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Military Medical Care Services: Questions and Answers

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Military Medical Care Services: Questions and Answers

SUMMARY

The primary mission of the Military Health Services System (MHSS), which encompasses the Defense Department's hospitals, clinics, and medical personnel, is to maintain the health of military personnel so they can carry out their military missions, and to be prepared to deliver health care during wartime. The military medical system also provides, where space is available, health care services in Department of Defense (DOD) medical facilities to dependents of active duty service members and to retirees and their dependents.

The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was established in 1966 legislation as the military equivalent of a health insurance plan, run by DOD, for active duty dependents, military retirees, and the dependents of retirees, survivors of deceased members, and certain former spouses. CHAMPUS reimburses beneficiaries for portions of the costs of health care received from civilian providers.

As a follow-on to CHAMPUS, DOD established **Tricare** to coordinate the efforts of the services' medical facilities. Tricare also provides beneficiaries with the opportunity to receive their care through a DOD-managed health maintenance organization, a preferred provider organization, or to continue to use regular CHAMPUS (now known as Tricare Standard).

The MHSS currently includes some 75 hospitals and 461 clinics serving an eligible population of 8.9 million. It operates worldwide and employs some 39,000 civilians and 92,000 active duty military personnel. Calculating the total cost of military medical spending is complicated by the different categories of funds involved; DOD statistics on total medical spending indicate a growth from $17.5 billion in FY2000 to an estimated $36 billion in FY2005 (the latter figure includes an accrual fund for future retirees).

Although CHAMPUS was intended to provide retirees with health care benefits from the time of their retirement, usually in their mid-40s, the FY2001 Defense Authorization Act provided that Tricare serve as a second payer to Medicare for retirees and their spouses and survivors beginning in FY2002. The act also extended a pharmacy benefit to Medicare-eligible beneficiaries. This program is known as Tricare for Life (TFL).

Some retirees groups advocate opening the Federal Employees Health Benefits Program (FEHBP) to military retirees, but an FEHBP demonstration project did not prove very popular among beneficiaries.

Military health care issues are addressed in annual Defense authorization and appropriations bills; for additional details and the status of current legislation, see CRS Report RL32305, *Authorization and Appropriations for FY2005: Defense*.

MOST RECENT DEVELOPMENTS

On April 21, 2005, senior Defense Department officials testified that total FY2005 military health spending will reach $36 billion and is likely to exceed $50 billion within five years. It was noted that, if current trends continue, 75-80 percent of that spending will be for individuals no longer on active duty or their family members. DOD's total pharmacy program has increased 500 percent since 2001 and now stands at $5 billion annually.

In March 2005, the Defense Department announced regulations regarding a new benefit for reservists, known as Tricare Reserve Select (TRS). Reservists who have served at least 90 days on active duty, and agree to continue in the reserves, are eligible to purchase TRS coverage. Monthly premiums are set at $75.00 for individual beneficiaries and $233.00 for beneficiaries and their families.

BACKGROUND AND ANALYSIS

Although the Military Health Services System (MHSS) is primarily designed to provide medical services to active duty service members, it is also a major source of medical care, in both military and civilian facilities, to the dependents of active duty personnel, military retirees, and retirees' dependents. Since 1967, civilian care to millions of dependents and retirees (and retirees' dependents) has been provided through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) although beneficiaries are responsible for certain co-payments. Since 1995, the Department of Defense (DOD) has sought to coordinate the medical care efforts of the Army, Navy, and Air Force, and to institute managed care principles in a program known as Tricare. Tricare provides beneficiaries with the opportunity of choosing a health maintenance organization option, a preferred provider option, or a fee-for-service option.

The implementation of Tricare and other efforts to manage DOD health care more efficiently as well as downsize the MHSS as part of the overall post-cold war reductions of the entire Defense Department, meant that less care was available to non-active duty beneficiaries, especially to those aged 65 and over. Informed, articulate, and well-organized, this population sought authorization to obtain health care benefits after they became eligible for Medicare. The Defense Authorization Act for FY2001 (P.L. 106-259) provided for both a pharmacy benefit and access to Tricare for those who became Medicare-eligible at age 65.

This issue brief attempts to answer basic questions about the MHSS, its beneficiary population, the medical services it provides, its costs, and major changes that are underway or have been proposed. Citations are made to more detailed CRS studies where appropriate. The General Accountability Office (GAO) and the Congressional Budget Office (CBO) have also published important studies. In addition, the Office of the Assistant Secretary of Defense for Health Affairs Home Page may be of interest [http://www.tricare.osd.mil/].

Questions and Answers

1. What Is the Purpose of the Military Health Services System?

The MHSS provides medical care to active duty military personnel, eligible military retirees, and eligible dependents of both groups. The primary mission of the medical services system is to maintain the health of military personnel, so they can carry out their military missions, and to be prepared to deliver health care required during wartime. Often described as the medical readiness mission, this effort involves medical testing and screening of recruits, emergency medical treatment of servicemen and women involved in hostilities, and the maintenance of physical standards of those in the armed services.

In support of those in uniform, the military medical system also provides, where space is available, health care services to dependents of active duty service members. Space available care is also provided to retirees and their dependents. Some former spouses are also included. Since 1966 civilian medical care for dependents of active duty personnel, and for retirees and their dependents who are under age 65 has been available (with certain limitations and co-payments) through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Since October 2001 Tricare benefits have been available to retirees and their dependents aged 65 and over.

2. What Is the Structure of the Military Health Services System?

Under the Secretary of Defense, the MHSS is headed by the Assistant Secretary of Defense for Health Affairs (ASD/HA). An October 1991 reorganization strengthened the role of the ASD/HA by giving the incumbent planning, programming, and budgeting responsibilities for the MHSS, including facilities operated by the Army, Navy (which also provides health care services to the Marine Corps), and Air Force. The Surgeons General of the Army, Navy and Air Force retain considerable responsibility for managing military medical facilities and personnel.

The MHSS currently includes 75 hospitals and 461 clinics operating worldwide, and employs more than 39,000 civilians and 92,000 active duty military personnel. Direct care costs include the provision of medical care directly to beneficiaries, the administrative requirements of a large medical establishment, and maintaining a capability to provide medical care to combat forces in case of hostilities. Civilian providers under contract to the Department of Defense (DOD) have constituted a major portion of the MHSS in recent years.

Although the number of active duty personnel in DOD is not projected to increase over the next few years, costs associated with the MHSS are not expected to follow suit. This results from general inflation in the cost of health care and an increasing percentage of care being provided to retirees and their dependents. (In 1950 retirees made up 8% of those eligible for military health care; by 1997 it was over 50%.) Reductions in direct care can actually lead to growth in overall DOD health spending because beneficiaries whose access to military medical facilities is removed through base closures may turn to more costly care from civilian providers, for which they can seek reimbursement from DOD.

Each year the Office of the Secretary of Defense (OSD) forwards a budget request to Congress for the Defense Health Program (DHP), which includes monies needed for

procuring equipment for the MHSS, operation and maintenance, and care for civilian beneficiaries. Funding for the compensation of military personnel assigned to the MHSS is contained in the Military Personnel appropriation accounts of the individual military departments. Additional requests are made in procurement and military construction accounts.

3. How Much Does Military Health Care Cost Beneficiaries?

Active duty service members receive covered medical care in military facilities without additional costs, other than small *per diem* charges. Other beneficiaries pay differing amounts depending on their status and where they receive care. If care can be obtained at military facilities, there is no charge for medical services, and only small daily charges for hospital stays.

Tricare costs vary by the option selected. Active duty personnel are automatically enrolled in Tricare Prime without any premiums; their dependents may join, also without premiums. Retirees (under age 65) must pay $230 (individual) or $460 (family) each year in enrollment fees. There have been small fees required for visits to civilian care providers who are part of the Tricare network, but DOD proposes that they be eliminated.

Tricare Standard or CHAMPUS has a more complicated cost structure. There are no premiums or enrollment fees. At present, for outpatient care in civilian hospitals and clinics, there is a yearly deductible of $150.00 for one person and $300.00 for a family (with lower fees for the most junior enlisted personnel). After the yearly deductible is met, dependents of active duty personnel pay 20% of CHAMPUS-approved care; all others pay 25%. For inpatient care, there is no deductible for CHAMPUS-approved care, but families of active duty service members pay a small *per diem*. Other CHAMPUS beneficiaries will pay the lesser of 25% of the billed charges or a fixed daily amount ($512. in FY2005) of care covered by CHAMPUS. In addition, there is a "cap" on annual care; active duty families are reimbursed for allowable expenses over $1,000 and other CHAMPUS families are reimbursed for allowable expenses over $3,000. These figures are generalized; there are a number of important exceptions that are explained in the CHAMPUS Handbook and in the underlying Federal Regulations (32 CFR 199). The Handbook urges beneficiaries to check with their Health Benefits Advisors before seeking care.

Tricare Extra, the preferred provider option, has a cost structure similar to CHAMPUS except that beneficiaries who use health care providers in the Extra network pay 5% less than they would if using non-network providers. Inpatient care costs $13.90 per day for active duty dependents and $512. per day (or 25% of daily hospital costs, whichever is less) for retirees and their dependents. Care may still be obtained from military facilities if space is available.

4. In What Ways Has the MHSS Been Changing in Recent Years?

During the Cold War, the MHSS was designed to support a full-scale, extremely violent war with the Soviet Union and its allies in Europe. High casualties were anticipated along with a need for in-theater medical treatment facilities. The collapse of the Soviet Union and the end of the Warsaw Pact led to a major reassessment of U.S. defense policy. In the future, defense planners believe, the most likely conflicts will be of limited duration and involve

smaller numbers of troops. The overall size of the active duty force has been reduced by one-third since the mid-1980s. Planners expect that casualties can be treated locally (with greater reliance on telemedicine) or, if necessary, evacuated to military medical facilities in the continental United States (CONUS). This strategic planning, along with associated military personnel reductions, requires a smaller MHSS, fewer military medical personnel, and the closure of a number of hospitals and clinics. In recent years. the number of military medical personnel has declined by 15% and the number of military hospital has been reduced by one-third. (For background, see Department of Defense, Medical Readiness Strategic Plan, 1995-2001, March 30, 1995.)

On the other hand, the number of potential beneficiaries of military medical care who are over age 65 has grown in absolute terms to 1.2 million, and now represents about one-half of the beneficiary population. This number is expected to grow until 2009. Most retirees become eligible for Medicare when they reach age 65 although some disabled retirees become eligible for Medicare earlier. In 1991 Congress acted (in P.L. 102-190) to reestablish CHAMPUS eligibility for persons under age 65 who become eligible for Medicare, Part A because of disability. Such persons are, however, required to enroll in Medicare Part B (and pay premiums) to be eligible for CHAMPUS/Tricare.

In addition to revisions in military planning, nation-wide changes in the practice of medicine have also affected the MHSS. In particular, managed care initiatives and capitated budgeting that are widely adopted in the civilian community are being implemented in DOD's Tricare program. Tricare is also designed to coordinate medical care efforts of the three military departments in some 12 geographical regions, each under a single military commander known as a lead agent. The lead agents are responsible for managing care provided by all military medical facilities in their respective regions, and for contracting for additional care from civilian providers. These competitively-bid, region-wide contracts represent a significant change in delivery of defense health care and will, it is anticipated, result in cost savings. Each region will have a capitated budget based on the total number of beneficiaries in the region. Detailed regulations governing Tricare were made effective on November 1, 1995 (32 CFR 199). Although care continues to be centered around military medical facilities, heavy reliance is placed on civilian contractors managed by the lead agent where necessary.

The centerpiece of Tricare is the Tricare Prime option, a DOD version of a health maintenance organization (HMO) that the beneficiary joins, and which provides essentially all of his or her medical care. Care is provided through DOD medical personnel, hospitals, and clinics, as well as affiliated civilian physicians, hospitals, and other providers. Costs are contained through administrative controls and treatment protocols. In civilian practice, HMOs have been credited with some success in reducing costs, although opponents of these systems complain about restrictions on provider choice and incentives that may be created to constrain the delivery of services.

CHAMPUS/Tricare Standard has been the military equivalent of a health insurance plan, run by DOD, for active duty dependents, military retirees, and the dependents of retirees, survivors of deceased members, and certain former spouses (for more information on those benefits available to former spouses, see CRS Report RL31663, *Military Benefits for Former Spouses: Legislation and Policy Issues*, by David F. Burrelli). Unlike private insurance plans, CHAMPUS/Tricare Standard does not require premiums. If care at a

military facility cannot be provided (due to space limitations, limitations on the types of services that a facility is capable of providing, or due to the fact that a beneficiary may not live close enough to a military facility to make such travel reasonable), CHAMPUS/Tricare Standard will share responsibility with the beneficiary for the payment of care received from non-military health care providers, subject to regulations. If beneficiaries need inpatient care or certain types of outpatient care and live within a catchment area, i.e., a geographical area surrounding a military hospital, they must seek care first at that military medical facility and receive a document (known as a non-availability statement (NAS)) stating that the needed care was not available at that military facility, before CHAMPUS/Tricare Standard will pay a share of their care at a non-military facility. Certain types of care, such as most dentistry and chiropractic services, are excluded.

In addition to CHAMPUS/Tricare Standard and Tricare Prime there is a preferred-provider option, Tricare Extra. In Tricare Extra beneficiaries do not enroll or pay annual premiums but use physicians and specialists in the Tricare network and are charged 5% less for medical services.

Many of the changes made in the past decade have been intended to improve medical care available to the active duty population, but they have also resulted in less medical care available in military facilities for retired personnel and their dependents. The introduction of Tricare for Life in FY2002 provided coverage for retired beneficiaries, but most of their care will undoubtedly be obtained from civilian providers reimbursed by Medicare and Tricare.

5. Who Is Eligible to Receive This Care?

Current law provides that active duty personnel are entitled to receive health care at military medical facilities. In addition, active duty dependents, military retirees and their dependents, and survivors of deceased members are eligible to receive health care at military medical facilities when space and professional services are available. Also eligible to receive care for a fixed fee in these facilities are certain government officials (including the President and Members of Congress) and certain foreign military personnel on active duty in the U.S. Reserve Component personnel and their dependents are also entitled to care in military medical facilities and participation in Tricare under certain conditions that were extended in March 2003 to accommodate reservists called up for more than 30 days. Provisions of the Iraq Supplemental (P.L. 108-106) and FY2004 defense authorization legislation (P.L. 108-136) permit non-activated Reservists and National Guardsmen who are eligible for unemployment or who have no access to an employer-sponsored health benefits plan to enroll in Tricare at fees somewhat higher than those prevailing for active duty personnel (although necessary regulations have not yet been published by the Defense Department).

Since 1967 DOD has funded, under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), care by civilian providers to dependents, retirees, and dependents of retirees who are under age 65 and unable to obtain access in a military health facility. After 1991 DOD began, with congressional support, moving towards managed care arrangements under the Tricare program that include greater use of civilian health care providers even for active duty personnel. CHAMPUS will continue but will be known as the Tricare Standard option.

6. How Are Priorities for Care in Military Medical Facilities Assigned?

Active duty personnel, military retirees, and their respective dependents are not afforded equal access to care in military medical facilities. Active duty personnel are entitled to health care in a military medical facility (10 USC 1074).

According to 10 U.S.C. 1076, dependents of active duty personnel are "entitled, upon request, to medical and dental care" on a space-available basis at a military medical facility. Title 10 U.S.C. 1074 states that "a member or former member of the uniformed services who is entitled to retired or retainer pay ... may, upon request, be given medical and dental care in any facility of the uniformed service" on a space-available basis.

This language entitles active duty dependents to medical and dental care subject to space-available limitations. No such entitlement or "right" is provided to retirees or their dependents. Instead, retirees and their dependents may be given medical and dental care, subject to the same space-available limitations. This language gives active duty personnel and their dependents priority in receiving medical and dental care at any facility of the uniformed services over military members entitled to receive retired pay and their dependents. The policy of providing active duty dependents priority over retirees in the receipt of medical and dental care in any facility of the uniformed services has existed in law since at least September 2, 1958 (P.L. 85-861).

Since the establishment of Tricare and pursuant to the Defense Authorization Act of FY1996 (P.L. 104-106), DOD has established the following basic priorities (with certain special provisions):

Priority 1: Active-duty service members;
Priority 2: Active-duty family members who are enrolled in Tricare Prime;
Priority 3: Retirees, their family members and survivors who are enrolled in Tricare Prime;
Priority 4: Active-duty family members who are not enrolled in Tricare Prime;
Priority 5: All other eligible persons.

The priority is given to active duty dependents to help them obtain care easily, and thus make it possible for active duty members to perform their military service without worrying about health care for their dependents. This is particularly important for active duty personnel who may be assigned overseas or aboard ship and separated from their dependents. As retirees are not subject to such imposed separations, they are considered to be in a better position to see that their dependents receive care, if care cannot be provided in a military facility. Thus, the role of health care delivery recognizes the unique needs of the military mission. The role of health care in the military is qualitatively different, and, therefore, not necessarily comparable to the civilian sector.

The benefits (including Tricare/CHAMPUS) available to service members or retirees, which require comparatively little or no contributions from the beneficiaries themselves, are considered by some to be a more generous benefit package than is available to civil servants or to most people in the private sector. Retirees may also be eligible to receive medical care at Department of Veterans' Affairs (VA) medical facilities (see CRS Report RL30099, *Veterans Issues in the 106th Congress*, by Dennis W. Snook).

7. What Is the Relationship of DOD Health Care to Medicare?

Active duty military personnel have been fully covered by Social Security and have paid Social Security taxes since January 1, 1957. Social Security coverage includes eligibility for health care coverage under Medicare at age 65. It was the legislative intent of the Congress that retired members of the uniformed services and their eligible dependents be provided with medical care after they retire from the military, usually between their late-30s and mid-40s. CHAMPUS was intended to supplement — not to replace — military health care. Likewise, Congress did not intend that CHAMPUS should replace Medicare as a supplemental benefit to military health care. For this reason, retirees become ineligible to receive CHAMPUS benefits when at age 65 they become eligible for Medicare. Many argue that the structure is inherently unfair because retirees lose Tricare/CHAMPUS benefits at the stage in life when they are increasingly likely to need them. Military retirees continue to be eligible for health care in military medical care facilities irrespective of age if space is available. The FY2001 Defense Authorization Act (P.L. 106-259) provided that, beginning October 1, 2001, Tricare will pay out-of-pocket costs for services provided under Medicare for beneficiaries over age 64 if they are enrolled in Medicare Part B. Disabled persons under 65 who are entitled to Medicare may continue to receive CHAMPUS benefits as a second payer to Medicare Parts A and B (with some restrictions). This benefit is known as Tricare for Life (TFL). For additional information regarding eligibility of Medicare eligible persons *under* age 65, see above, Question 4.

8. Have Military Personnel Been Promised Free Medical Care for Life?

Some military personnel and former military personnel maintain that they and their dependents were promised "free medical care for life" at the time of their enlistment. Such promises may have been made by military recruiters and in recruiting brochures; however, if they were made, they were not based upon laws or official regulations which provide only for access to military medical facilities for non-active duty personnel if space is available as described above. Space was not always available and Tricare options could involve significant costs to beneficiaries. Rear Admiral Harold M. Koenig, the Deputy Assistant Secretary of Defense for Health Affairs, testified in May 1993: "We have a medical care program for life for our beneficiaries, and it is pretty well defined in the law. That easily gets interpreted to, or reinterpreted into, free medical care for the rest of your life. That is a pretty easy transition for people to make in their thinking, and it is pervasive. We [DOD] spend an incredible amount of effort trying to re-educate people [that] that is not their benefit." (U.S. Congress, House of Representatives, Committee on Armed Services, Military Forces and Personnel Subcommittee, 103rd Congress, 1st session, National Defense Authorization Act for Fiscal Year 1994 — H.R. 2401 and Oversight of Previously Authorized Programs, Hearings, H.A.S.C. No. 103-13, April 27, 28, May 10, 11, and 13, 1993, p. 505.)

Dr. Stephen C. Joseph, Assistant Secretary of Defense for Health Affairs until April 1998, however, argued that because retirees believe they have had a promise of free care, the government did have an obligation. Joseph did not specify the precise extent of the obligation. The FY1998 Defense Authorization Act (P.L. 105-85) included (in Section 752) a finding that "many retired military personnel believe that they were promised lifetime health care in exchange for 20 or more years of service," and expressed the sense of Congress that "the United States has incurred a moral obligation to provide health care to members and [retired] members of the Armed Services." Further, it is necessary "to provide quality,

affordable care to such retirees." For additional background, see David F. Burrelli, *Military Health Care: the Issue of "Promised" Benefits*, CRS Report 98-1006, updated November 21, 2002.

9. What Actions Are Being Taken to Improve Military Medical Care for Retirees Aged 65 and Over? What is Tricare for Life?

As noted above, military medical care is theoretically available to all retirees on a space-available basis. As a practical matter, however, the amount of space available to retirees over age 65 who are eligible for Medicare has become increasingly limited. This results from base closures, changing approaches to military medicine, and growth in the number of retirees. Retirees and retiree organizations have complained of being frozen out of military facilities, of being responsible for higher costs at a stage of life when more health care is required, and, especially, of the burden of having to pay for expensive pharmaceuticals that are taken on a regular basis.

As a result of legislation in the 105th and 106th Congresses, several demonstration projects were established in specific localities to assess beneficiary acceptance and the fiscal viability of different approaches. These included:

- **Medicare subvention** by which care would be provided by DOD to retirees age 65 and over essentially on the same basis as is provided to retirees under 65 in Tricare Prime [enrollment fees of $230/460 (self/self+dependent) are required annually]; the legislation provides that DOD would be reimbursed for a portion of the costs of this care by Medicare. (The Medicare subvention demonstration project was established by Section 4015 of the Budget Reconciliation Act of 1998 (P.L. 105-33); it was a three-year project (termed **Tricare Senior Prime**) at six sites that was phased in beginning in July 1998 and concluding in December 2001.) For background on the Medicare subvention issue, see David Burrelli and Tina Nunno, *Military Medical Care and Medicare Subvention Funding*, CRS Report 96-207, March 17, 1997. The project ended on December 31, 2001.

- **Access to the FEHBP** plans used by civil service retirees with DOD paying the same share of premiums that is paid by the government for civilian enrollees (approximately 72%). (An FEHBP demonstration was established by Section 721 of the FY1999 Defense Authorization Act (P.L. 105-261); it was conducted at eight sites for three years, ending December 31, 2002.)

- **Tricare as a supplement to Medicare**. Established by Section 722 of the FY1999 Defense Authorization Act (P.L. 105-261), this program was scheduled to begin in 2000 and end in December 2002 but was overtaken by the establishment of Tricare for Life.

- **A DOD-sponsored pharmaceutical benefit**. The FY2001 Defense Authorization Act (P.L. 106-398) extended pharmacy benefits to all retirees beginning in April 2001. Beneficiaries who became 65 before April 1, 2001, do not have to enroll in Medicare Part B to receive the DOD

pharmacy benefit; those who turned 65 on or after April 1, 2001, have to be enrolled in Medicare Part B to use the pharmacy benefit.

On February 12, 1998, the Administration announced that the Medicare subvention demonstration, to be known as **Tricare Senior Prime**, would be conducted at Keesler Air Force Base, Biloxi, Mississippi; Brooke Army Medical Center and Wilford Hall Medical Center, San Antonio, Texas, Fort Sill, Lawton, Oklahoma, Sheppard Air Force Base, Wichita Falls, Texas; Fort Carson and the Air Force Academy, Colorado Springs, Colorado; Madigan Army Medical Center, Fort Lewis, Washington; Naval Medical Center, San Diego, California.; and Dover Air Force Base, Dover, Delaware. Enrollments for the Madigan demonstration began in July 1998. The demonstration project ended on December 31, 2001.

On January 14, 1999, the Defense Department announced **sites for the FEHBP demonstrations**. They were Dover Air Force Base, Delaware; Commonwealth of Puerto Rico; Fort Knox, Kentucky; Greensboro/Winston-Salem/High Point, North Carolina; Dallas, Texas; Humboldt County, California area; Naval Hospital, Camp Pendleton, California; and New Orleans, Louisiana. Coverage started in January 2000 and ended in December 2002. Beneficiaries had to enroll in an FEHBP plan and pay applicable premiums; the government's contribution was computed the same as it has been for other FEHBP enrollees. Those who were eligible included over-65 retirees who are eligible for Medicare and their dependents, unremarried former spouses of military members, and dependents of deceased members or former members.

The FY1999 Defense Authorization Act (P.L. 105-261) also directed a demonstration project that would have Tricare serve as a supplement to Medicare. It was scheduled to begin in 2000 and last through the end of 2002, the **Tricare Senior Supplement Demonstration Program** is conducted in Cherokee, Texas, and Santa Clara, California. Those living in those locations who chose to participate had to pay an enrollment fee (as well as join Medicare Part B), but Tricare covered some costs that are not covered by Medicare.

On August 16, 1999, DOD announced a **Tricare Pilot Pharmacy Benefit** projects that was established during 2000 in Okeechobee, Florida and Fleming, Kentucky.

In late 1999 and early 2000, a number of bills were introduced to provide more extensive medical care options to beneficiaries aged 65 and over. Some of the bills would extend the durations of the demonstration projects or expand them nationwide; others would have DOD pay 100% of FEHBP premiums for certain older retirees. All such proposals would entail significant expenditures.

During consideration of the FY2001 Defense Authorization Bill (H.R. 4205) on May 18, 2000, the House adopted an amendment that would extend Medicare subvention nationwide by 2006. During consideration of its version of the FY2001 Defense Authorization Bill (S. 2549), the Senate on June 7, 2000, adopted an amendment that extended eligibility for participation in Tricare to beneficiaries over age 64, effective October 2001. Medicare would serve as a first payer for services provided, with Tricare providing reimbursement for some types of care that Medicare does not cover. Beneficiaries would be required to participate in Medicare Part B. Another floor amendment that would have included retiree access not only to Tricare but also to FEHBP (with the government paying all premiums for those whose service began before June 1956) failed on a procedural vote

that required support by three-fifths of the senators. In late August 2000, the Clinton Administration indicated opposition to these initiatives to extend Tricare to beneficiaries over age 64 because of concerns with potential costs.

The Senate amendment was essentially adopted by the conference committee along with provisions establishing a Medicare-eligible retiree health care fund that would accumulate regular transfers of funds from DOD to pay for Tricare benefits to Medicare-eligible beneficiaries. The conference version was adopted by large majorities in the House on October 11 and in the Senate on October 12 and was signed into law on October 30, 2000, becoming P.L. 106-398.

Beginning October 1, 2001, for beneficiaries over age 64 who are enrolled in Medicare Part B, the Defense Department, through a program known as **Tricare for Life (TFL)** is serving as a second payer to Medicare, paying out-of-pocket costs for medical services covered under Medicare. The beneficiaries are also eligible for medical benefits covered by Tricare but not by Medicare.

The requirement for enrollment in Medicare Part B, which currently costs $66.60 per month, is a source of concern to some beneficiaries, especially those who did not enroll in Part B when they became 65 and thus must pay significant penalties. Some argue that this requirement is unfair since Part B enrollment was not until this year a prerequisite for access to any DOD medical care. On the other hand, waiving the penalty for military retirees could be considered unfair to other Medicare-users who did not enroll in Part B upon turning 65. The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173), enacted in December 2003, waives penalties for military retirees in certain circumstances. (See CRS Report RS21731, *Medicare: Part B Premium Penalty*, by Jennifer O'Sullivan.)

10. What Is Medicare Subvention? Should Medicare Reimburse DOD for Care Provided to Medicare-eligible Beneficiaries?

Current law generally prohibits Medicare from paying for services provided or paid for by another governmental entity (Section 1862(a)(3) of the Social Security Act (42 USC 1395y)). Medicare subvention is the term given to proposals that Medicare (the Centers for Medicare and Medicaid Services (CMS)) of the Department of Health and Human Services) reimburse DOD for care provided to Medicare-eligible beneficiaries at DOD facilities or through Tricare. (It is estimated that currently some $1.2 billion annually is spent by DOD to provide care for Medicare-eligible beneficiaries.) In other words, when care is given by DOD to a retiree or dependent who is over age 65, Medicare would be asked to reimburse DOD according to an agreed-upon rate, much as Medicare would reimburse a civilian physician who provides care to an eligible person. (For additional information, see CRS Report 96-207, *Military Medical Care and Medicare Subvention Funding*, by David F. Burrelli and Tina Nunno.)

Advocates of Medicare subvention claimed that military retirees, even those over age 65, were promised "free health care for the rest of their lives" by military recruiters and have come to expect it, regardless of "legal technicalities." They argued that ending access to military medical facilities when beneficiaries reach an age when they will have greater need for it is fundamentally unfair. Reimbursement from Medicare would provide an important revenue source that, advocates say, will enable and encourage DOD to provide care to

over-65 retirees. Further, it was argued that Medicare will save money because DOD can provide care less expensively than civilian providers (largely because of more austere facilities).

Opponents of Medicare subvention pointed out that there has never been a statutory guarantee that retirees and their dependents would have "free health care to the rest of their lives." In accordance with congressional intent, CHAMPUS has served as a health insurance system to cover military personnel until they became eligible for Medicare at age 65. Retirees over age 65, they note, continue to have access to military medical facilities on a space-available basis. A major concern was the widely perceived need to curtail rather than expand Medicare spending. Additional spending under a subvention proposal, if it was to be required, would necessitate further Medicare spending reductions. Some observers expressed concern that subvention could, in particular, lead to greater costs to Medicare if DOD care attracts beneficiaries who are currently using non-government health care plans. The transfer of funds from Medicare, an entitlement program, to the discretionary accounts of DOD, and thus subject to the annual authorization/appropriation process, would be complicated, given the provisions for budget enforcement. Further, some observers believe that giving DOD greater responsibilities for geriatric medicine may compete with its combat readiness mission.

In the 104th Congress, several Medicare subvention bills were introduced. Language in the FY1996 Defense Authorization Act expressed the sense of Congress that DOD should be reimbursed by Medicare for care given by DOD to Medicare-eligible beneficiaries in areas where Tricare is implemented. On June 20, 1996 the Senate approved an amendment to the FY1997 Defense Authorization Bill (S. 1745) that required the Administration to submit by September 6, 1996 "a specific plan" for a demonstration project that would permit Medicare-eligible beneficiaries to enroll in the managed care Tricare option. Medicare would reimburse DOD on a capitated basis for beneficiaries who choose to enroll. The requirement for a plan for a demonstration project was included in the subsequent conference version (H.R. 3230), and a draft plan was circulated by the Administration, but no mandate for implementing a plan was enacted in the 104th Congress, and the legislation as signed (P.L. 104-201) did not authorize spending for a Medicare subvention demonstration project nor were funds appropriated for this purpose.

In the 105th Congress, Section 4015 of the Budget Reconciliation Act (P.L. 105-33), signed into law on August 5, 1997, included complex provisions authorizing the establishment of a **three-year Medicare subvention demonstration project** at six sites. DOD would be reimbursed by Medicare at a rate equal to 95% of that paid to Medicare+Choice HMOs. The aggregate amounts to be reimbursed under this section will not exceed $50 million for FY1998, $60 million for FY1999, and $65 million for FY2000. The act stipulates that "no new military treatment facilities will be built or expanded with funds from the demonstration project." Medicare HMOs are authorized to enter into contracts in which DOD will provide care to Medicare-eligible military retirees and their dependents and receive reimbursement from the HMOs. A separate component of the effort will allow retirees enrolled in a limited number of Medicare+Choice plans to contract with DOD military facilities to provide specialty and inpatient care to military retirees in those plans. The FY2001 Defense Authorization Act (P.L. 106-398) extended the Medicare subvention demonstration to the end of 2001.

Some observers expressed concern that the formula used to reimburse DOD for care provided to Medicare-eligible beneficiaries might not result in transfers of significant funds from Medicare to DOD. Tricare for Life as initiated in 2001 incorporates some aspects of Medicare subvention, but it does involve transfers of funds from Medicare to DOD.

11. Should the Federal Employees Health Benefits Program (FEHBP) Be Open to Military Retirees?

Some have advocated making the health care plans for Federal civil servants and civil service retirees also available to Medicare-eligible military retirees instead of or in addition to Medicare subvention plans. The civil service system, known as the Federal Employees Health Benefits Program (FEHBP), is widely considered to be successful. It allows beneficiaries to choose among a number of health care plans. The government pays some 72% of the premiums and beneficiaries are responsible for the rest. (See CRS Report RL31231, *Health Insurance for Federal Employees and Retirees,* by Carolyn L. Merck.) Opening FEHBP to Medicare-eligible military retirees would cause minor administrative expenses, but subsidizing annual enrollment fees for retirees and their dependents over 65 could involve around $2 billion annually (if the government paid 72% of average premiums), according to a Congressional Budget Office estimate. On the other hand, an FEHBP option would allow retirees to choose the type of health care plan they prefer and it would not affect the delivery of military medical care to the active duty population. In addition, FEHBP plans would also ensure the availability of care in geographic areas that might not be reached by Tricare options. Some potential beneficiaries, however, would not be willing to make the substantial premiums that are required for participation in FEHBP.

Despite objections from the Defense Department, the FY1999 Defense Authorization Act (P.L. 105-261) included a FEHBP demonstration project limited to 66,000 participants in 6-10 geographic areas. (Beneficiaries would not be required to participate in Medicare Part B (which requires a monthly premium) but will be urged to do so.) At least one area will be near a Military Treatment Facility (MTF); one will not. One area will be an area in which a Medicare Subvention demonstration has been underway. There will be no more than one area for each Tricare region. Enrollees will have to pay the same level of premiums as paid by civil servants and agree not to seek care in MTFs during the length of the demonstration. The Defense Department will contribute the rest of the premiums. The demonstration project began in January 2000 and ran for three years ending on December 31, 2002. It was evaluated by the Defense Department and the GAO, and it was it was evident that relatively few retirees opted for FEHBP coverage even after the initial open season was extended and additional brochures mailed out. (See GAO Report GAO-03-547, *Military Retiree Health Benefits: Enrollment Low in Federal Employee Health Plans under DOD Demonstration*, June 2003.)

Legislation introduced in the 106th, 107th, and 108th Congresses would have extended FEHBP eligibility to military retirees. Some bills included provisions by which DOD would pay the entire costs of FEHBP for those retirees (and their families) who served prior to June 7, 1956 (since statutory medical benefits for retiree medical care came into force on that date). Such a proposal has been estimated to cost over $4 billion annually.

The FEHBP demonstration was completed at the end of 2002, but enrollees are eligible for other Tricare options.

12. How Are User's Fees and Fee Schedules for Medical Services Assessed?

User's fees for medical services represent a means of generating revenues from those who use the services. In recent years user's fees, also known as co-payments, have been considered as a means of generating revenues in the military medical care system. Some observers see increased users' fees as a primary way to increase beneficiaries' cost-consciousness, arguing that far more than premiums and deductibles, cost-sharing discourages unnecessary medical services. The consideration of these fees has been subject to strong opposition from military personnel, retirees, and others who have viewed free or inexpensive health care as an important benefit of military service. To these individuals, user's fees represent an "erosion of earned benefits." Specifically, these benefits are not viewed by some beneficiaries as an insurance program paid for in a market context, but rather as a benefit that is earned by the unique nature of demands inherent in performing military service.

By law (P.L. 102-396), health care providers treating Tricare/CHAMPUS patients cannot bill for more than 115% of charges authorized by a DOD fee schedule. In some geographic areas, providers have been unwilling to accept Tricare/CHAMPUS patients because of the limits on fees that can be charged. DOD has authority to grant exceptions. Efforts have been made to bring payment levels for health care services provided by the MHSS into alignment with the Medicare's fee schedule. Over 90% of Tricare payment levels are now equivalent to those authorized by Medicare, about 10% are higher, and steps are being taken to raise some to Medicare levels.

13. What Will Be the Effect of Base Realignment and Closure (BRAC) on Military Medical Care?

Base realignment and closures undertaken as part of the restructuring of the Defense Department in the post-Cold War period have prompted changes in the military health services system. As a result of base realignment and closure (BRAC) actions, 35% of the DOD medical treatment facilities providing services in 1987 were closed by the end of 1997 (although the number of eligible beneficiaries decreased by only 9%). Another BRAC round is scheduled for 2005; see CRS Report RL32216, *Military Base Closures: Implementing the 2005 Round*. Criteria for realignments and closures, established by DOD with congressional consent, include the need to deploy a force structure capable of protecting the national security, anticipated funding levels, and a number of military, fiscal, and environmental considerations that encompass community economic impact and community infrastructure.

Four base realignment and closure Commissions have specifically considered the effect of closing DOD hospitals and clinics on active duty military personnel as well as on other beneficiaries and potential beneficiaries of the MHSS. The first two BRAC Commissions recommended 18 military hospital closures; the third BRAC Commission recommended an additional 10. Facilities closed include hospitals in Philadelphia, PA; Oakland, CA; Orlando, FL; San Francisco, CA; Ft. Devens, MA; Ft. Ord, CA; and Long Beach, CA. In one case, the Commission overruled a DOD proposal to close the Naval Hospital in Charleston, SC. (See CRS Report 95-435, *Military Retiree Health Care: Base Closures and Realignments*, by David F. Burrelli and Elizabeth A. Dunstan.)

With congressional encouragement, DOD has developed transition medical plans for certain closure sites. Medicare-eligible users of closed military hospitals will be encouraged to avail themselves of HMO and pharmacy programs established by the Department of Health and Human Services or a mail-order pharmacy system being established by DOD. Nonetheless, the closure of military hospitals and clinics can be a source of anxiety, especially in communities that have attracted large numbers of residents seeking access to the MHSS.

14. What Is the DOD Pharmacy Benefit?

According to DOD officials, the pharmacy benefit is the one most in demand by beneficiaries. GAO has estimated that it costs some $1.3 billion annually. Those with access to military treatment facilities and those who are enrolled in Tricare Prime receive prescribed pharmaceuticals free of charge. Users of Tricare Extra and Tricare Standard are reimbursed for pharmaceuticals in accordance with the same schedule of deductibles and co-payments required for other medical services. In accordance with the provisions of the FY2001 Defense Authorization Act (P.L. 106-398), effective April 1, 2001, retirees have access to DOD's National Mail Order Pharmacy and retail pharmacies in addition to pharmacies in military treatment facilities. Beneficiaries who turned 65 prior to April 1, 2001 qualify for the benefit whether or not they purchased Medicare Part B; beneficiaries who attain the age of 65 on or after April 1, 2001 must be enrolled in Medicare Part B to receive the pharmacy benefit. (There will be deductibles for use of non-network pharmacies and co-payments for pharmaceuticals received from the National Mail Order Pharmacy and from retail pharmacies.)

Military pharmacies do not necessarily carry every pharmaceutical available; thus, even some with access to military facilities must have certain prescriptions filled in civilian pharmacies; for these prescriptions beneficiaries can be reimbursed through Tricare/CHAMPUS. In October 1997, DOD implemented the National Mail Order Pharmacy (subsequently known as the Tricare Mail Order Pharmacy) that allows beneficiaries to obtain some pharmaceuticals by mail with small handling charges. The mail order program is designed to fill long-term prescriptions to treat conditions such as high blood pressure, asthma, or diabetes; it does not include medications that require immediate attention such as some antibiotics.

Media accounts in late 2003 described proposals that were not supported by DOD to raise co-pays for pharmaceuticals for retired beneficiaries. There are also media accounts of proposals to establish a uniform formulary for all DOD beneficiaries to discourage use of expensive pharmaceuticals when others are medically appropriate. Regulations to this effect were published in the Federal Register on April 1, 2004 (vol. 69, pp. 17035-17052).