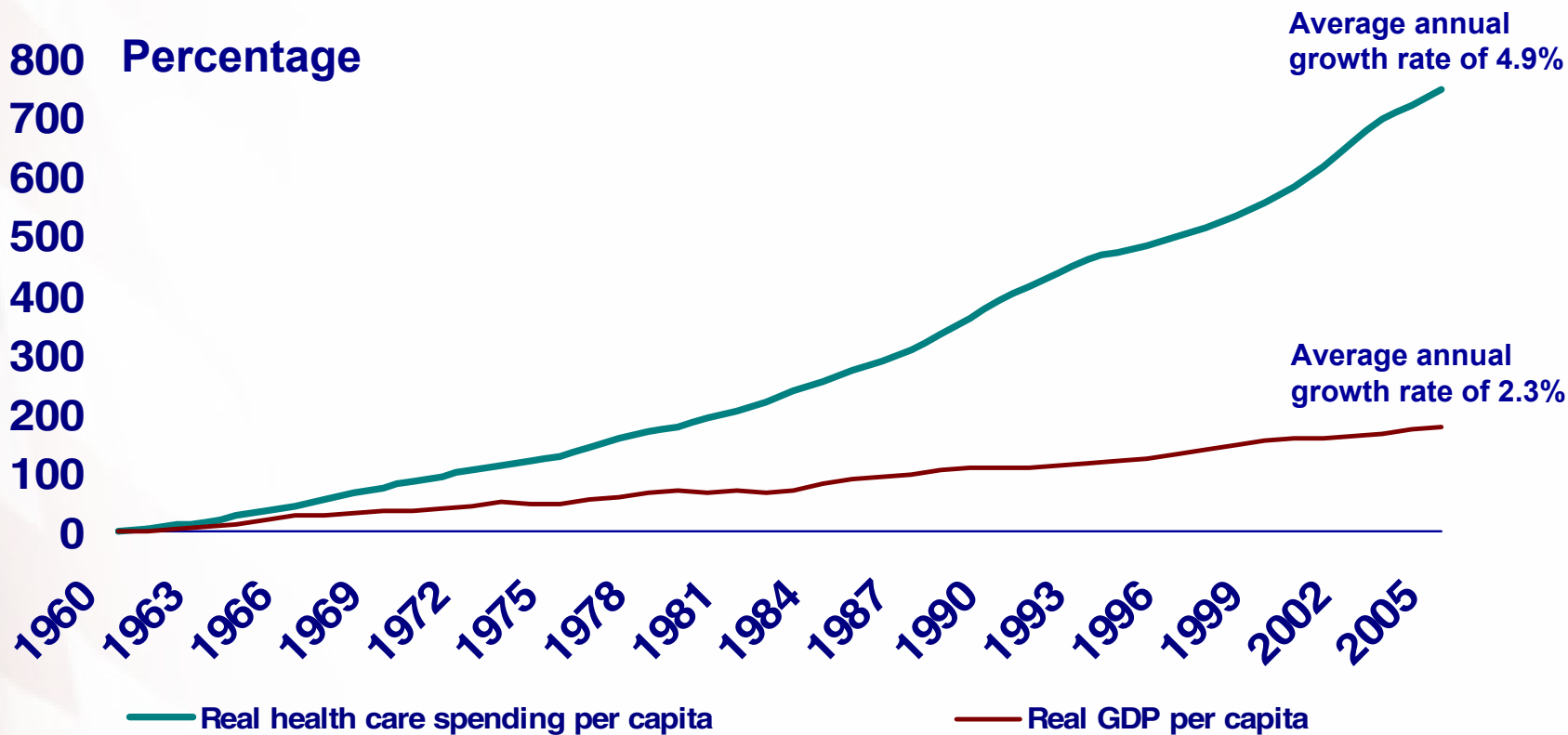
50 Cumulative percentage



Source: Bureau of Labor Statistics, The Centers for Medicare & Medicaid Services, Office of the Actuary, and the Bureau of Economic Analysis.

Note: The most current data available on health care spending per capita are for 2005.

Cumulative Growth in Real Health Care Spending Per Capita and Real GDP Per Capita, 1960-2005



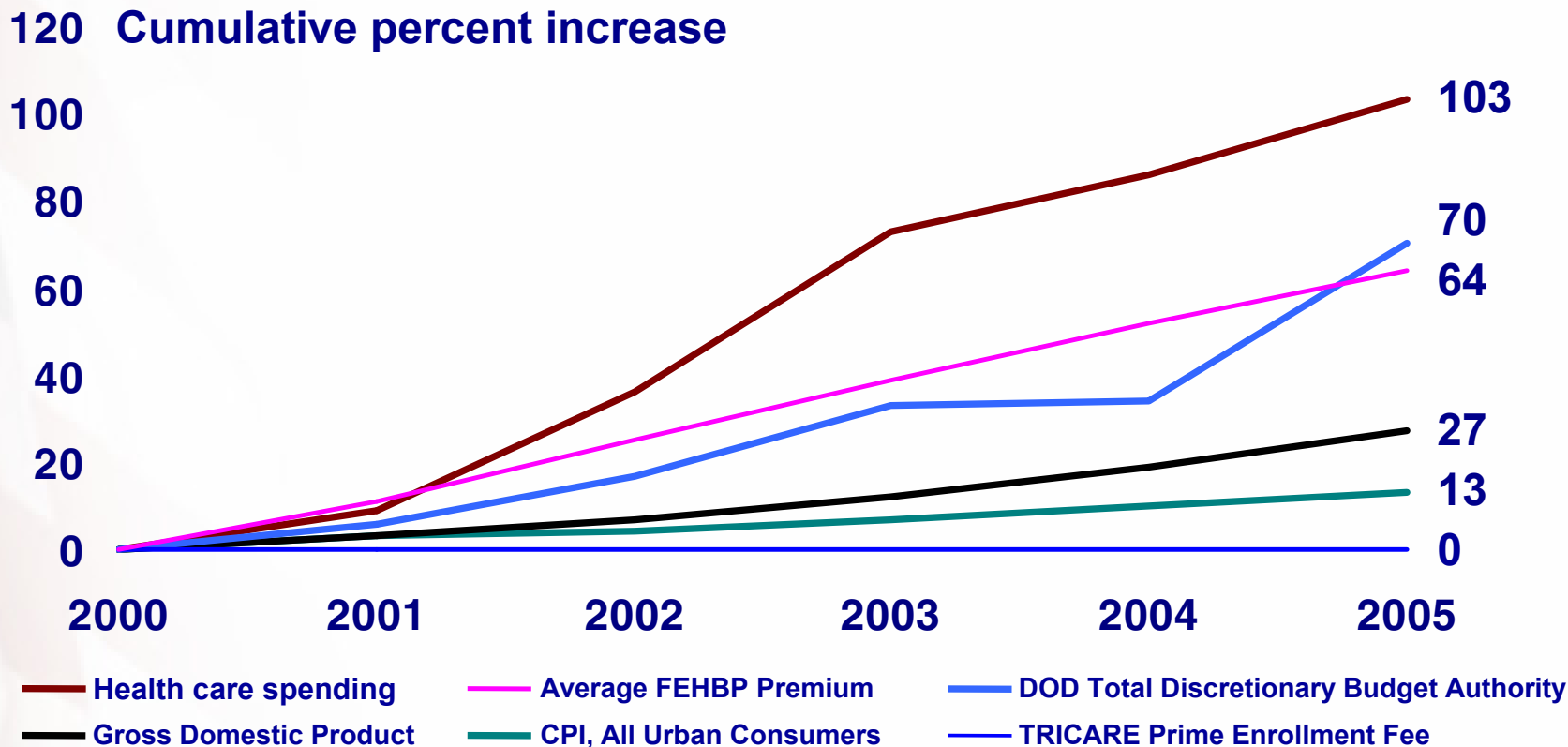
Source: GAO analysis of data from the Centers for Medicare & Medicaid Services, Office of the Actuary, and the Bureau of Economic Analysis.

Note: The most current data available on health care spending per capita are for 2005.

Drivers of Health Care Spending Growth

- **Over the last 4 decades, health care spending growth has been driven by**
 - population growth
 - increase in health insurance coverage
 - medical inflation, and
 - increased utilization of services—that is, growth in the number of services (volume) and the complexity of these services (intensity)

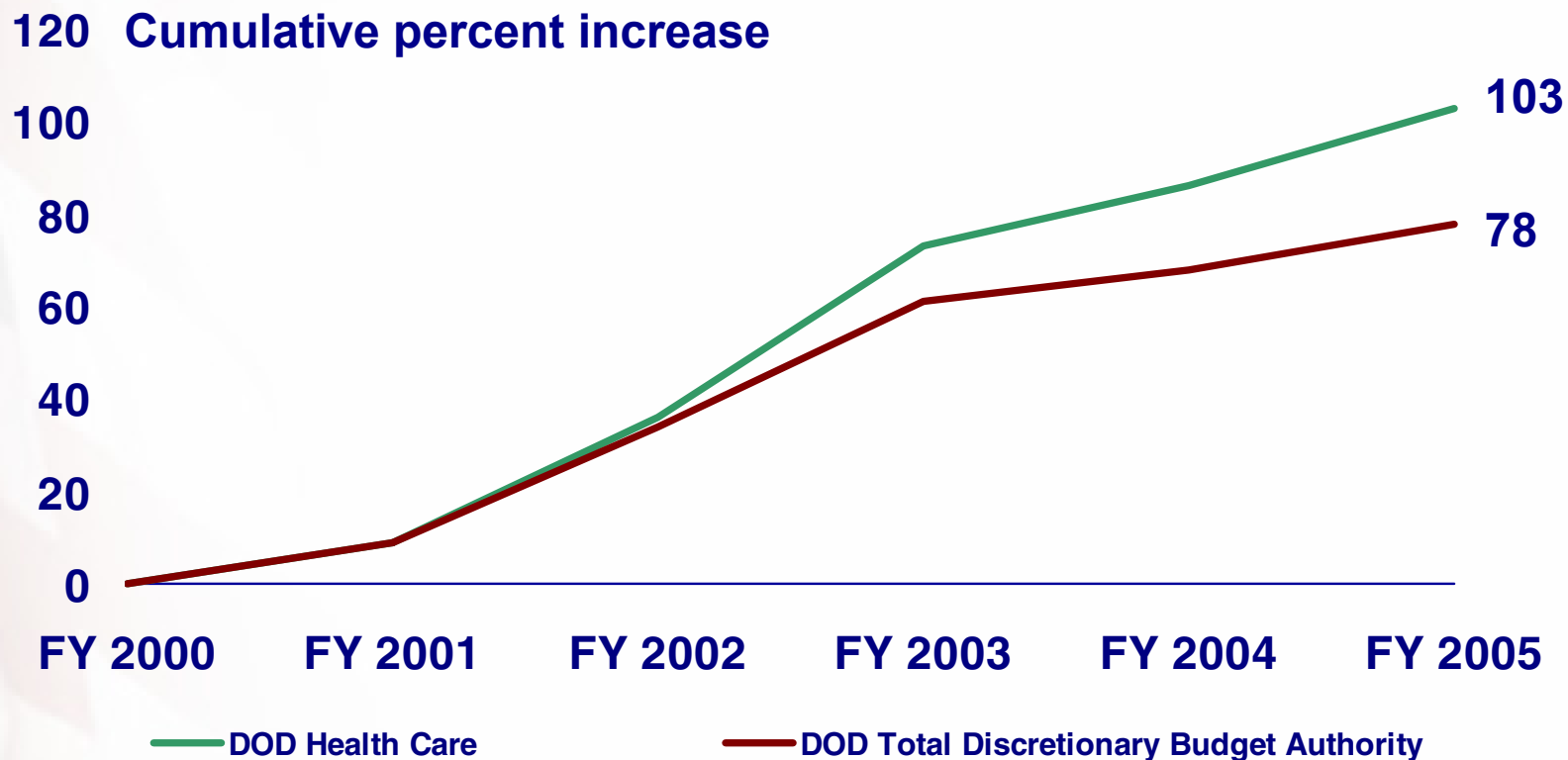
Comparison of Growth in DOD Health Care Spending, TRICARE Enrollment Fees, Other Insurance Premiums, and Economic Indicators



Source: DOD, Bureau of Economic Analysis, Bureau of Labor Statistics, and Office of Personnel Management.

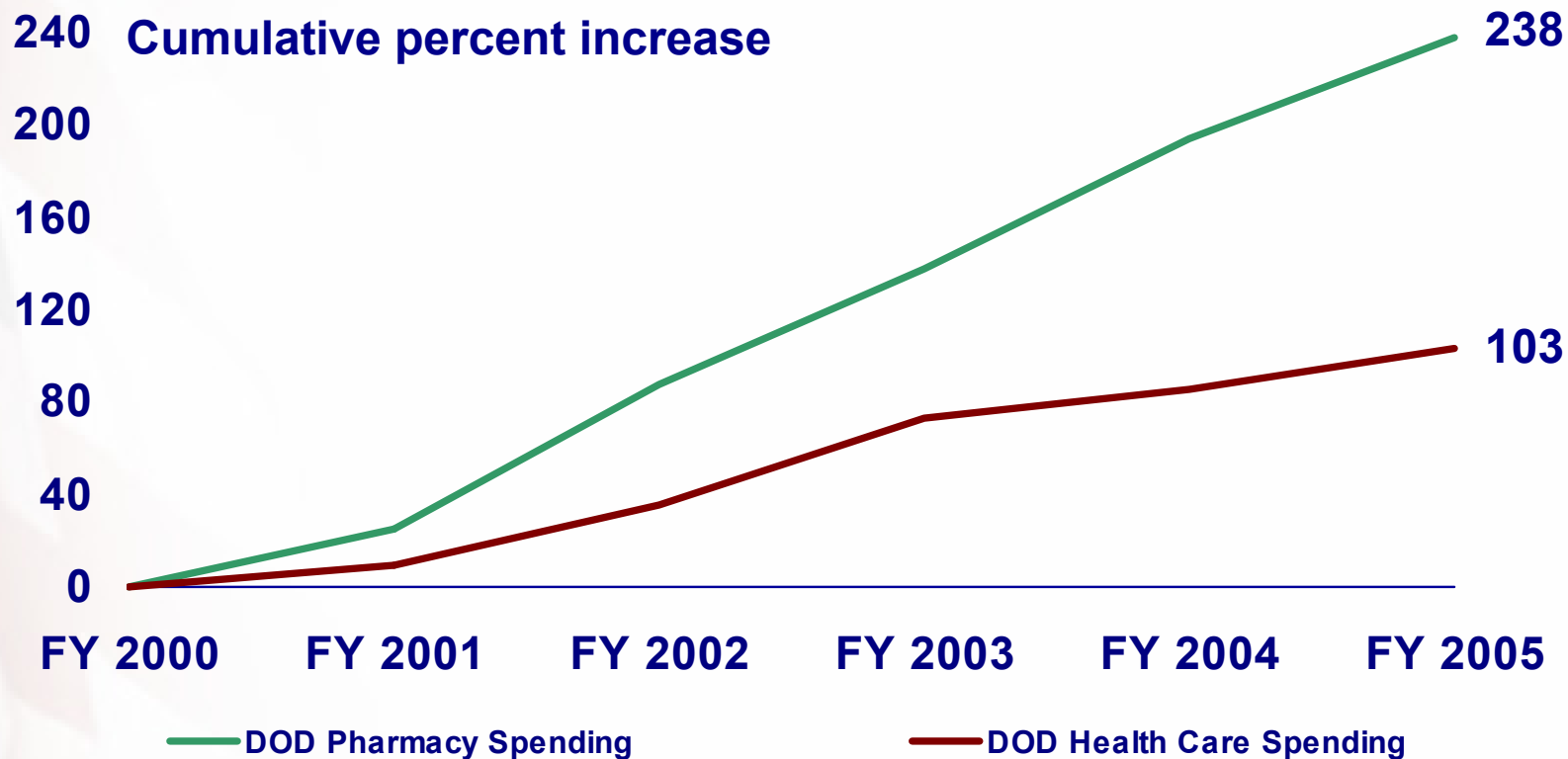
Note: The most current data available on DOD health care spending are for 2005.

DOD Health Care Spending has been Growing Faster than DOD's Discretionary Budget Authority



Source: GAO analysis of DOD data.

DOD Pharmacy Spending Grew Faster than Overall DOD Health Care Spending



Source: GAO analysis of DOD data.

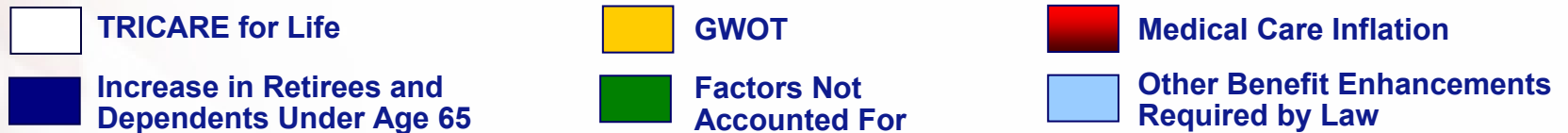
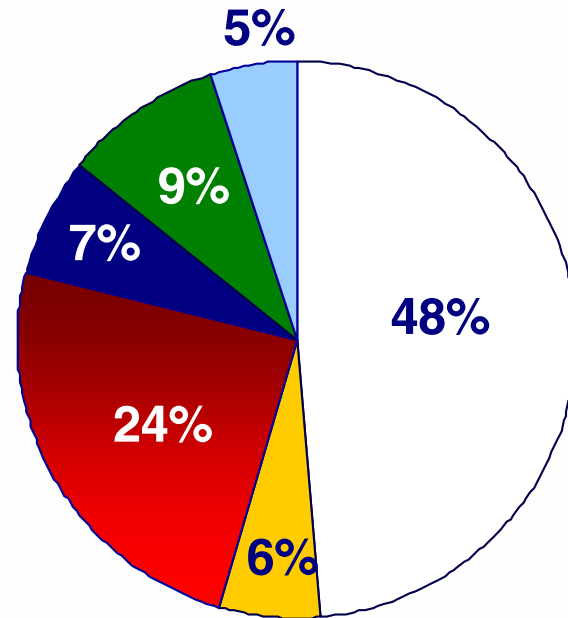
Growth in DOD Health Care Spending

- **From FY 2000 to FY 2005**

- DOD health care spending (primarily TRICARE) more than doubled, from \$17.4B to \$35.4B, growing at an average annual rate of 16 percent
- TRICARE spending on prescription drugs more than tripled, from \$1.6B to \$5.4B

- **In FY 2005, health care spending accounted for 7.5 percent of DOD's total discretionary budget and is expected to increase to 12 percent by FY 2015**

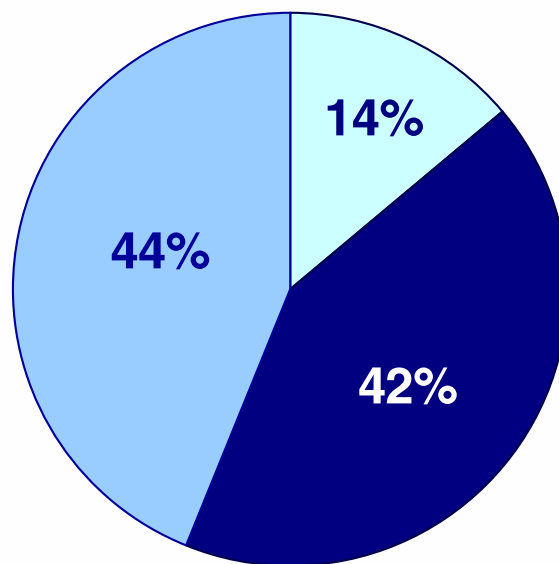
DOD Estimates of Factors Contributing to Increases in DOD's Health Care Spending, FY 2000-FY 2005



Source: DOD.

Majority of TRICARE Beneficiaries are Not Active Duty Personnel

TRICARE Beneficiaries in FY 2005



TRICARE for Life retirees and dependents (generally age 65 and older)

Retirees and dependents (generally under age 65)

Active duty personnel and dependents

Government's (Taxpayers') Share of TRICARE's Financing has Grown

- **While TRICARE spending has increased, beneficiaries' costs have remained unchanged or have been lowered over the last decade**
 - No enrollment fee (TRICARE Standard, Extra) or no increase in enrollment fee (TRICARE Prime) since 1995
 - Lowering of catastrophic cap (limit on beneficiary's costs) for the under-65 retirees and dependents in 2001 (from \$7,500 to \$3,000)
 - No increase in TRICARE deductibles since 1995
 - Elimination of TRICARE Prime copayments for dependents of active duty service members

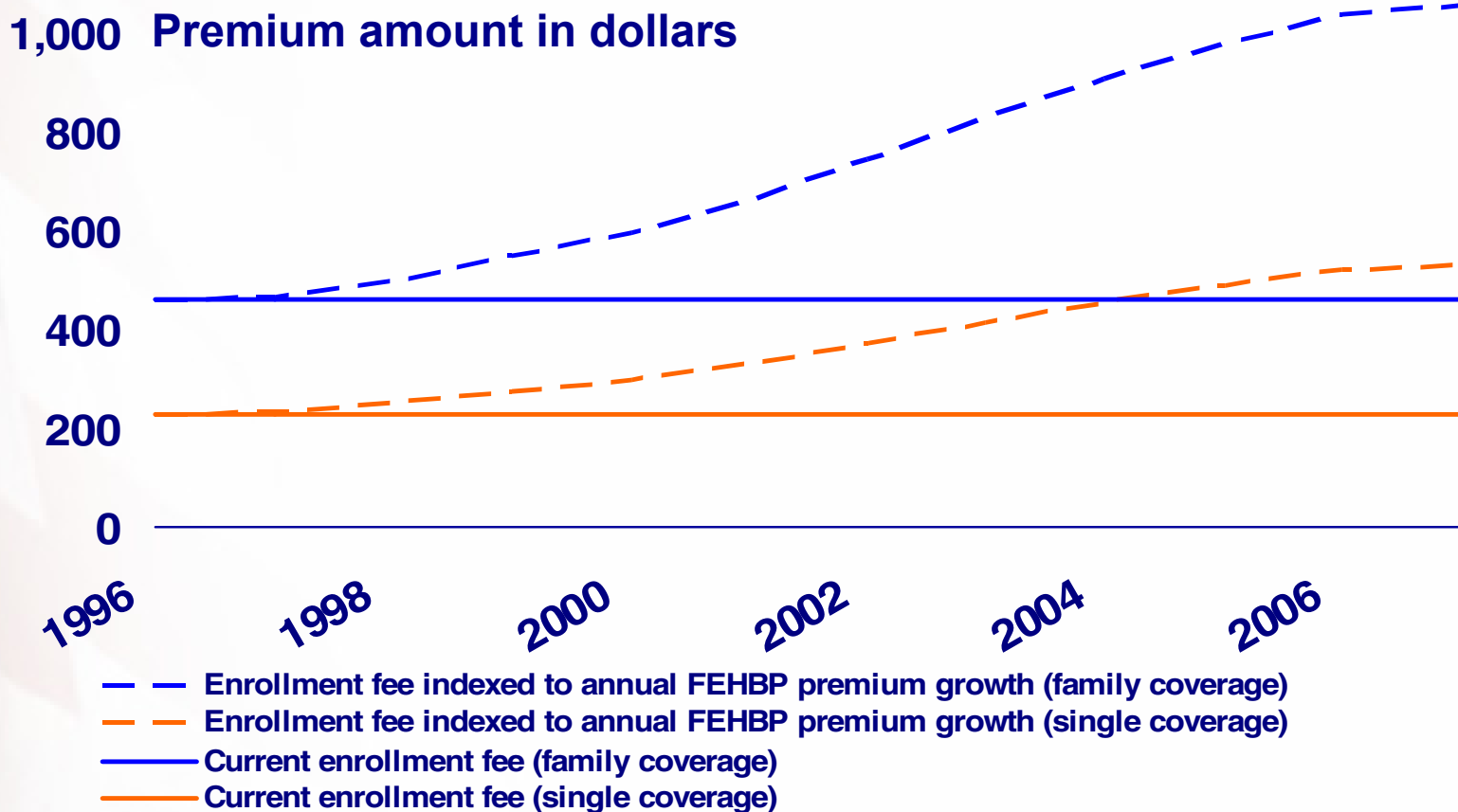
Government (Taxpayers') Share of TRICARE's Financing has Grown

- The Congress has expanded benefits each year since FY 2001
- Beneficiaries' out-of-pocket share of TRICARE costs has declined
- For example, DOD reports that under-65 retirees and dependents paid 12 percent of their health care costs in FY 2005, down from 27 percent in FY 1996

TRICARE Cost-Sharing is Out of Step with Other Public and Private Payers

- While TRICARE enrollment fees are either absent or nominal, other public programs and private plans typically raise premiums annually, in part to account for rising health care expenditures

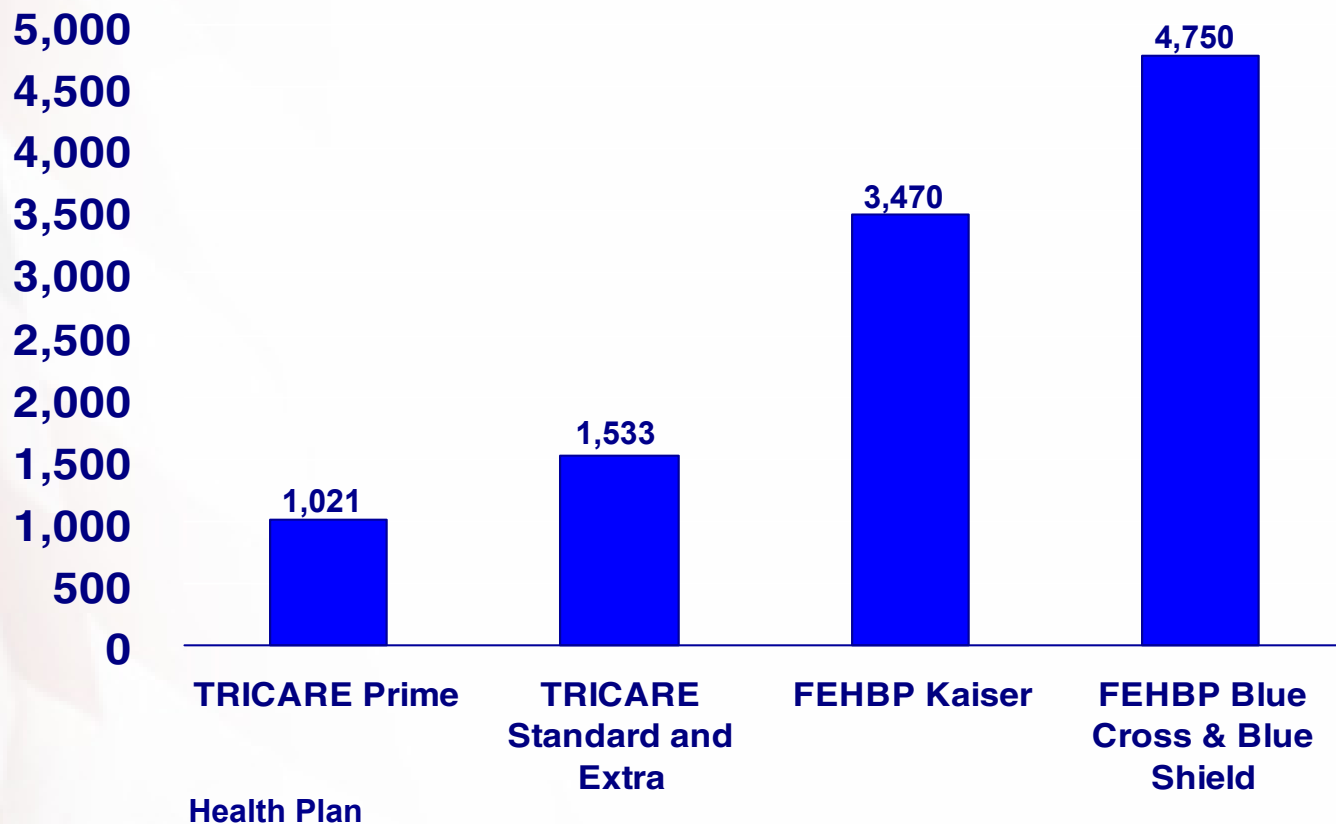
Comparison of Current TRICARE PRIME Enrollment Fees with Fees if they were Indexed to FEHBP Premium Increases, 1996-2007



Source: DOD and Office of Personnel Management.

Comparison of Average Out-of-Pocket Costs—Including Premiums, Copayments, Coinsurance, and Deductibles—for a Family of Three in Various Health Plans, 2005

Out-of-pocket costs in dollars



Source: DOD.

TRICARE Cost-Sharing is Out of Step with Other Public and Private Payers

- TRICARE counts a beneficiary's enrollment fee toward the catastrophic cap on the beneficiary's out-of-pocket costs, whereas other public and private payers exclude a beneficiary's premium from counting toward the cap

TRICARE Cost-Sharing is Out of Step with Other Public and Private Payers

- **TRICARE's copayment requirements for prescription drugs are not structured to encourage the use of the less expensive mail order option over the use of more expensive retail pharmacies**
 - In FY 2004, TRICARE beneficiaries obtained more than twice as many prescriptions from retail pharmacies as from mail order pharmacies
 - Other payers use stronger financial incentives to steer patients toward least costly option

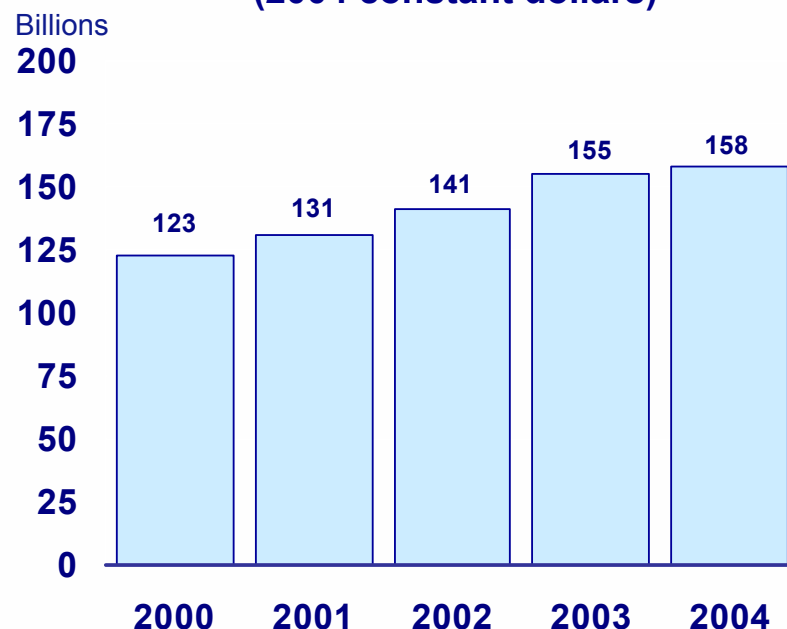
TRICARE Cost-Sharing is Out of Step with Other Public and Private Payers

- **Because of low out-of-pocket costs for prescription drugs, TRICARE for Life beneficiaries have little incentive to enroll in Medicare Part D, which has more aggressive cost-sharing requirements**
 - Part D requires an annual premium, which may increase yearly
 - Part D has gap in coverage (i.e., “doughnut hole”)

Health Care is Part of a Package of Military Benefits that May be Unsustainable Over the Long-term

- The cost of active duty pay and benefits was \$158 billion in fiscal year 2004 and growing
- Enhanced pay and benefits, including health care costs, increased costs to an average of \$111,783 per person

Total Compensation Costs for Fiscal Years 2000-2004
(2004 constant dollars)



Source: GAO-05-798.

Note: Our calculations include supplemental funding for the Global War on Terrorism. Since fiscal year 2002 over 100,000 mobilized reservists were paid out of the cash compensation. If you considered these personnel, the average costs to provide compensation would be about \$5,000 per capita lower.

Issues to Consider

- **In examining the federal government's 21st century challenges, the following are issues we have asked the Congress to consider in regard to DOD and VA health care programs:**
 - How can the benefits, eligibility, and health delivery systems of DOD and VA be optimally structured to ensure quality and efficiency? For example, should changes in eligibility of the military and VA health systems be considered?
 - With billions of dollars going to DOD and VA for health care, what options are available to reduce spending growth through increased collaboration in, and integration of, health care delivery both within and between those two agencies?

Issues to Consider

- To ensure the affordability and sustainability of TRICARE, should DOD's long-term commitment for health care for non-active duty military and their families be reexamined?
- Should TRICARE's provide financial incentives to encourage under-65 military retirees and dependents to obtain health care coverage when available through non-DOD sources?

Issues to Consider

- **Should TRICARE cost-sharing requirements be brought into parity with those of other public and private payers?**
 - Should cost sharing, including enrollment fees, deductibles, and copayments, for retirees and their dependents in TRICARE be indexed to inflation or increases in other public and private sector insurance, so that they increase over time?
- **How can cost-sharing requirements be designed to encourage TRICARE beneficiaries to use options that are most cost-efficient for DOD, such as purchasing drugs through mail order rather than retail pharmacies?**

Issues to Consider

- **Should DOD's compensation structure, which is weighted toward non-cash and deferred benefits (e.g., health care benefits and retirement), be reexamined?**

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On the Web

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