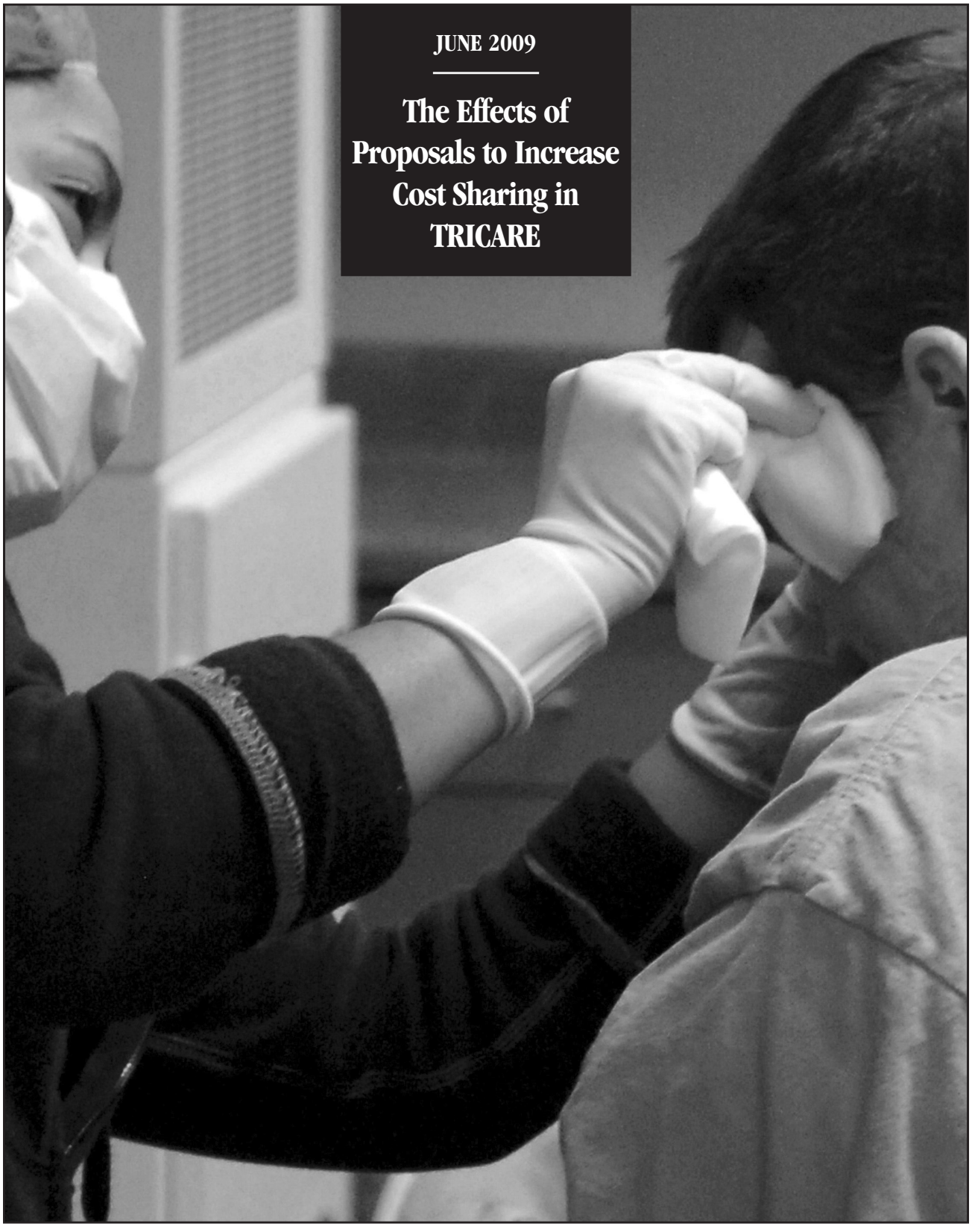
CONGRESS OF THE UNITED STATES
CONGRESSIONAL BUDGET OFFICE

A
CBO
PAPER



JUNE 2009

The Effects of Proposals to Increase Cost Sharing in TRICARE

Pub. No. 3201

A

CBO

PAPER

The Effects of Proposals to Increase Cost Sharing in TRICARE

June 2009

The Congress of the United States ■ Congressional Budget Office

Notes

Unless otherwise indicated, all years referred to are federal fiscal years (which run from October 1 to September 30).

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

Cover photo by Staff Sgt. Erin M. Peterson, courtesy of Lackland Air Force Base.

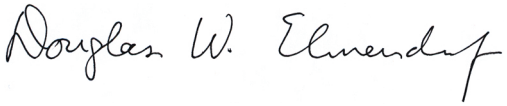
Preface

With the growth of health care costs outstripping the rate of growth of the economy, many policymakers worry that the current TRICARE program—which provides health care for the uniformed services, military retirees, and their families—will become unaffordable in the future. In its budget submissions for 2007, 2008, and 2009, the Department of Defense (DoD) proposed that the enrollment fees, deductibles, and copayments of some TRICARE beneficiaries be increased to encourage more efficient use of the system and to reduce medical spending. The President's budget request for fiscal year 2010 did not include a similar proposal, but the issue of how to address the military's growing health care costs remains unresolved.

At the request of the Ranking Member of the Senate Budget Committee, the Congressional Budget Office (CBO) examined the potential effects of increased cost sharing in the TRICARE program. As a basis for its analysis, CBO used DoD's most recent proposal—the President's budget request for fiscal year 2009—and the recommendations of the Task Force on the Future of Military Health Care, issued in December 2007. CBO found that the higher out-of-pocket costs that DoD proposed reflected the growth seen in civilian health care spending. In addition, CBO determined that, on the basis of currently available research, DoD had used reasonable assumptions about the responses of TRICARE beneficiaries to some of the proposed changes but that those responses might actually be stronger, leading to larger reductions in spending than DoD had estimated. CBO also found, however, that DoD's estimates did not include the possible effects that increased cost sharing for TRICARE might have on other federal programs (such as Medicaid and the Federal Employees Health Benefits program) and on federal revenues. Those effects would reduce, though only modestly, the potential savings to be realized from increasing TRICARE beneficiaries' costs.

Carla Tighe Murray of CBO's National Security Division wrote the paper under the general supervision of Matthew S. Goldberg and J. Michael Gilmore, with contributions from Adebayo Adedeji and Matthew Schmit. David Auerbach, Paul Cullinan, Philip Ellis, Sarah Jennings, and Allison Percy, all of CBO, offered helpful comments, as did Paul F. Dickens III, formerly in the Office of the Secretary of Defense. (The assistance of an outside reviewer implies no responsibility for the final product, which rests solely with CBO.)

Leah Mazade edited the paper, and Christine Bogusz proofread it. Cindy Cleveland produced drafts of the manuscript and the tables. Maureen Costantino prepared the report for publication and designed the cover. Lenny Skutnik printed the initial copies, and Linda Schimmel coordinated the print distribution. Simone Thomas prepared the electronic version for CBO's Web site (www.cbo.gov).



Douglas W. Elmendorf
Director

June 2009

Contents

Tables

Figure

Boxes

The Effects of Proposals to Increase Cost Sharing in TRICARE

Summary and Introduction

The TRICARE program provides health care for the military's uniformed personnel and retirees, and for their dependents and survivors—the more than 9 million people eligible to use its integrated system of military health care facilities and providers and regional networks of contracted civilian providers. In 2008, the Department of Defense's (DoD's) costs for that medical care were $42 billion, or about 6 percent of DoD's total funding for that year. The Congressional Budget Office (CBO) has projected DoD's future spending on the basis of the information in the most recent Future Years Defense Program (FYDP).[1] Those projections indicate that costs for medical care will rise more rapidly than overall resources for defense and require an estimated 13 percent of total defense funding by 2026.[2]

To accommodate that growth could require reductions in spending for other defense programs, such as the procurement and maintenance of weapon systems. Alternatively, if policymakers chose to increase DoD's resources, such boosts in funding might put pressure on other types of federal spending. Thus, many policymakers have expressed the concern that the current TRICARE program will become unaffordable in the future.

One approach to managing DoD's health care spending that has been discussed would be to increase the out-of-pocket costs paid by some beneficiaries. The enrollment fees, deductibles, and copayments that TRICARE beneficiaries pay today have remained the same (or even been reduced) since the mid-1990s, when the program was first set up. For example, the cost today for a 45-year-old military retiree to enroll his or her family in the TRICARE program's managed care plan, TRICARE Prime, is $460 per year—the same cost in nominal terms that prevailed in 1995. (Box 1 briefly describes the TRICARE Prime, Standard, and Extra health plans.) DoD has thus proposed, among other changes, to increase the share of health care costs paid by military retirees who are not yet eligible for Medicare (generally retirees between the ages of 38 and 65) and their survivors or dependents. DoD first proposed to increase annual cost sharing for those beneficiaries in February 2006, as part of the President's budget request for 2007, calling the program "Sustain the Benefit." DoD submitted an amended version of its plan in the budget requests for 2008 and 2009. The proposal was not enacted.

Nevertheless, the approaches reflected in DoD's proposal continue to be explored. This paper presents the results of CBO's analysis of how those higher enrollment fees, copayments, and deductibles for the TRICARE program would affect DoD's health spending.

- CBO found that the higher out-of-pocket costs that DoD proposed reflected the growth seen in civilian health care spending.
- It also determined, on the basis of currently available research, that DoD may have used relatively conservative assumptions about TRICARE beneficiaries' responses to some of the changes in the 2009 proposal and that the actual reductions in spending could be larger than DoD has foreseen.

1. The FYDP is a database that comprises a historical record of defense forces and funding as well as DoD's plans for future programs. The historical portion of the FYDP shows costs, forces, and personnel levels since 1962. The plan portion presents DoD's program budgets (estimates of funding needed for the next five or six years, based on the department's current plans for all of its programs).
2. Congressional Budget Office, *Long-Term Implications of the Fiscal Year 2009 Future Years Defense Program* (January 2009), pp. 7–8.

Box 1.

The TRICARE Program's Health Plans

The military's health care program, TRICARE, comprises nine health plans that cover uniformed service members, retirees, and their dependents in the United States and abroad. Some of the plans have a relatively narrow focus; for example, the TRICARE Reserve Select plan offers coverage to certain reservists when they are not on active duty. Most military beneficiaries, however, receive services through one of three health plans.

TRICARE Prime is a managed care option similar to a health maintenance organization—like such civilian arrangements, the plan's features include a primary care manager (either a military or a civilian health care provider) who oversees care and provides referrals to specialists, which are required for such visits. To participate, beneficiaries must enroll annually—and most must pay an enrollment fee, which is similar to an annual premium. (Active-duty service members are the exception, because they are required to use the Prime plan and are therefore charged nothing.) Of the three largest TRICARE plan options (Prime, Standard, and Extra), the Prime plan offers the greatest coverage of preventive and primary care services. Enrollment in the plan brings other advantages as well: Its enrollees receive first priority for appointments at military health care facilities and pay less out of pocket than do beneficiaries who use the other TRICARE plans.

TRICARE Standard is a traditional fee-for-service option that does not require beneficiaries to enroll in order to participate. The Standard plan allows participants greater freedom, compared with the Prime plan, to select providers and access care, but it also requires users to pay higher out-of-pocket costs. In addition to satisfying an annual deductible, beneficiaries who use the Standard option must pay any difference between a provider's billed charges and the rate of reimbursement allowed under the plan.

TRICARE Extra, a variant of the Standard plan that also has no formal enrollment requirement, mirrors a civilian preferred provider network. Under the military's version of such an arrangement, network providers accept a reduced payment from TRICARE in return for the business that the local military facility refers to them and agree to file all claims for participants. TRICARE Extra does not require beneficiaries to use network providers, but those who do generally incur lower out-of-pocket costs than beneficiaries who choose to access out-of-network health services.

Because enrollment in the Standard and Extra plans is not required, the distinction between the two lies in whether beneficiaries choose network providers—in which case they are considered by the Department of Defense (DoD) to have used the Extra plan—or nonnetwork providers (in which case DoD considers them to be Standard plan users). Thus, a single beneficiary may participate in both the Standard and Extra plans over the course of a year, but only someone who enrolls in the Prime plan may receive its benefits.

- CBO also found, however, that DoD did not include in its estimates the effects that increased cost sharing for TRICARE might have on other federal programs—such as Medicaid and the Federal Employees Health Benefits (FEHB) program—and on revenues.[3] Those effects would decrease, though to a relatively small degree, the reductions in spending that might be realized from increasing TRICARE beneficiaries' costs.

Overview of DoD's 2009 Proposal

The changes to TRICARE that DoD outlined in its 2009 budget submission were largely based on a review conducted by the Congressionally authorized Task Force on the Future of Military Health Care, which was established in 2007 to examine a wide array of health-related

3. The FEHB program is the health insurance program offered to civilians who work for or have retired from the federal government.

topics. The authorizing language directed the task force to assess and make recommendations on 10 elements of the military's health care system ranging from initiatives to promote wellness and better manage chronic diseases to cost accounting and performance contracting. One of the elements that the task force was to address was "the beneficiary and Government cost sharing structure required to sustain military health benefits over the long term"; another was to evaluate programs "focused on managing the health care needs of Medicare-eligible military beneficiaries."[4]

Because of the growing cost of providing health care to military retirees, the task force advocated a gradual rise in the annual fee paid by retirees who were not eligible for Medicare (and their families) who wished to enroll in TRICARE Prime. It recommended that the new enrollment fees be tiered on the basis of retirement pay, so that retirees who received less in retirement pay would incur a lower annual fee than retirees who received more. The task force also recommended that annual enrollment fees be instituted for working-age retirees and their families who wished to participate in the Standard and Extra plans and that the annual deductibles in those programs be increased. A further recommendation was that retirees who were eligible for Medicare (those over the age of 65 or disabled individuals) pay an enrollment fee to join the TRICARE for Life program—the military's "Medicare-wraparound" coverage designed to minimize its retirees' out-of-pocket expenses—in addition to the program's current requirement to enroll in Medicare Part B, which pays for outpatient health care. In addition, the task force recommended that all TRICARE beneficiaries—including family members of active-duty personnel—pay larger copayments for prescriptions filled at nonmilitary pharmacies or through mail orders. DoD included spending reductions from the bulk of those recommendations in its 2009 budget submission.

Magnitude of Potential Spending Reductions Under the Proposal

Instituting a policy that increased cost sharing for some beneficiaries could slow the rate of increase in DoD's medical spending. DoD has estimated that if policymakers had implemented all of the task force's proposals beginning 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 $6.0 billion in 2013, or by 11 percent, relative to projections that assume the continuation of current law and policy (see Table 1).

If a cost-sharing proposal was implemented, the changes it would make in the fee structure for the TRICARE program would reduce DoD's outlays in three ways. First, the increased cost-sharing payments that were collected would be used to offset DoD's costs for health care for military retirees. (Some people refer to those offsetting collections as "revenues.") Second, those increased payments would induce some retirees who otherwise would have used the TRICARE program to enroll instead in a civilian health plan—one available, for example, through their spouse's employment. Third, the larger copayments and deductibles under the proposal would reduce the utilization of health care services by beneficiaries who remained in one of the TRICARE plans.

Policy changes such as those proposed by DoD and the task force would affect two components of the Defense Department's spending for health care: the TRICARE program and TRICARE for Life.

- First, increasing the enrollment fees and copayments for the Prime plan as well as increasing the cost sharing for the Standard and Extra plans paid by working-age retirees would reduce spending for TRICARE, as would increasing the copayments for prescriptions paid by family members of active-duty personnel and by working-age retirees and their dependents.

- Second, charging Medicare-eligible military retirees and their families fees to enroll in TRICARE for Life, as well as increasing their copayments for prescription drugs, would reduce spending for that program.

TRICARE for Life is funded through accrual contributions to the Medicare-Eligible Retiree Health Care Fund (MERHCF). Accrual budgeting accounts for the cost of deferred benefits (in this case, for retirement) in the years in which members of the military are serving; that is, DoD pays for the benefits while those individuals are on active duty and not after they retire, when the benefits are actually received. Each year, the Treasury, on behalf of DoD, contributes an amount to the MERHCF based on the number of expected retirees and their future health care costs. Although the Treasury makes the contribution,

4. The authorizing language can be found in the John Warner National Defense Authorization Act for Fiscal Year 2007 (Public Law 109-364, section 711, pp. 2284–2287).

Table 1.

DoD's Estimated Health Care Spending, Including Reductions from Proposed Increases in Annual Cost Sharing for TRICARE

(Billions of dollars)

	2009	2010	2011	2012	2013
DoD's Health Care Spending	41.1	45.0	47.6	50.3	53.4
Proposed Reduction in TRICARE Spending[a]	-1.2	-2.6	-3.7	-4.0	-4.4
Proposed Reduction in Outlays from the Medicare-Eligible Retiree Health Care Fund[b]	-0.7	-1.0	-1.3	-1.4	-1.6
Total Proposed Reductions	-1.9	-3.6	-5.0	-5.5	-6.0
DoD's Health Care Spending After Proposed Reductions	39.2	41.4	42.6	44.9	47.4

Source: Congressional Budget Office using data and information from the Department of Defense (DoD).

Note: The proposed increases in the TRICARE program's cost sharing are based on recommendations of the Task Force on the Future of Military Health Care and DoD's budget submission for fiscal year 2009. DoD did not propose any changes in its 2010 budget submission.

a. The military's TRICARE program provides health care to uniformed and retired service members and their dependents and survivors through an integrated system of military and civilian facilities and providers. The program comprises several health plans, the largest of which are TRICARE Prime, which operates similarly to a civilian health maintenance organization, and TRICARE Standard and Extra, two fee-for-service plans differentiated by beneficiaries' use of network versus nonnetwork providers.

b. The Medicare-Eligible Retiree Health Care Fund (MERHCF) finances the TRICARE for Life program, which generally acts as a second payer, after Medicare, for the health care costs of Medicare-eligible military retirees. TRICARE for Life is funded through accrual contributions to the MERHCF—annual contributions made by DoD during service members' active-duty years to fund their later retirement benefits. Reductions in outlays from the MERHCF would in turn lower the accrual contributions made by DoD.

the amount is included in DoD's funding in the budget and appropriation process.

Reductions in outlays for the TRICARE for Life program would reduce the accrual contributions that the Treasury makes on behalf of DoD. Thus, in addition to the estimated $4.4 billion reduction in spending for the TRICARE program in 2013, changes made to the TRICARE for Life program under the task force's recommendations would have reduced outlays from the MERHCF by $1.6 billion in that year, DoD has estimated.

In its analysis, CBO compared the proposed increase in the fees for military retirees with the growth seen in several measures of nonmilitary health care spending. It found that the proposed enrollment fees accurately adjusted for trends in spending growth observed in the civilian sector since 1995. That is, if the Prime plan's enrollment fee of $460 for family coverage had grown at the same pace as—for instance—the average premium in civilian health plans, the amounts would be close to the new fees proposed by DoD. Nevertheless, DoD's proposed fees would still be below similar premiums commonly seen in civilian plans. The average annual health insurance premium for family coverage in a health maintenance organization in 2008, for example, was about $13,100, of which the average worker's contribution was about $3,400.[5] Under the proposal, most DoD retirees who were not yet eligible for Medicare would have paid $1,100 per year to enroll their family in TRICARE Prime in 2011 (the first year in which the higher fees were fully implemented).

The magnitude of the savings that might be realized from implementing such increases in cost sharing would depend on how strongly military beneficiaries responded to the changes. That is, the savings would depend on how many retirees opted to use a civilian plan rather than TRICARE and the degree to which beneficiaries who

5. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2008 Summary of Findings* (September 7, 2008), p. 2, available at ehbs.kff.org/images/abstract/7791.pdf.

remained in TRICARE reduced their demand for services.

Beneficiaries' Responses to Increased Cost Sharing

Economists measure behavioral responsiveness through "elasticities"—the estimated change in the quantity of a good or service that people demand if the price of that good or service rises or falls. In the policy changes that CBO analyzed, a number of elasticities were in play. Instituting or changing an enrollment fee (which corresponds to an annual insurance premium) would cause some current enrollees to leave the TRICARE program and would discourage some new people from enrolling. Increasing deductibles and copayments would lead some people to visit health care providers less often, to fill fewer prescriptions, or to switch from brand-name pharmaceuticals to generics. Most economists agree that the demand for health insurance and health care is inelastic; that is, a 10 percent increase in a health plan's premiums (or, equivalently, in enrollment fees) would result in a decrease of less than 10 percent in the number of people enrolled in the plan. Similarly, a 10 percent increase in the copayment for each office visit would reduce the number of visits by less than 10 percent. The magnitude of those reductions, however, is uncertain and must be estimated. An elasticity of zero, for example, would imply that a 10 percent increase in an enrollment fee had no effect on the number of enrollees. The stronger the response to the new fee—the greater the number of users who chose not to enroll or who left the program—the more negative the elasticity would be.

In calculating the reductions in spending that its proposal might produce, DoD used specific elasticity assumptions drawn from the health economics literature about how beneficiaries were likely to respond to changes in their cost sharing for health care. CBO examined those assumptions and found, on the basis of its review of empirical studies of the demand for health insurance and health care, that the elasticities DoD used were at the conservative end of the range of results from the literature. That finding suggests that the reductions in DoD's spending from implementing the proposal could be greater than DoD has projected.

CBO focused its analysis on the elasticity assumption that had the largest effect on the estimates of savings: the number of non-Medicare-eligible beneficiaries who could be expected to stop using the TRICARE program if enrollment fees for the Prime plan were raised. The literature, which primarily covers civilian populations, suggests a possible range of enrollment elasticities of -0.05 to -0.25.[6] (That is, an increase of 10 percent in the Prime plan's enrollment fees could lead to a drop of 0.5 percent to 2.5 percent in the number of beneficiaries who chose to enroll.) Using an elasticity assumption of -0.10, DoD projected that under TRICARE's current fee structure, about 2.5 million working-age military retirees, survivors, and family members would participate in the Prime, Standard, or Extra plans in 2011. Using the range of potential elasticities from the literature, CBO estimated that increased enrollment fees and deductibles beginning in 2009 would have reduced that number by between 180,000 and 880,000 people in 2011.

The range of potential savings varies with different assumptions about elasticities (see Table 2). If policymakers had enacted the 2009 proposal for higher enrollment fees, deductibles, and copayments for the TRICARE program, the reduction in spending (including offsetting receipts) for 2011, for example, could have ranged from $2.6 billion to $6.8 billion, depending on how strongly people had responded to the new cost sharing.

Other Analyses and Reports

The initial plan that DoD proposed for 2007 was reviewed at the Congress's behest by the Government Accountability Office (GAO), which concluded that DoD's projected savings were too large.[7] According to GAO's analysis, the elasticity assumptions that DoD used were too strong. Specifically, DoD's projection of the number of users who would either leave the TRICARE program (leave the Prime plan and not switch to using the Standard or Extra plans) or who would decline to participate in it if cost sharing was increased was too big. One concern that the analysis cited was that military beneficiaries would not respond to changes in the price of

6. Results from the literature actually justify the use of an even broader range of elasticities. However, CBO, in evaluating the results of the linear model for calculating the number of enrollees who would leave the plan, judged those results to be unrealistic when the model used more negative elasticities—for example, -0.4 or -0.6. (In some cases, the results showed that more than half of enrollees would forgo participating.)

7. See Government Accountability Office, *Military Health Care: TRICARE Cost-Sharing Proposals Would Help Offset Increasing Health Care Spending, But Projected Savings Are Likely Overestimated,* GAO-07-647 (May 2007).

Table 2.

Estimated Reductions in Discretionary Spending for TRICARE Under Alternative Assumptions About the Behavior of Non-Medicare-Eligible Beneficiaries

(Billions of dollars)

Enrollment Elasticity[a]	2009	2010	2011	2012	2013
-0.05	0.9	1.9	2.6	2.9	3.1
-0.10 [b]	**1.2**	**2.6**	**3.7**	**4.0**	**4.4**
-0.15	1.4	3.3	4.7	5.2	5.7
-0.20	1.6	3.6	5.3	5.8	6.3
-0.25	2.0	4.6	6.8	7.4	8.1
Memorandum:					
DoD's Health Care Spending	41.1	45.0	47.6	50.3	53.4

Source: Congressional Budget Office using data and information from the Department of Defense (DoD).

Note: The military's TRICARE program provides health care to uniformed and retired service members and their dependents and survivors through an integrated system of military and civilian facilities and providers.

a. The enrollment elasticity assumption is the percentage reduction in the number of enrollees in TRICARE Prime (the military's health plan that generally corresponds to a civilian health maintenance organization) when the annual enrollment fee is increased by 1 percent. The potential reductions in spending depend on how many people choose alternative insurance arrangements.

b. DoD used an elasticity assumption of -0.10 in estimating proposed spending reductions from increased TRICARE cost sharing for its fiscal year 2009 budget submission. This set of calculations corresponds to the line in Table 1, "Proposed Reduction in TRICARE Spending."

health plans in the same way that civilian populations responded, in which case elasticities that reflected civilians' health care choices—which is what most studies in the literature reported—were not necessarily applicable to choices about TRICARE. In particular, GAO asserted that significant numbers of working-age retirees either would not have access to other forms of health insurance or would have only options that were more expensive than TRICARE. Therefore, fewer retirees (and their dependents) than DoD had estimated would leave TRICARE Prime and more beneficiaries would shift to the Standard or Extra plans. In that event, the reductions in spending that DoD had projected under the proposal would not be realized.

The recommendations of the Task Force on the Future of Military Health Care, as incorporated in DoD's 2009 budget submission and the 2009–2013 Future Years Defense Program, addressed some of GAO's concerns. In particular, the 2009 plan that DoD submitted added an enrollment fee to the TRICARE Extra and Standard plans, which DoD estimated would reduce the number of beneficiaries who shifted to them from the Prime plan and instead cause more users to leave the TRICARE program altogether. DoD also altered one of the elasticity assumptions used to analyze the 2009 plan to bring it more into line with GAO's findings.

Nevertheless, policymakers still confront the question of how military retirees—particularly those without low-cost alternatives to TRICARE—would respond to proposed fee increases. In reviewing the literature, CBO found two studies relevant to the concern that people who do not have access to employment-based insurance will not respond strongly to the higher proposed fees for TRICARE. The studies, which gathered data from civilians who could not secure coverage from employment-based health plans, estimated elasticities that ranged from -0.3 to -0.6—each one several times larger than DoD's assumption of -0.1.[8] Elasticities of that magnitude suggest that even people without the option of employment-based coverage are more responsive than DoD has assumed to changes in premiums or enrollment fees.

8. The two studies were those of M. Susan Marquis and Stephen H. Long, "Worker Demand for Health Insurance in the Non-Group Market," *Journal of Health Economics,* vol. 14 (1995), pp. 47–63; and David Auerbach and Sabina Ohri, "Price and the Demand for Nongroup Health Insurance," *Inquiry*, vol. 43 (Summer 2006), pp. 122–134.

CBO found a third study that addressed the issue that military beneficiaries would behave differently than civilians. Published after GAO's analysis, in 2008, the study examined non-Medicare-eligible military retirees (and their families) and estimated an elasticity of -0.2, or double the elasticity used by DoD.[9] If working-age beneficiaries responded that strongly to the new fee structure in the 2009 proposal—in other words, twice as strongly as DoD had assumed—annual reductions to the military's health spending after five years could be closer to $8 billion than to the $6 billion that DoD estimated.

How the Proposal Could Affect Other Federal Spending

Increased cost sharing for military beneficiaries could reduce DoD's health care funding by several billion dollars per year, but other components of federal spending would probably be affected as well. Higher fees in the TRICARE program could cause some working-age retirees to switch to other federal programs—such as Medicaid (if an individual was disabled or elderly and had low income) or the Federal Employees Health Benefits program (if a person was employed by or had retired from the federal government as a civilian)—which could increase mandatory spending for Medicaid and for FEHB annuitants. (Mandatory spending does not require annual appropriations, and the available funding is not limited.) In addition, eligible retirees might use the services offered by the Veterans Health Administration more intensively, increasing that agency's costs.

DoD's proposal could also reduce tax revenues. Some of the retirees who left TRICARE might switch to employment-based health benefits if they were available, and for the most part, those benefits are not taxed. An increase in such benefits would shift more compensation from being taxable to being nontaxable.

CBO did not independently estimate the total effects that the 2009 plan might have had on federal spending because most of the associated reductions in health spending would have been classified as discretionary (subject to appropriation acts). For the purpose of estimating the effects of the President's annual budget request, CBO generally assumes the enactment of the appropriations proposed by the Administration. Therefore, no specific estimate of the 2009 plan was included in CBO's analysis of the budget (although the Administration's estimate was presumably reflected in the requested funding level). However, a related estimate may be instructive. In its recent report detailing options for reducing federal health care costs, CBO explored the budgetary implications of a plan similar to DoD's proposal.[10] That option called for raising the enrollment fees, copayments, and deductibles paid by non-Medicare-eligible retirees, beginning in 2010, to reflect the growth in nationwide health care spending per capita since 1995. Unlike the task force's and DoD's proposals, the option would not increase pharmacy copayments or change the costs faced by Medicare-eligible retirees.

CBO estimated that under such an option, DoD's discretionary outlays would drop by about $2.4 billion in 2014, mandatory spending for other federal programs would increase by $80 million, and revenues would decline by $350 million. Thus, increases in the cost sharing paid by working-age military retirees and their dependents under the 2009 proposal, which could reduce DoD's health care spending by more than $2.0 billion annually, would also entail smaller increases in mandatory spending and decreases in revenues that DoD did not incorporate in its estimates.

TRICARE's Beneficiaries and Current Cost Sharing

The TRICARE system is a complicated mix of health insurance plans and providers. The three largest health plans—Prime, Standard, and Extra—offer coverage to most DoD beneficiaries. Several smaller programs and pilot projects serve limited populations (for example, beneficiaries who live in places where regular networks of TRICARE providers are not available). CBO's analysis excluded those smaller programs because they generally were not covered in the recommendations of the Task Force on the Future of Military Health Care and in the proposals for increased TRICARE cost sharing that DoD submitted with the rest of its budgets for fiscal years 2007 to 2009.

9. Lawrence Goldberg and others, *Controlling TRICARE Cost Growth: An Evaluation of Three Policies*, IDA Document NSD-3481 (Alexandria, Va.: Institute for Defense Analyses, January 2008).

10. See Congressional Budget Office, "Option 97—Increase Medical Cost Sharing for Military Retirees Who Are Not Yet Eligible for Medicare," *Budget Options, Volume 1: Health Care* (December 2008), pp. 176–177.

Beneficiary Groups

The bulk of the health care that the TRICARE plans offer is provided to dependents and retirees, not to the active-duty force. In part, that is because the uniformed military represents less than 20 percent of eligible TRICARE beneficiaries. In addition, most of the active-duty force is young and healthy, generally requiring less care than do older retirees.

Four groups of beneficiaries receive health care through TRICARE. The first two are uniformed service members on active duty (including members of the National Guard and reservists who have been called up) and their family members and other legal dependents. All active-duty personnel must use TRICARE Prime; most family members of such personnel also choose to enroll in the Prime plan. In CBO's estimation, health care for the average active-duty service member (or dependent) cost DoD about $3,000 in 2007.[11]

People who have retired from military service and their dependents or survivors make up the other two groups. (Survivors comprise widows and widowers who have not remarried, unmarried children up to age 21, and disabled dependents of deceased active-duty or retired service members.) Retirees generally have at least 20 years of service in the armed forces or have retired before reaching the 20-year mark because of an illness or injury that occurred while they were on active duty. Most people join the military between the ages of 18 and 25, and most people who retire from it are between the ages of 38 and 45. Military retirees may thus be subdivided into two groups: those who are not eligible for Medicare (generally retirees who are under the age of 65, the usual age of eligibility for the program), and those who are eligible (people age 65 and older or those who are permanently disabled). Currently, fewer than half of all military retirees are over the age of 65.

The benefits that the two groups of retirees receive under TRICARE differ because of Medicare. For retirees who are eligible for Medicare and who enroll in Part B of that program, TRICARE generally acts as a second payer, covering the providers' charges that remain after Medicare has issued its payment or payments. (TRICARE is the first payer for services that the military's plan covers but Medicare does not.) This part of the TRICARE program, known as TRICARE for Life, was begun in October 2001; according to DoD's estimates, at the end of that year, TRICARE for Life covered 1.6 million Medicare-eligible retirees and their qualifying dependents. By the end of 2008, that number had increased to about 1.8 million. DoD estimates that about 85 percent of Medicare-eligible retirees and their dependents use the TRICARE system in some way; about 10 percent use only the pharmacy benefit.[12]

Funding for TRICARE for Life is not part of the appropriation for the Defense Health Program, which finances most of DoD's health care costs, but is instead provided through the department's annual contributions to the Medicare-Eligible Retiree Health Care Fund. The MERHCF pays for most, if not all, of a retiree's health care expenses that are not paid for by Medicare. CBO estimates that the annual cost to the MERHCF for a military retiree is about $4,300 and the cost to Medicare is at least $7,000. The budget treats all costs incurred on behalf of Medicare-eligible military retirees (and their dependents and survivors) as mandatory outlays. Policies that reduce costs in the TRICARE for Life program, then, affect DoD's appropriation only indirectly—by reducing the accrual charges that count against it.

Retirees who are not yet eligible for Medicare have several options under TRICARE. They may enroll in the Prime plan by paying an annual fee, or they may receive benefits under the Standard or Extra plans. DoD estimates that of the 3.4 million working-age retirees and dependents who were eligible to receive health care under TRICARE in 2008, about 1.5 million enrolled in the Prime plan and another 980,000 used the Standard or Extra options.[13] (The remainder did not use TRICARE, despite their being eligible, and DoD did not collect information about them.) About 200,000 of the 980,000 beneficiaries who used the Standard and Extra plans used only the TRICARE pharmacy coverage—to fill prescriptions that they obtained from non-TRICARE providers.

11. That estimate includes most of the resources used by military treatment facilities but may exclude some costs for base support and construction. Because of insufficient data, estimates of the cost per user among active-duty family members and among retirees or their dependents do not include the costs incurred by other federal programs, such as Medicaid, the Federal Employees Health Benefits program, and the Veterans Health Administration.

12. Department of Defense, *Evaluation of the TRICARE Program: FY2009 Report to Congress* (February 28, 2009), pp. 21 and 26.

13. Ibid.

CBO estimates that DoD's cost per participant for non-Medicare-eligible retirees (or dependents) in 2008 was about $4,100 for enrollees in the Prime plan and $3,300 for users of the Standard or Extra plans. The cost for the latter users tends to be lower than the cost for a Prime enrollee in part because some Standard and Extra users have other, primary health insurance that they supplement by using TRICARE as a second payer.

Fee Structure

The enrollment fees, deductibles, and copayments that TRICARE beneficiaries pay vary by the type of health plan (Prime, Standard, or Extra) that they choose to use and by the beneficiary group to which they belong (active-duty service members and their families or retirees and their dependents). In addition, copayments may vary—beneficiaries pay different cost-sharing amounts for a visit to a health care provider and for a prescription.

Active-Duty Personnel and Their Dependents. DoD estimates that 1.8 million active-duty service members, including some members of the National Guard and reservists, were eligible for TRICARE at the end of 2008. Active-duty personnel are charged no copayments or deductibles under TRICARE, whether they see a military or a civilian health care provider. They are enrolled automatically (and at no cost) in TRICARE Prime.

An additional 2.5 million dependents of service members were also eligible for TRICARE in 2008, DoD estimates. Those family members may enroll in TRICARE Prime without paying a fee (see the top panel of Table 3). Those who do not wish to enroll in Prime may use the Standard or Extra plans as their primary insurance or to supplement other health insurance coverage. A catastrophic cap applies to the costs of those beneficiaries: Families pay a maximum of $1,000 annually in out-of-pocket costs, after which TRICARE pays 100 percent of all remaining (allowable) charges. (TRICARE's 100 percent coverage of charges that exceed the catastrophic cap applies to all groups of beneficiaries.)

Retirees Who Are Not Yet Eligible for Medicare and Their Dependents. About 3.4 million working-age retirees and their dependents were eligible for TRICARE benefits in 2008, according to DoD.[14] People who fall into those categories are generally between the ages of 38 and 65; they may enroll in TRICARE Prime by paying an annual enrollment fee—$230 for an individual or $460 for a family (see the bottom panel of Table 3). Those fees, which have not risen since 1995, do not vary by rank or income.

Under the Prime plan, each basic outpatient visit to a civilian provider requires a copayment of $12, and visits to military providers are free. Retirees in this group who do not enroll in Prime but use Standard or Extra face annual deductibles and pay a percentage of each provider's fee. The catastrophic cap for non-Medicare-eligible retirees and their dependents is $3,000 annually in out-of-pocket costs. In general, working-age military retirees who use TRICARE as their primary source of health insurance will incur lower out-of-pocket costs by enrolling in Prime, particularly if they live near military treatment facilities.

Yet many younger retirees do not enroll in the Prime component of TRICARE. One reason may be that they have access to other sources of health insurance. According to DoD's *2003 Survey of Retired Military* (the most recent publicly available data), about 70 percent of the approximately 1 million retirees under age 65 in that year and about half of their spouses were employed full-time.[15] Their employers probably offered health insurance, given that almost 80 percent of private-sector employees and all federal government employees are offered employment-based coverage.[16] CBO thus estimates that about three-quarters of younger military retirees have access to health insurance either through their employer or their spouse's employer.[17] Those who have other health insurance may supplement those plans with benefits from the Standard or Extra plans as much or as often as they choose without enrolling beforehand. (By law, TRICARE is the second payer after any other health insurance plan.)

14. Ibid.

15. Defense Manpower Data Center, *2003 Survey of Retired Military: Tabulation of Responses,* Report No. 2004-007 (August 2004).

16. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits*, Exhibit 3.2, p. 48.

17. RAND conducted a similar survey of military retirees in 2005 and estimated that 78 percent of working-age retirees had access to civilian insurance through their own or their spouse's employer or through a union or professional association. See Louis T. Mariano and others, *Civilian Health Insurance Options of Military Retirees: Findings from a Pilot Survey,* MG-583-OSD (Santa Monica, Calif.: RAND Corporation, 2007).

Table 3.

Current Cost Sharing Under TRICARE for Dependents of Active-Duty Personnel and for Non-Medicare-Eligible Retirees and Their Families

	Prime[a]	Extra[b]	Standard
		Active-Duty Family Members	
Annual Catastrophic Cap[c]	$1,000	$1,000	$1,000
Annual Deductible	0	$50 single/$100 family for rank E-4 and below; $150/$300 for rank E-5 and above	$50 single/$100 family for rank E-4 and below; $150/$300 for rank E-5 and above
Annual Enrollment Fee	0	n.a.	n.a.
Emergency Services[d]	0	15 percent of the negotiated charge	20 percent of allowed charges
Inpatient Hospitalization[d]	0	15 percent of the negotiated charge	20 percent of allowed charges
Mental Health Visit[d]	0	15 percent of the negotiated charge	20 percent of allowed charges
Outpatient Visit[d]	0	15 percent of the negotiated charge	20 percent of allowed charges
		Non-Medicare-Eligible Retirees and Their Families	
Annual Catastrophic Cap[c]	$3,000	$3,000	$3,000
Annual Deductible	$0	$150 single/$300 family	$150 single/$300 family
Annual Enrollment Fee	$230 single/$460 family	n.a.	n.a.
Emergency Services[d]	$30	20 percent of the negotiated charge	25 percent of allowed charges
Inpatient Hospitalization[d]	$11/day ($25 minimum)	In network: $250 per day or 25 percent for hospital services (whichever is less) plus 20 percent for separately billed professional charges	$535 per day or 25 percent of institutional services (whichever is less) plus 25 percent for separately billed professional charges
Mental Health Visit[d]	$25 individual/$17 group	20 percent of the negotiated charge	25 percent of allowed charges
Outpatient Visit[d]	$12	20 percent of the negotiated charge	25 percent of allowed charges

Source: Congressional Budget Office using information from the Department of Defense.

Notes: The military's TRICARE program provides health care to uniformed and retired service members and their dependents and survivors through an integrated system of military and civilian facilities and providers. The program comprises several health plans, the largest of which are TRICARE Prime, which operates similarly to a civilian health maintenance organization, and TRICARE Standard and Extra, two fee-for-service plans differentiated by beneficiaries' use of network versus nonnetwork providers.

n.a. = not applicable.

a. Prime plan members may see specialty providers without a referral under a "point-of-service" (POS) option. The POS option carries a $300/$600 deductible and cost sharing of 50 percent.

b. Extra requires the use of a preferred provider network. Going outside the network incurs the Standard benefit.

c. The catastrophic cap is the maximum amount of out-of-pocket costs that a family will have to pay annually for TRICARE-covered services.

d. Charges apply to civilian providers only. Visits to or treatments by military providers involve no out-of-pocket costs to TRICARE beneficiaries. Enrollees in the Prime plan receive priority in scheduling appointments with military providers.

Table 4.

Medicare Part B Premiums in 2009, by Tax-Filing Status and Income

	Annual Medicare Part B Premiums (Dollars)[a]
Individual with Income Less Than or Equal to $85,000	1,157
Married Filing Jointly with Income Less Than or Equal to $170,000	1,157
Married Filing Separately with Income Less Than or Equal to $85,000	1,157
Individual with Income Exceeding $85,000 But Less Than or Equal to $107,000	1,619
Married Filing Jointly with Income Exceeding $170,000 But Less Than or Equal to $214,000	1,619
Individual with Income Greater Than $107,000 But Less Than or Equal to $160,000	2,312
Married Filing Jointly with Income Greater Than $214,000 But Less Than or Equal to $320,000	2,312
Individual with Income Greater Than $160,000 But Less Than or Equal to $213,000	3,006
Married Filing Jointly with Income Greater Than $320,000 But Less Than or Equal to $426,000	3,006
Married Filing Separately with Income Exceeding $85,000 But Less Than or Equal to $128,000	3,006
Individual with Income Greater Than $213,000	3,700
Married Filing Jointly with Income Greater Than $426,000	3,700
Married Filing Separately with Income Greater Than $128,000	3,700

Source: Congressional Budget Office using data from the Centers for Medicare and Medicaid Services.

Note: The income measure is modified adjusted gross income as defined by the Internal Revenue Service.

a. Medicare Part B covers outpatient health care. Premiums are the same for military and civilian retirees.

Medicare-Eligible Military Retirees and Their Dependents. Under TRICARE for Life, Medicare-eligible military retirees pay no enrollment fees for TRICARE but must enroll in Part B of Medicare, the premiums for which vary with income (see Table 4). Beneficiaries in TRICARE for Life may visit any Medicare provider or receive care at a military treatment facility on a space-available basis. The same catastrophic cap applies to the out-of-pocket costs of Medicare-eligible beneficiaries as applies to the costs of working-age retirees: Families pay a maximum of $3,000 annually. Most TRICARE for Life beneficiaries are not eligible to enroll in the Prime plan. They may, however, use TRICARE's pharmacy benefit, including the TRICARE retail pharmacy network.[18]

Copayments and Deductibles Under DoD's Pharmacy Benefit

Prescriptions for active-duty service members, retirees, and dependents are available from military pharmacies at no cost, and such pharmacies fill prescriptions written by any qualified provider, whether military or civilian, in or out of a network. Beneficiaries who prefer not to use military pharmacies may take prescriptions to retail pharmacies in the TRICARE network or use TRICARE's mail-order pharmacy. All beneficiaries who live in the United States face the same costs for such prescriptions, although the deductible charged for families of junior enlisted personnel (ranks E-4 and below) who use the Standard or Extra plans and nonnetwork pharmacies is smaller than the deductible for other beneficiary groups.

Copayments for pharmaceuticals vary by the type of drug. Beneficiaries will pay the least for generic drugs, incur larger copayments for brand-name drugs from the TRICARE formulary, and pay the most for brand-name drugs that are not part of the formulary (see Table 5).[19]

18. Many health insurers establish networks of retail pharmacies. A pharmacy that belongs to such a network will process a prescription claim electronically, adhere to—in the case of TRICARE—the plans' guidelines for filling the prescription (for example, by using generic rather than brand-name pharmaceuticals), and charge the insured beneficiary the appropriate copayment. Someone who fills a prescription in a nonnetwork pharmacy must pay the entire cost at the store and then file a claim for reimbursement. The TRICARE network comprises more than 54,000 retail pharmacies and includes many national drug- and grocery-store chains.

19. A formulary is a list of approved pharmaceuticals maintained by health insurance providers.

Table 5.

Current TRICARE Pharmacy Copayments in the United States for Dependents of Active-Duty Personnel and for Military Retirees and Their Families

	Copayment[a]
Mail Order (90-day supply)	
Formulary, generic	$3
Formulary, brand name	$9
Nonformulary	$22
Military Pharmacy (30-day supply)	
Formulary, generic	0
Formulary, brand name	0
Nonformulary	n.a.
Network Retail Pharmacy[b] (30-day supply)	
Formulary, generic	$3
Formulary, brand name	$9
Nonformulary	$22
Nonnetwork Retail Pharmacy[c] (30-day supply)	
Prime enrollee	50 percent of the cost after a deductible is met ($300 single/$600 family)
Standard or Extra user[d]	Formulary: $9 or 20 percent of the cost, whichever is greater, after a deductible is met Nonformulary: $22 or 20 percent of the cost, whichever is greater, after a deductible is met

Source: Congressional Budget Office using data from the Department of Defense.

Notes: The military's TRICARE program provides health care to uniformed and retired service members and their dependents and survivors through an integrated system of military and civilian facilities and providers. The program comprises several health plans, the largest of which are TRICARE Prime, which operates similarly to a civilian health maintenance organization, and TRICARE Standard and Extra, two fee-for-service plans differentiated by beneficiaries' use of network versus nonnetwork providers.

A formulary is a list of approved pharmaceuticals maintained by health insurance providers. Retail pharmacies are located off-base and typically include many common drugstore chains.

For the purposes of this table, the "United States" includes Puerto Rico, Guam, and the U.S. Virgin Islands; n.a. = not applicable.

a. Different copayments apply overseas.

b. Network retail pharmacies file insurance claims electronically and charge beneficiaries the appropriate copayment.

c. Beneficiaries who fill prescriptions at nonnetwork pharmacies must pay the entire cost up front and then file for reimbursement from TRICARE.

d. The deductibles for nonnetwork pharmacy costs for users of TRICARE Standard or Extra are $50 per individual and $100 per family for dependents of active-duty personnel ranks E-1 to E-4 and $150 per individual and $300 per family for all others, including retirees.

Many beneficiaries are "pharmacy-only" users of the TRICARE program. One reason may be that the copayments that military beneficiaries owe are smaller than those paid by participants in civilian pharmacy plans (and are zero at military pharmacies). Another reason many beneficiaries use the pharmacy plan may be that enrollment is not required to receive benefits under TRICARE's Standard or Extra plans. DoD estimates that of the 7.5 million participants in TRICARE in 2008, about 430,000 used only the pharmacy benefit.[20]

20. Department of Defense, *Evaluation of the TRICARE Program.*

DoD's Cost-Sharing Proposal

DoD first proposed to increase beneficiaries' costs in order to "Sustain the Benefit" as part of the President's budget request for 2007. The department's most recent proposal—submitted as part of the 2009 budget request—was based on the recommendations of the Task Force on the Future of Military Health Care, which published its final report in December 2007. Among its wide-ranging findings, the task force recommended that DoD adjust the cost-sharing arrangements between TRICARE and working-age military retirees. The task force also believed that some of the new fees—particularly the enrollment fees—should be indexed to keep pace with growth in the military's health care costs per capita.[21]

In particular, retirees who were not eligible for Medicare (and their dependents) who wished to participate in the Prime plan would pay higher annual enrollment fees and copayments under the task force's recommendations. That body recommended that DoD establish three tiers of enrollment fees for those beneficiaries.[22] The tiers were to be based on retirement pay: the first tier for retirees who received less than $20,000 annually in retirement pay, the second for those paid at least $20,000 but less than $40,000, and the third for those who received $40,000 or more (generally senior enlisted personnel and officers). Working-age military retirees who wished to use the Standard or Extra plans would pay an annual enrollment fee for the first time since the program was instituted (they would also face higher deductibles).

The task force's recommendations extended to older military retirees as well. Those who were eligible for Medicare would pay a new enrollment fee (in addition to the premiums for Part B of Medicare) to join TRICARE for Life. In addition, the task force recommended that the pharmacy program be restructured to realign the designations of generic, formulary, and nonformulary drugs and to change the various prescription copayments to encourage all beneficiaries to use medications that were more cost-effective.

DoD used that report not only as a basis for the 2009 proposal but also in constructing the 2009 Future Years Defense Program (covering 2009 to 2013).[23] Under the proposal, fees would have been gradually increased in 2009 and 2010, so that 2011 would have been the first year of the higher fees' full implementation. Specifically, DoD's proposal for implementing the task force's recommendations would have done the following:

- Increased the enrollment fee and copayments for TRICARE Prime for retirees who were not yet eligible for Medicare (and their dependents). Specifically, the proposal called for increasing the annual enrollment fee paid by younger retirees from the current amounts of $230 for single coverage and $460 for family coverage. The enrollment fee charged would vary by the amount of retirement pay and would be indexed as noted above (see the top panel of Table 6). Copayments for outpatient visits under the proposal would have risen from $12 to $28 and then been adjusted for inflation every five years. Copayments for emergency room visits and mental health visits would also have risen and been similarly adjusted.

- Charged an annual enrollment fee and raised the annual deductible for retirees who were not eligible for Medicare and who wished to use TRICARE Standard or Extra (see the bottom panel of Table 6). Under the proposal, a retiree with dependents would have paid nothing to access the Standard (or Extra) plan in 2008, but by 2011, the same retiree would need to enroll at a cost of $150 annually (and that amount would have increased each year thereafter to keep pace

21. See "The DoD Pharmacy Program" and "Retiree Cost Sharing," Chapters 9 and 10, respectively, of Department of Defense, Task Force on the Future of Military Health Care, *Final Report* (December 2007), pp. 73–90 and pp. 91–106.

22. Ibid.

23. The President's budget request for 2009 was submitted to the Congress in February 2008, and the 2009 FYDP was submitted in April 2008. For areas in which details of the proposal were not specified in the budget or the FYDP, CBO consulted with DoD officials regarding their projections, assumptions, and background information to build a more complete description of DoD's plan.

Table 6.

Cost Sharing for Non-Medicare-Eligible Beneficiaries Implied by the Data and Assumptions in DoD's Fiscal Year 2009 Budget Submission

(Dollars)

	Current Law/Policy	2009	2010	2011	2012	2013[a]
			TRICARE Prime			
Annual Catastrophic Cap[b]	3,000	2,500	2,500	2,500	2,500	2,500
Annual Family Enrollment Fees[c]						
Tier 1	460	730	900	1,100	1,180	1,260
Tier 2	460	890	1,160	1,460	1,560	1,670
Tier 3	460	1,190	1,640	2,140	2,290	2,460
Visit Copayments						
Office	12	12	28	28	28	28
Emergency	30	30	70	70	70	70
Mental health	25 individual/ 17 group	25 individual/ 17 group	28	28	28	28
			TRICARE Standard and Extra			
Annual Catastrophic Cap[b]	3,000	3,000	3,000	3,000	3,000	3,000
Annual Family Enrollment Fees[c]	n.a.	65	100	150	160	170
Annual Family Deductibles[c]						
Tier 1	300	420	500	600	600	600
Tier 2	300	500	640	800	800	800
Tier 3	300	670	920	1,180	1,180	1,180

Source: Congressional Budget Office calculations based on data from the Department of Defense.

Notes: The military's TRICARE program provides health care to uniformed and retired service members and their dependents and survivors through an integrated system of military and civilian facilities and providers. The program comprises several health plans, the largest of which are TRICARE Prime, which operates similarly to a civilian health maintenance organization, and TRICARE Standard and Extra, two fee-for-service plans differentiated by beneficiaries' use of network versus nonnetwork providers.

Tier 1 rates apply to retirees who receive retirement pay of less than $20,000 per year, Tier 2 rates to those with pay of more than $19,999 but less than $40,000 annually, and Tier 3 rates to those with annual pay of $40,000 or more.

n.a. = not applicable.

a. Future enrollment fees would be indexed to match the annual growth in the military's health care costs. Copayments, deductibles, and the catastrophic cap amounts would not be indexed and adjusted annually but instead would be adjusted every five years. Also, deductibles would be waived for preventive care.

b. The catastrophic cap is the maximum amount of out-of-pocket costs that a family will have to pay annually for TRICARE-covered services.

c. In accordance with DoD's longtime practice, rates for individuals are assumed to be half the family rates.

with growth in the military's health care costs).[24] The deductible would have been waived, however, for preventive care.[25]

- Restructured the annual catastrophic cap on the out-of-pocket costs of non-Medicare-eligible beneficiaries. The cap of $3,000 per retiree family would have remained at that amount for TRICARE Standard or Extra users but would have been lowered to $2,500 for Prime enrollees. Both caps would have been adjusted every five years to reflect trends in the military's health care costs.

- Increased pharmacy copayments for active-duty family members and all military retirees and their dependents. Prescriptions filled at military pharmacies would continue to require no cost sharing. Copayments for prescriptions filled at participating network pharmacies would rise from $3, $9, or $22 per prescription (for generic, brand-name formulary, and brand-name nonformulary drugs, respectively) to $15, $25, and $45. Copayments for mail-order prescriptions would change from $3, $9, and $22 to zero, $15, and $45 to encourage greater use of generic pharmaceuticals.

Although the task force recommended that Medicare-eligible retirees be charged the same enrollment fee that working-age retirees were charged for using Standard or Extra, DoD did not include that recommendation in its 2009 budget proposal.

CBO—using the same data and assumptions that DoD employed—estimated that those initiatives, if implemented in 2009, would have reduced defense health spending in 2011 by nearly $5.0 billion (see Table 7). The reduction in outlays from the Medicare-Eligible Retiree Health Care Fund would have been about $1.3 billion; the remaining estimated savings—$3.7 billion—represents funds that DoD assumed could be reallocated within its budget and used for other programs. Almost all of the $3.7 billion reduction estimated for 2011 would have come from changes that affected working-age retirees and their families.

Most of the estimated savings generated among working-age retirees and their dependents would have come from a drop in enrollment in TRICARE Prime—current users who would leave the program and prospective users who would choose not to enroll (see Table 8). For example, about $2.1 billion of the estimated reduction in spending for 2011, or 60 percent, would have resulted from increasing enrollment fees and copayments in the Prime plan. Another $800 million would have come from larger pharmacy copayments, and the remaining $600 million would have stemmed from instituting enrollment fees and increasing deductibles for non-Medicare-eligible beneficiaries who used the Standard and Extra plans.

In general, CBO's estimates of the reductions in spending from the legislative proposals that accompanied the President's budget requests for 2007 through 2009 were lower than DoD's (see Box 2). The analysis presented in this paper evaluates potential reductions in spending in DoD's health program but is not equivalent to a CBO cost estimate for a legislative proposal.

Comparing Growth in Measures of Civilian Health Care Spending with the Proposed Increase in TRICARE's Enrollment Fees

In general, health care costs—military and civilian—have grown more rapidly than prices in the economy as a whole. Inflation in the overall economy, as estimated by the gross domestic product price index, has averaged 2 percent to 3 percent per year since 2001 (see Figure 1 on page 20). By contrast, premiums for employment-based civilian plans and premiums for the Federal Employees Health Benefits program have increased by more than 7 percent per year, on average, during the same period. And measures of the growth of per capita national health expenditures as well as the yearly percentage increase in the medical portion of the consumer price index (CPI) have risen at an annual average pace of more than 4 percent. Thus, if the enrollment fees, deductibles, and copayments of TRICARE beneficiaries had increased at the same rate as health care spending in the civilian

24. The enrollment fees and deductibles for retirees without dependents would have been half the "with-dependents" rate, which has been TRICARE's convention since the program was created.

25. That small part of the proposal was enacted. Section 711 of the 2009 National Defense Authorization Act (Public Law 110-417) waives the copayments and deductibles for preventive care paid by non-Medicare-eligible retirees and dependents. Beneficiaries who are eligible for Medicare are excluded from the waiver, but the law permits DoD to refund the payments made by that group.

Table 7.

Estimated Reductions in DoD's Spending from Increasing Annual Cost Sharing for TRICARE, by Beneficiary Group

(Millions of dollars)

	2009	2010	2011	2012	2013
Dependents of Active-Duty Personnel—Pharmacy Copayments	100	140	180	200	220
Non-Medicare-Eligible Retirees					
Prime plan[a]	550	1,430	2,080	2,390	2,730
Standard and Extra plans[b]	100	400	630	580	500
Pharmacy copayments	440	630	810	880	960
Subtotal	1,090	2,460	3,530	3,850	4,180
Medicare-Eligible Retirees[c]					
Enrollment fees, TRICARE for Life	120	190	280	310	340
Pharmacy copayments	550	770	990	1,110	1,240
Subtotal	670	960	1,270	1,420	1,580
Total Reductions	**1,850**	**3,570**	**4,980**	**5,460**	**5,970**

Source: Congressional Budget Office calculations using data and assumptions from the Department of Defense (DoD).

Notes: The estimated reductions in spending stem from proposed increases in the TRICARE program's cost sharing based on recommendations of the Task Force on the Future of Military Health Care and DoD's budget submission for fiscal year 2009. DoD did not propose any changes in its 2010 budget submission.

The military's TRICARE program provides health care to uniformed and retired service members and their dependents and survivors through an integrated system of military and civilian facilities and providers. The program comprises several health plans, the largest of which are TRICARE Prime, which operates similarly to a civilian health maintenance organization, and TRICARE Standard and Extra, two fee-for-service plans differentiated by beneficiaries' use of network versus nonnetwork providers.

a. Reductions in spending would come from increasing enrollment fees and copayments.

b. Deductibles for both plans would be increased, and enrollment fees would be instituted. The larger deductibles would increase gradually and remain constant from 2011 through 2015, and the enrollment fees would increase annually. Thus, the reductions in spending for the Standard and Extra plans would be smaller in 2012 and 2013 than if the deductibles had risen each year.

c. Savings are in the form of reduced outlays from the Medicare-Eligible Retiree Health Care Fund (MERHCF), which finances the TRICARE for Life program. TRICARE for Life generally acts as a second payer, after Medicare, for the health care costs of Medicare-eligible military retirees. The program is funded through accrual contributions to the MERHCF—annual contributions made by DoD during service members' active-duty years to fund their later retirement benefits. Reductions in outlays from the MERHCF would in turn lower the accrual contributions made by DoD.

DoD did not propose changing the TRICARE for Life benefit in its 2009 budget submission, although the Task Force on the Future of Military Health Care had recommended it.

Table 8.

Estimated Reductions in Spending for TRICARE from Increasing Cost Sharing for Non-Medicare-Eligible Beneficiaries

(Millions of dollars)

	2009	2010	2011	2012	2013
			TRICARE Prime[a]		
Increase Enrollment Fees					
Revenues from fee collection[b]	190	290	390	420	450
Savings from users leaving the program	350	940	1,460	1,730	2,030
Increase Copayments					
Revenues from copayments	0	140	130	130	130
Savings from fewer visits	0	60	100	105	110
Total Savings, TRICARE Prime	**550**	**1,430**	**2,080**	**2,390**	**2,730**
			TRICARE Standard and Extra		
Institute New Enrollment Fees, and Increase Deductibles					
Revenues from higher fees and deductibles[b]	50	90	120	120	120
Savings from users leaving the program[c]	60	180	290	190	80
Savings from less use of services	40	170	270	300	340
Administrative Costs for Beneficiaries' Enrollment	-40	-20	-20	-30	-30
Costs for Preventive Care Waivers[d]	-10	-10	-10	-20	-20
Total Savings, TRICARE Standard and Extra	**100**	**400**	**630**	**580**	**500**
			All TRICARE Savings		
Health Care	650	1,830	2,720	2,970	3,220
Pharmacy	440	630	810	880	960
Total	**1,090**	**2,460**	**3,530**	**3,850**	**4,180**

Source: Congressional Budget Office calculations using data and assumptions from the Department of Defense.

Notes: All calculations assume that the proposed increases in cost sharing were implemented in 2009.

The military's TRICARE program provides health care to uniformed and retired service members and their dependents and survivors through an integrated system of military and civilian facilities and providers. The program comprises several health plans, the largest of which are TRICARE Prime, which operates similarly to a civilian health maintenance organization, and TRICARE Standard and Extra, two fee-for-service plans differentiated by beneficiaries' use of network versus nonnetwork providers.

a. Savings for TRICARE Prime are net of annual costs of $1 million for reducing the catastrophic cap for Prime enrollees from $3,000 per family to $2,500 per family.

b. The term "revenues" is often used to refer to offsetting collections from enrollment fees, copayments, and deductibles.

c. Such savings (or spending reductions) would be smaller in 2012 and 2013 because although enrollment fees would increase annually, deductibles would remain unchanged from 2011 through 2015.

d. Deductibles would be waived for services involving preventive care.

Box 2.

The Congressional Budget Process and Proposals for Changing TRICARE

For proposals to change fees, copayments, or deductibles in TRICARE, the military's health care program, the cost estimates that the Congressional Budget Office (CBO) provides to the Congress as part of the budget process in many cases differ from other estimates—for example, those submitted by the Department of Defense (DoD) as part of its yearly request for funding. There are several reasons for that variation.

First, the cost analysis that CBO prepares for a legislative proposal shows the estimated costs or savings relative to expected spending under current law, whereas DoD usually presents savings relative to its most recent budget. Suppose, for example, that DoD's budget submission for fiscal year 2011 included a reduction of $100 million in requested funding as a result of a new plan to charge larger copayments for prescription drugs. DoD would most likely display the entire $100 million in savings in its budget exhibits. Yet in the case of prescription drugs, current law already gives DoD the authority to increase copayments—within statutory limits—without any further action by the Congress. As a result, for the purposes of the cost estimate, CBO would assume that DoD would eventually do so—which means that CBO would consider some of the $100 million to be a reduction in "expected spending under current law." Therefore, if the Congress enacted legislation that allowed DoD to increase the copayments, CBO's cost estimate for the legislation would show, at most, only a portion of the $100 million in savings that DoD's calculations incorporated. Likewise, if the Congress enacted legislation to prevent DoD from increasing the copayments, CBO would estimate a cost to DoD's budget from the proposal, because the legislation would prohibit DoD from realizing the savings that current law would allow.

DoD's ability under current law to change cost sharing in the TRICARE program differs among the Prime, Standard, and Extra plans, the three predominant TRICARE health plan options. In turn, CBO's treatment of costs or savings will differ. For instance, like the authority to adjust copayments for prescription drugs, the authority to adjust enrollment fees and copayments in TRICARE Prime is available to DoD under current law. But the cost-sharing amounts for TRICARE's Standard (and by inference its Extra) plans are spelled out in current law, and any proposal by DoD to change those amounts would require legislative action. Therefore, CBO's estimate of costs or savings for proposals related to the Standard plan would be calculated differently than its estimates for similar proposals for TRICARE's Prime plan or its pharmacy program.

Second, CBO must consider whether a proposal, if implemented, would affect the discretionary or mandatory portion of the federal budget. In some cases, legislation that affected mandatory spending could trigger a point of order against it during its consideration on the floor of the House or Senate, depending on the budget-enforcement mechanisms that are

Continued

Box 2. **Continued**

The Congressional Budget Process and Proposals for Changing TRICARE

in place at the time.[1] Most spending for the various TRICARE plans is discretionary and thus is funded through annual appropriations in the categories of operations and maintenance, military personnel, and construction. However, spending related to certain Medicare-eligible retirees and beneficiaries is considered mandatory, because portions of their federal health benefits are paid for by the Medicare-Eligible Retiree Health Care Fund, or MERHCF (for further discussion of the MERHCF, see the "Summary and Introduction"). It is not always obvious whether various proposals to change TRICARE's cost sharing would affect discretionary spending, mandatory spending, or both. Changes to TRICARE's Prime plan would affect only discretionary appropriations, but changes to the Standard plan or to the pharmacy program—which provides benefits to a large number of Medicare-eligible retirees—could affect both discretionary and mandatory spending.[2] In its estimates, DoD generally shows the effects of its proposals only on discretionary funding, because that is the funding that DoD directly controls. (Mandatory spending from the MERHCF is presented in a different part of the federal budget and does not count against DoD's allocations in the annual appropriation process.)

A third reason for differences between CBO's and others' cost estimates for proposals to change TRICARE is that CBO must also judge how those proposals would affect other federal health programs and revenues. For instance, Medicare usually acts as the first payer of health care costs for military retirees and beneficiaries who are eligible for its benefits. Therefore, changing the benefits available to that population under the TRICARE program might affect outlays for Medicare (and vice versa). In addition, some TRICARE beneficiaries are eligible for other federal health care programs, including those of the Veterans Health Administration, Medicaid, and the Federal Employees Health Benefits program. Changing benefits under TRICARE might affect eligible beneficiaries' use of those programs, which could have implications for both discretionary and mandatory costs. Moreover, many TRICARE beneficiaries also have access to health insurance offered by private-sector employers. Because employment-based health premiums are often nontaxable, proposals involving TRICARE that changed the degree of beneficiaries' usage of such insurance could have implications for collections of federal revenues. CBO is required to consider all of those effects in analyzing the costs of any given legislative proposal that would affect the TRICARE program.

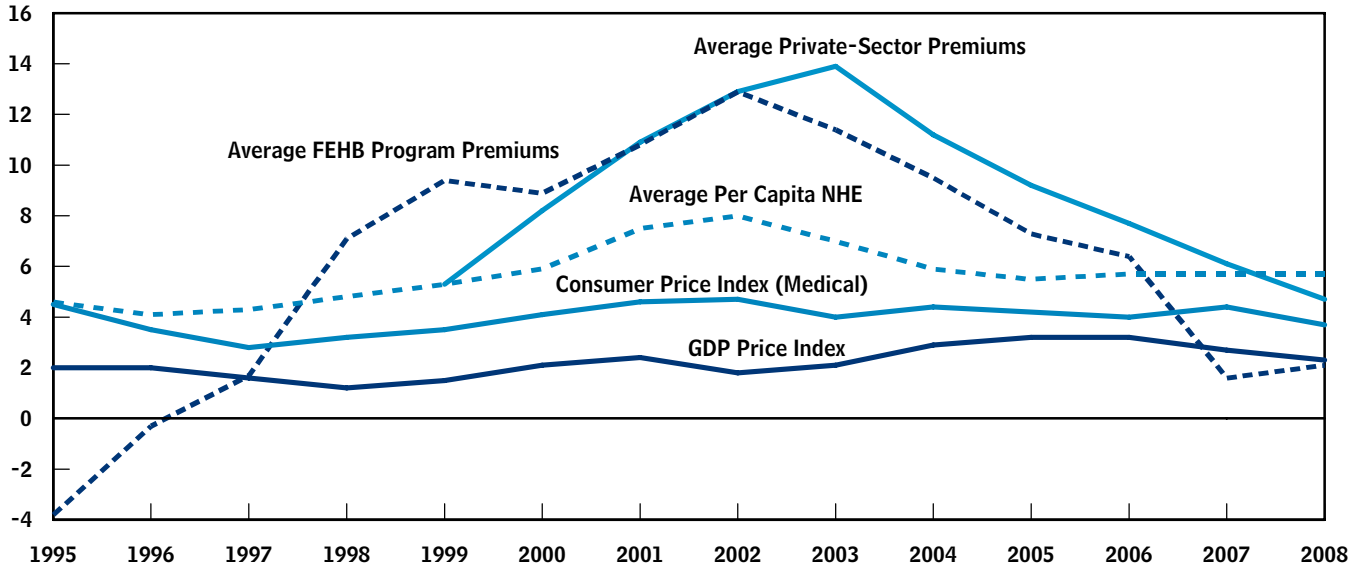
1. A point of order is a claim made by a legislator—during the process of "marking up" a bill (when Congressional committees and subcommittees debate, amend, and rewrite proposed legislation) or from the floor of the House or Senate—that a rule is being violated. If the Chair sustains the point of order, the action in violation of the rule (in this case, the consideration of the legislation) is not permitted to continue.

2. The benefits provided under TRICARE for Medicare-eligible retirees are referred to in this paper and by others as the TRICARE for Life program. Although TRICARE for Life is considered by many people to be separate from the rest of the TRICARE program, its underlying rules and regulations are derived from the same sections of the U.S. Code that provide authority for TRICARE's Standard health plan. Therefore, in many instances, any changes to the statutes for the Standard plan will also affect TRICARE for Life.

Figure 1.

Trends in Measures of Health Care Spending

(Percent)



Source: Congressional Budget Office based on the following: the medical care component of the consumer price index, from the Bureau of Labor Statistics; data on premiums (specifically, the average employee share) for the Federal Employees Health Benefits (FEHB) program, from the Office of Personnel Management; data on premiums in the private sector, from the 2007 survey of employment-based health benefits by the Kaiser Family Foundation and the Health Research and Educational Trust; the gross domestic product (GDP) price index, from the Bureau of Economic Analysis; and per capita data on national health expenditures (NHE), from the Centers for Medicare and Medicaid Services.

sector, those cost-sharing amounts would be substantially larger than they currently are (see Table 9).

If DoD had implemented new enrollment fees for TRICARE Prime in 2009, how would they compare with civilian benchmarks? DoD's proposal would have varied the fees by the amount of a working-age retiree's retirement pay. For example, the proposed enrollment fee for 2009 for the family of a retiree receiving retirement pay of less than $20,000 per year—the so-called Tier 1 group, which comprises approximately 60 percent of retirees—would be about $730 (see Table 6 on page 14). The fee for family enrollment for those in Tier 2 would be $890. Those amounts roughly correspond to what would have happened to TRICARE Prime's original enrollment fee of $460 (in nominal terms) if it had grown at the same rate as the medical CPI or national health expenditures since 1995. Retirees and dependents categorized as Tier 3 would have seen annual enrollment fees—at about $1,200 per family in 2009—that were $100 per year higher than those they might have expected if the TRICARE fee had increased at the same rate as premiums for the FEHB program.

Yet comparing those rates of growth says nothing about the absolute costs. Even if the original enrollment fees for TRICARE Prime had grown since 1995 to the amounts shown in Table 9, retirees who enrolled in that plan would still pay lower premiums, on average, than civilians who purchased employment-based coverage. In 2008, for example, the average premium for family coverage through a health maintenance organization was about $13,100; the average worker's contribution for such coverage was about $3,400.[26] Under DoD's proposal, non-Medicare-eligible retirees who enrolled their families in the Prime plan would pay between $1,100 and $2,140 in 2011 (the first year in which the new fees would be fully implemented), depending on the tier in which their retirement pay placed them.

26. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2008 Summary of Findings.*

Table 9.

Estimated Growth in TRICARE Prime's Family Enrollment Fee Using Selected Measures, 1995 to 2008

(Dollars)

	Estimated Prime Fee[a]
Consumer Price Index (Medical)	760
Premiums for the Federal Employees Health Benefits Program	1,080
Gross Domestic Product Price Index	610
National Health Expenditures per Capita	960
Memorandum:	
Current TRICARE Prime Fee	460

Source: Congressional Budget Office based on the following: the medical portion of the consumer price index, from the Bureau of Labor Statistics; data on premiums (specifically, the average employee share) for the Federal Employees Health Benefits program, from the Office of Personnel Management; the gross domestic product price index, from the Bureau of Economic Analysis; and per capita data on national health expenditures, from the Centers for Medicare and Medicaid Services.

a. The estimated amount of the fee in 2008 if its growth had mirrored that in the measures noted. The original nominal value used for the calculations was $460, the amount of the TRICARE Prime enrollment fee in 1995.

Comparing the enrollment fee proposed for the TRICARE Standard and Extra plans with the average fee-for-service premium paid by private-sector employees shows an even greater difference. Under DoD's proposal, the new enrollment fee for the Standard and Extra plans would have been about $150 in 2011 for family coverage. By comparison, the average premium that civilians paid for fee-for-service coverage was $3,730 in 2008.[27] (However, relatively few civilian employers still offer fee-for-service plans.)

27. Ibid. The share of their health insurance costs that employees (military or civilian) must pay is part of their overall compensation package. A more comprehensive look at the issue of military compensation relative to civilian compensation can be found in Congressional Budget Office, *Evaluating Military Compensation* (June 2007).

The Effects of Cost Sharing on the Demand for Health Care

The magnitude of the reductions in health spending that could be attained by increasing cost sharing for military beneficiaries depends on how strongly they would respond to the new fees, copayments, and deductibles. On the one hand, if military retirees and their dependents did not respond by leaving TRICARE or by consuming fewer health care services, DoD's estimated spending reductions would not be realized. If, on the other hand, beneficiaries responded more strongly than DoD had assumed, annual reductions in its spending for health care could exceed its estimates.

In general, people can be expected to consume less of a good or service as it becomes more expensive to obtain. But the degree of their response may vary widely, depending on many factors, including the availability of substitutes and the fraction of a household's budget that is involved. People would be expected to respond more strongly to changes in the price of luxury vacations, for example, than to changes in the price of gasoline, because gasoline is viewed as more of a necessity, with few substitutes available. Economists measure the degree of responsiveness with an "elasticity" and would therefore describe the demand for luxury vacations as more elastic than the demand for gasoline.

A price elasticity measures the change in the quantity of a good or service demanded in response to a change in its price. If the response is relatively mild, as in the case of gasoline, demand is said to be inelastic, and the measured price elasticity is between 0 and -1. For a good that has a price elasticity in that range, an increase of 10 percent in its price will reduce the quantity demanded by less than 10 percent. If the quantity demanded is highly responsive to changes in price, demand is said to be elastic, meaning that a 10 percent increase in price will reduce the quantity demanded by more than 10 percent, and the measured elasticity will be more negative than -1. The inverse relationship between the price and the quantity demanded means that price elasticities will almost always be negative.

In some ways, the demand for health care may not seem to mirror the consumption of other goods. Many people seek and purchase such services not solely on their own initiative but because they have been referred for additional care by their doctors; also, a person in the midst of

a life-threatening emergency generally is not weighing costs and benefits as the ambulance arrives. In general, however, people respond to the price of health insurance programs when they choose one plan over another (or decide not to buy insurance at all). They also respond to the amount of cost sharing they must pay when they decide whether to see a doctor or fill a prescription. The availability of substitutes will affect people's use of health care services—and the estimated elasticity—as well. Economists would expect that people who were eligible for TRICARE and who lacked access to employment-based health insurance or government health programs would be less responsive to changes in TRICARE's fees. They might also expect some people to respond to higher copayments for prescription drugs at retail pharmacies by filling more prescriptions at military pharmacies (where the copayment for all TRICARE beneficiaries is zero).

Estimates of Elasticities from the Health Economics Literature

Studies in economics and health policy have estimated the effects that increases in beneficiaries' costs might have on enrollment in health insurance plans, on the utilization of and expenditures for health care, and on health outcomes. Most researchers use civilian populations for their studies. The largest such investigation was the RAND Health Insurance Experiment conducted from 1974 to 1982.[28] In that experimental study, researchers randomly assigned 2,750 families (more than 7,700 individuals) to particular health insurance plans and observed their behavior over a period of three to five years. Families were randomly assigned to one of five types of plan, each of which required beneficiaries to pay a different amount of out-of-pocket costs.

Conducting experimental studies, however, is difficult and expensive; thus, most researchers have conducted observational studies of beneficiaries' responses to increased cost sharing for health care. Observational studies look at relatively large populations as health costs change over time—or they may consider how costs vary geographically. But such studies may have difficulty separating out the effects on people's choices of differences in the quality of the various plans.

An alternative is "natural experiments," which analyze the demand of the same set of individuals before and after changes in the cost of their group health insurance.[29] The advantage of using natural experiments is that changes in a plan's premiums are unrelated to the plan's quality—in other words, the characteristics of a plan stay the same, but the beneficiaries' costs change. The disadvantage of a natural experiment is that it focuses on a limited population, so the estimates it produces may not easily be extrapolated to another group or to the population as a whole. For example, findings from a study of university employees—who may have more education and higher income than the overall U.S. population—may not indicate how a broader population of civilians or military service members will behave.[30]

Researchers commonly measure two different aspects of responsiveness. The elasticities that measure how current and potential beneficiaries respond to changes in the annual premium or enrollment fee are generally called premium elasticities. Those that measure how people alter the number of visits they make to health care providers or the number of prescriptions they fill in response to changes in copayments are generally referred to as copayment or coinsurance elasticities.[31]

Premium Elasticities. Researchers in this area generally agree that the demand for health insurance is relatively inelastic—that is, the elasticity is between 0 and -1. In

28. See Willard G. Manning and others, "Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment," *American Economic Review,* vol. 77, no. 3 (June 1987), pp. 251–277; or John P. Newhouse and the Insurance Experiment Group, *Free for All? Lessons from the RAND Health Insurance Experiment* (Cambridge, Mass.: Harvard University Press, 1993).

29. See, for example, D.M. Cutler and S. Reber, *Paying for Health Insurance: The Tradeoff Between Competition and Adverse Selection,* Working Paper No. 5796 (Cambridge, Mass.: National Bureau of Economic Research, 1996); and A.B. Royalty and N. Solomon, "Health Plan Choice: Price Elasticities in a Managed Competition Setting," *Journal of Human Resources,* vol. 34, no. 1 (Winter 1999), pp. 1–41.

30. Researchers may not only vary the type of study they do or the data they use but also the way they calculate elasticities. The RAND Health Insurance Experiment generally reported *arc elasticities*, whereas other researchers tend to report *point elasticities*. (An arc elasticity is the average elasticity over a range of values and therefore equals the corresponding point elasticity only at the midpoint of the range.)

31. Coinsurance is the share of the cost that is paid by the beneficiary; thus, a coinsurance rate of zero means that an office visit is free for the patient, and a coinsurance rate of 95 percent means that the patient pays almost the entire cost.

other words, an increase of 10 percent in a plan's premium or enrollment fee will reduce enrollment in the plan by something less than 10 percent. Yet studies from the economics literature have estimated premium elasticities ranging from -0.1 to -1.8.[32] Older or less healthy individuals respond less strongly to changes in premiums than do younger or healthier people, so studies of the former tend to produce elasticities closer to zero. Elasticities that are estimated from observational studies also tend to be closer to zero than elasticities reported from natural experiments, in part because of the difficulty in observational studies of separating out the effects of differences in plans' quality.

Copayment or Coinsurance Elasticities. The premium or enrollment fee is a large factor in people's decisions about participating in health care plans. Once people choose a plan, however, they must also decide how intensively to use the system. That decision will depend on the amount they must pay—their copayment or coinsurance—for each visit to a health care provider and each prescription.

CBO found that estimates of coinsurance elasticities in the literature ranged from -0.1 to -2.1, whereas the experimental approach of the RAND study produced estimates at the less responsive end of that broader span. For coinsurance ranging from zero to 25 percent, the estimated elasticity for outpatient visits to a physician, according to the RAND research, was -0.17; coinsurance rates that ranged from 25 percent to 95 percent produced an estimated elasticity of -0.31. Other research that featured either natural experiments or observational studies of civilian populations reported estimated outpatient elasticities (for physician visits) of -0.04 to -0.36.[33] Three studies of prescription copayments or coinsurance found a range of -0.10 to -0.35.[34]

Elasticities and TRICARE

Most of the policy proposals that CBO considered in its analysis would affect military retirees, particularly working-age retirees.[35] To what extent are elasticity estimates from the literature, which are based on the responses of civilians, applicable to the military retirees who use TRICARE?

Most military retirees who are between the ages of 38 and 65 and thus not yet eligible for Medicare work in civilian jobs. Because of their age, they are less likely than active-duty personnel to have young children at home, and their spouses are more likely to work outside the home. CBO estimates that about three-quarters of working-age military retirees have access to employment-based health insurance. To the extent that they have other options than TRICARE for obtaining insurance, their elasticity (on average) would be expected to be similar to that of civilian populations. Because military retirees may be older than the average civilian, however, their demand for health insurance may be less elastic.

Beneficiaries who use TRICARE have access to free care if they live near a military base and rely on military treatment facilities. Enrollees in TRICARE Prime receive priority for appointments at those facilities. As a result, those beneficiaries would not be affected by the higher copayments charged for visits to civilian providers and might not respond as strongly to higher enrollment fees for the Prime plan as the estimates from civilian populations might suggest. Therefore, although civilian studies may offer useful insights into the responses that might be expected in the wake of changes to TRICARE fees, a case can be made for DoD's use of elasticities at the less negative end of the range identified in civilian studies (that is, of elasticities closer to zero). Indeed, the assumptions about elasticities that DoD used in developing its proposal were relatively conservative.

Because more than half of the estimated savings rest on the assumption about how many people will leave the TRICARE system, the premium elasticity assumption is particularly important.[36] DoD used an elasticity assump-

32. Jeanne S. Ringel and others, *The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System,* MR-1355-OSD (Santa Monica, Calif.: RAND Corporation, 2002), pp. 39–44.

33. Ringel and others, *The Elasticity of Demand for Health Care*, pp. 21 and 30.

34. Ibid.

35. None of the policy proposals would affect active-duty service members. However, the part of the proposal that would increase copayments for prescription drugs would affect their families.

36. DoD attributed about 54 percent of the proposal's estimated savings in 2011 to current Prime enrollees' decisions to leave that plan; it attributed another 10 percent of savings to reductions in the use of health care services by current Standard and Extra users. However, DoD also assumed that some enrollees who left the Prime plan would then use the Standard and Extra plans, so the savings it calculated were net of people it had estimated would make that switch.

tion of -0.1 for the proposed increase in the Prime plan's enrollment fee. In other words, DoD estimated that an increase of 10 percent in the Prime plan's fee would result in a reduction of 1 percent in the number of people enrolled. DoD used a smaller elasticity (-0.075) to estimate the number of people who would stop using the Standard and Extra plans if the cost sharing for those plans was increased.

The magnitude of the proposed changes in cost sharing is another consideration in making assumptions about elasticities to estimate potential savings. The initial increases for military retirees under DoD's proposal would, in general, be much larger (in percentage terms) than those seen in civilian plans. Changing the family enrollment fee in the Prime plan from $460 to $730, for example, is a much larger one-year percentage change than civilian plans generally impose. (Under the proposal, the indexed fees after the first three years would rise approximately in line with the military's health care costs.) Particularly in the early years of implementing DoD's proposal, then, estimates of responses based on changes seen in civilian plans might not accurately predict how military personnel and military retirees would behave. Even if users responded only weakly to the cost-sharing changes in TRICARE (that is, an elasticity close to zero), many users could end up pursuing other health insurance options.

DoD also used elasticity assumptions from the low end of the response range seen among civilians for estimating beneficiaries' responses to increased copayments. The department assumed for its 2009 proposal that the number of office visits to physicians would decline by -0.08 percent as a result of an increase of 1 percent in the copayments; it applied elasticities of -0.25 for mental health visits and -0.15 for emergency room visits. To estimate the savings from increased pharmacy copayments, DoD applied an elasticity of -0.2—again, an estimate taken from the more conservative (less responsive) end of the range identified in the literature.[37]

DoD had used similar elasticities in estimating the potential reductions in spending that might arise under its 2007 proposal. In analyzing that proposal, however, the Government Accountability Office concluded that the reductions in spending that DoD had projected were too large.[38] DoD estimated that 500,000 users would respond to the new fee structure by leaving (or declining to enroll in) TRICARE. But GAO raised the concern that significant numbers of working-age retirees would not have access to other forms of health insurance or that beneficiaries' options would be more expensive than TRICARE. In its 2009 plan, DoD proposed that a new fee be charged to enroll in the Standard and Extra plans (to reduce the incentive for people to switch from Prime into those other plans). DoD also altered one of its elasticity assumptions in developing the 2009 plan to be more in line with GAO's findings. After incorporating those changes, DoD projected that under the 2009 plan, TRICARE would have seen 360,000 fewer users and not the larger reduction that had concerned GAO.

Yet the question about how retirees would respond, and what their alternatives might be, remains. In reviewing the literature, CBO identified four studies that provide additional insight. There is some evidence that even people who have no access to lower-cost insurance plans may still respond strongly to changes in health insurance premiums. Estimated elasticities from two studies of civilians who did not have access to employment-based health coverage ranged between -0.3 and -0.6—or several times stronger than DoD's elasticity assumption of -0.1.[39]

Two other studies are useful because they examined military beneficiaries and not civilians. The first study, published in 1995, estimated an elasticity of -0.5 for military beneficiaries under the age of 65 (including their dependents).[40] The data in that study, however, were collected before TRICARE was fully implemented, so the results may not be particularly relevant today. However, a second study, published in 2008, examined non-Medicare-

37. Ringel and others, *The Elasticity of Demand for Health Care*.

38. Government Accountability Office, *Military Health Care*.

39. Marquis and Long, "Worker Demand for Health Insurance in the Non-Group Market," and Auerbach and Ohri, "Price and the Demand for Nongroup Health Insurance."

40. Susan D. Hosek and others, *The Demand for Military Health Care: Supporting Research for a Comprehensive Study of the Military Health-Care System,* MR-407-1-OSD (Santa Monica, Calif.: RAND, 1995). RAND conducted a later study that surveyed a small number of military retirees who chose *not* to use TRICARE; that study measured elasticities ranging from -0.8 to -2.0. Researchers focused on the extent to which beneficiaries would respond to higher premiums in civilian health plans by switching to TRICARE, but the choices presented were hypothetical. See Mariano and others, *Civilian Health Insurance Options of Military Retirees*.

Table 10.

Estimated Reductions in Spending for TRICARE Prime Under Alternative Assumptions About Non-Medicare-Eligible Users Who Leave the Plan

(Billions of dollars)

Enrollment Elasticity[a]	2009	2010	2011	2012	2013
-0.05	0.4	0.8	1.2	1.3	1.4
-0.10 [b]	**0.4**	**0.9**	**1.5**	**1.7**	**2.0**
-0.15	0.5	1.4	2.2	2.6	3.1
-0.20	0.7	1.9	2.9	3.5	4.1
-0.25	0.9	2.4	3.7	4.3	5.1

Source: Congressional Budget Office using data from the Department of Defense (DoD).

Note: The amounts in the table do not reflect other components of the proposal in DoD's fiscal year 2009 budget submission to increase enrollment fees, copayments, and deductibles in TRICARE, nor do they incorporate "revenues" from collections of enrollment fees in the Prime plan.

a. The enrollment elasticity assumption is the percentage reduction in the number of enrollees in TRICARE Prime (the military's health plan that generally corresponds to a civilian health maintenance organization) when the annual enrollment fee is increased by 1 percent.

b. DoD used an elasticity assumption of -0.10 in estimating proposed spending reductions for its 2009 budget submission. This set of calculations corresponds to the line in the top panel of Table 8, "Savings from users leaving the program."

eligible military retirees (and their families) and estimated an elasticity of -0.2, or double the one used by DoD.[41]

In sum, despite some basis for the belief that military retirees and their dependents would not respond strongly to increased cost sharing, empirical estimates for both civilian and military populations suggest that the elasticities DoD used in its proposal were relatively conservative. If the military beneficiaries who would be affected by the changes responded more strongly to the new fee structure than DoD assumed, annual reductions in defense spending for health care after five years could be closer to $8 billion than to DoD's estimate of $6 billion.

Possible Effects on Federal Spending Under Various Elasticity Assumptions

Of the possible savings that might accrue to DoD from a new fee structure for the TRICARE program, the largest portion would come from the increase in the Prime plan's enrollment fees. Specifically, those savings would depend on how many younger retirees (those not yet eligible for Medicare) would choose not to enroll in the Prime plan after the enrollment fees were increased. Because the actual response to a new fee structure is unknown, CBO considered how the estimated savings would change under different elasticity assumptions. DoD's assumption that an increase of 10 percent in the annual enrollment fee for TRICARE Prime would reduce the number of users by 1 percent—an elasticity of -0.1—results in estimated savings of $1.5 billion in 2011 (see Table 10). But alternative elasticity assumptions—consistent with those measured by other researchers—could result in savings in 2011 ranging from $1.2 billion (an elasticity of -0.05) to $3.7 billion (an elasticity of -0.25). Substituting the elasticity of -0.2 measured by the 2008 study conducted by Lawrence Goldberg and others, CBO estimated that annual savings in 2011 would amount to $2.9 billion, or about twice DoD's estimate for that year.

Under DoD's proposal, the second-largest amount of estimated savings that might result from changing benefits for non-Medicare-eligible military retirees would come from increasing their pharmacy copayments. DoD has estimated, using an elasticity assumption of -0.2, that its spending for health care in 2011 with that higher cost sharing might be reduced by $800 million. Varying the elasticity between the range of -0.2 to -0.35 (the range observed in civilian studies of such a change) yields estimated savings of between $800 million and $1.1 billion.

41. Goldberg and others, *Controlling TRICARE Cost Growth*.

Thus, the potential savings from changes in the enrollment fees, copayments, and deductibles in the TRICARE program can vary widely, depending on the responsiveness of military beneficiaries. If people responded more strongly than DoD assumed, the reductions in defense spending for health care under the proposal might be greater than those DoD used in developing its budget submission for 2009 and the 2009–2013 Future Years Defense Program. Yet the reduction in federal spending overall would be smaller than that for defense spending. Some military retirees who met the eligibility requirements might seek more of their care from the Veterans Health Administration if TRICARE became more expensive, and lower-income retirees might switch to Medicaid. Military retirees or their spouses who work for the federal government are eligible for the Federal Employees Health Benefits program; higher fees for TRICARE might encourage many of them to take up the FEHB coverage. Each of those scenarios could raise federal spending for programs other than TRICARE.

Federal revenues might also be affected under the proposal. If many military beneficiaries shifted to civilian employment-based health plans, revenues could fall, because under those plans, more of those beneficiaries' compensation would shift from being taxable to being nontaxable.

In December 2008, as part of its volume of options for reducing federal spending for health care, CBO estimated the budgetary effects of a program that was similar but not identical to DoD's proposed changes.[42] The option explored the effects of raising enrollment fees, copayments, and deductibles for non-Medicare-eligible military retirees, but it did not vary the fees by the amount of retirement pay a beneficiary received or alter other components of TRICARE (such as pharmacy copayments). CBO estimated that DoD's outlays under such a program would be reduced by $7.7 billion over the five-year period from 2010 to 2014. Mandatory spending was estimated to increase by $240 million, and revenues were projected to fall by $1 billion. Thus, increasing fees for military retirees could save DoD several billion dollars over a five-year period, but other parts of the federal budget would be affected in the opposite direction, though by a lesser amount.

42. Congressional Budget Office, "Option 97—Increase Medical Cost Sharing for Military Retirees Who Are Not Yet Eligible for Medicare."