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HOW THE MILITARY HEALTH SYSTEM CAN "FULFILL THE PROMISE"

AN ANALYSIS OF THE FEDERAL EMPLOYEES HEALTH BENEFIT PROGRAM FOR THE DOD

by

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Abstract

Rising health care costs consume an increasing portion of the United States economy. These cost increases exist in the Department of Defense, and based on recent requests to increase TRICARE enrollment fees, an inevitable cost increase to the DoD beneficiary will occur within the next few years. Instead of increasing beneficiary costs, DoD could control health care costs by looking at other health care delivery models. An option available to DoD is utilizing the Federal Employee's Health Benefit Program (FEHBP) – "the nations largest voluntary employer-sponsored health insurance program." This study looked at the structure of TRICARE and FEHBP, then looked at advantages and disadvantages to converting DoD beneficiaries to the federal civilian's program, and finally presented recommendations for the future.

This paper determined each health plan offers similar coverage options and distinct advantages over the other. If DoD utilized FEHBP, advantages of size, shifting financial risk to insurers, keeping the health benefit up to date, and improved provider reimbursement could be realized. On the other side, DoD could risk benefit confusion, unprecedented premiums for members, beginning an outsourcing process for DoD health care, and diminished readiness skills by moving patients to the FEHBP system.

After weighing all of the advantages and disadvantages, this study recommended non-AD beneficiaries utilize FEHBP and DoD divest from administering a civilian health plan (TRICARE) to focus on AD care. The movement toward a premium based commercial health plan is possible with low FEHBP rates and the establishment of an allowance for health care. DoD health costs could be controlled with member fiscal involvement and true insurer coverage. Without a change to the present DoD health care system, the percentage of the personnel costs consumed by health care promises to grow in the future.

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Introduction

> Military health benefit has gained critical attention this year due to the Department's proposal to initiate control over the long-term costs and sustain this important benefit for our current and future retirees. This truly outstanding health benefit is important for accessions, retentions, and military readiness. Each service has taken action over the past few years to improve efficiencies and control healthcare costs. However, these actions alone will not stem the rising costs in the military health benefit.
>
> Lt Gen Kevin Kiley, U.S. Army Surgeon General, 3 May 2006[1]

The cost of health care across the United States rose dramatically over the past fifteen years.[2] A debate currently rages on in the public policy arena regarding the factors contributing to this increase, but large health care costs are a reality of the future. This rise in cost has not escaped military members as the Department of Defense (DoD) must address similar cost increases in the health care cost projections for its beneficiaries. In fiscal year (FY) 2000 DoD spent $17.5 billion for health care, by FY2006 this number grew to $37 billion, and by FY2015 DoD health care costs are projected to exceed $64 billion.[3] From 1988 to 2003, annual medical spending per active duty (AD) member tripled from $6,600 to $19,600.[4] These dramatic cost increases created a situation where the Department of Defense must choose between, "health versus weapons."[5]

To address this growing portion of the budget (assuming the DoD budget as a whole remains static) the Department of Defense can look for internal savings, eliminate benefits, increase member cost sharing, or try to significantly alter the delivery of the current health benefits. Recently DoD attempted to pursue the cost sharing alternative by requesting an increase to TRICARE enrollment fees.[6] While the U.S. Congress and DoD disagree regarding the appropriate level of fee increase to match the rising costs, most agree some cost saving measures must be implemented within the next few years. The main sticking point on increasing TRICARE fees is ensuring implementation of all internal cost containment measures prior to

asking the beneficiary to increase their portion. At the same time, elimination of benefits for military, family members, and retirees is not politically feasible when the U.S.'s participation in wars in Iraq and Afghanistan dominate the news. With a long war on the horizon, recruitment and retention are extremely important and health care benefits are a key component of the compensation packages the U.S. military offers.

With the elimination of benefits unreasonable and increasing cost sharing meeting resistance, the DoD must look at ways to alter the delivery of current health care benefits. One of the obvious alternative health care models is the health plan utilized by non-military federal employees—the Federal Employees Health Benefit Program (FEHBP). This health program currently serves over 9 million federal employees, retirees and family members,[7] and has been called the, "the nations largest voluntary employer-sponsored health insurance program."[8]

Through an analysis of the current DoD health care benefit, and then FEHBP, one can see FEHBP could answer several problems facing the department. By utilizing FEHBP, DoD could focus on AD care and divest from administering a civilian health plan and reimbursement system (TRICARE). Without a change to the present DoD health care system, the percentage of personnel costs consumed by health care promises to grow in the future. This paper looks at the current DoD health care system, the current health care program available to federal civilians (FEHBP), advantages of utilizing FEHBP for DoD beneficiaries, disadvantages of utilizing FEHBP, and finally recommends a possible way ahead.

Description of current TRICARE benefit

Before presentation of any analysis of options to fix the current military health care system (MHS), a brief discussion should occur to summarize the current benefit. This paper will not try to encapsulate the history of military health care[9], rather briefly describe the current benefit responsible for 9.1 million DoD beneficiaries.[10]

The mission of the military health system is two-fold—to provide care for military members when deployed and to provide in-garrison care for military members, retirees, and families.[11] To accomplish this mission DoD is responsible for a beneficiary population, or "eligibles", comprised of uniformed active duty (AD) members, AD family members (ADFMs), military retirees, and their family members. The nature of fighting wars requires a large number of healthy, young people and thus militaries find they have a large young population. Because a large percentage of the military begins service before 20 years of age, a distinct feature of the military population is the relative young age of retirees and their family members—often in their early forties who qualify for lifetime eligibility for care. Most in the civilian sector do not retire until age 55 to 65, so DoD carries a larger number of retirees and their family members for a lengthy period of time.[12] Since DoD must carry this large population for possibly fifty years or more, the majority of the costs for health care are not for current military members, rather for care of families, previous military members, and their families. Recently Dr. David Chu, Under Secretary of Defense for Personnel and Readiness, testified to Congress that if current trends continue, 75 to 80 percent of military health care spending would be for non-AD members.[13]

To care for this diverse population, DoD devised a system that has been classified as a hybrid of a direct care system and an insurance purchaser.[14] This definition means the Department of Defense is both producing health care with professionals that work directly for DoD (including uniformed service members) and purchasing care through an insurance-like

program. This hybrid system delivers, "a comprehensive coverage, including inpatient and outpatient care, mental health, and prescription drugs but not dental care."[15] Dental coverage is available to all non-AD beneficiaries via a purely commercial insurance product currently called the TRICARE Dental Program. By offering both generated health care and purchased health care, DoD attempts to provide care to all of its beneficiaries.

Perhaps the biggest difference between the MHS and any private sector health plan is the in-house production of inpatient and outpatient health care,[16] called the direct care system in DoD. The direct care benefit is that which most people associate with military medical care – care delivered at the military treatment facility, normally on a military installation. This care traditionally was the only care available prior to development of the TRICARE civilian networks,[17] and was designed and sized to provide care for wartime casualties.[18] The current number of military providers is not only comprised of the number needed to deploy, but also those required to care for military causalities that return from war, those needed to prepare members to deploy, and those needed to train medical members to develop deployment skills.[19]

DoD designed the military health system to provide care with purchased health care only when the military providers were unavailable.[20] The primary purpose of the MHS is to, "maintain the individual and group health needed to accomplish a military mission."[21] In order to ensure military operations continue despite casualties, uniformed military medics must be prepared to deploy with units and provide care on the battlefield. These military medics must maintain medical readiness skills during non-deployed times so they are prepared for the wartime mission. To maintain these skills, DoD wanted a diverse patient population and allowed ADFMs, retirees, and their FMs to be seen by MHS providers in-garrison. Military providers see non-AD members primarily to maintain the readiness skills needed for contingencies.

Prior to military draw downs in the 1980s and 1990s, the military medical systems were structured to care for large scale conventional wartime threats.[22] These large, conventional threats drove a requirement for a large wartime military medical system that provided peacetime health care in excess of that required for AD members.[23] As the Cold War ended and the military end strengths waned, the medical force contracted to match this new force size and threat. The reduction in medical forces created a situation characterized by some as, "space available care has dried up."[24] To add to this reduction in end-strength, the Base Realignment and Closure (BRAC) commissions reduced the number of bases where medical treatment facilities exist.[25] For example from 1990 to 2001, 74 percent of the inpatient bed capacity at DoD MTFs were eliminated or reduced.[26] When the medical force began to reduce in size the development of civilian networks (TRICARE) became necessary.

Once DoD could no longer handle providing care for all of the eligible beneficiaries, they had to develop ways to utilize civilian providers from the private sector. This civilian health network utilizes pre-negotiated TRICARE contracts to offer DoD beneficiaries an option when MTF care is unavailable. The Department of Defense organized a CONUS civilian network in three regions: North, South, and West. Each of these regions has one contractor, sometimes called a managed care support contractor or TRICARE regional contractor (TRC), which is responsible for establishing local provider networks and administering the benefit outside of the MTF.[27] Through these contractors, all private sector care is delivered, arranged, and paid.

The current military system allows beneficiaries to enroll in either a fee-for-service (FFS) plan called TRICARE Standard, or a preferred-provider organization (PPO) called TRICARE Extra, or a health maintenance organization (HMO) called TRICARE Prime.[28] Currently TRICARE Extra and Standard do not have any enrollment fees, and have limited co-pays for beneficiaries who chose to utilize these options. TRICARE Prime has a enrollment fee, currently

$230 annually for retirees and $460 annually for retiree families, and no co-pays. AD members and families enroll in TRICARE Prime for no fee. This extremely limited fee structure is one key difference between TRICARE and civilian health insurance plans. In 2004, the average family premium contribution to health care in the private sector is $2,661 per year—which does not include co-pays and other non-premium individual costs.[29] Health economists estimate a military member saves approximately $1600-$2800 per family per year by not paying any enrollment or other co-payment fees in the "no cost" military health system.[30] Once enrolled in TRICARE, an individual or family must stay enrolled in their plan for one year.[31]

Beneficiaries may choose one of two options: either enroll to the MTF or enroll to a downtown civilian provider. If a beneficiary is in TRICARE Prime and the MTF does not have available space, they are allowed to enroll with a civilian provider. When enrolling to a downtown provider, military patients operate as if they are utilizing civilian health plans. In some instances, they are brought back into the MTF, but the majority of health care is delivered by civilian network providers. In most instances where non-AD beneficiaries enroll in with civilian providers, they basically use TRICARE as a commercial insurance product.

As stated above, the use of civilian providers has grown in the past 15 years. "Between fiscal years 2000 and 2005, the percent of inpatient care delivered to TRICARE beneficiaries by civilian providers increased from about 50 percent to an estimated 75 percent. During the same time frame, the percent of outpatient care delivered by civilian providers increased from 39 percent to an estimated 65 percent."[32] As more patients utilize TRICARE as a commercial insurance product, two particular problems are brought to light.

The first of these problems is that civilian providers are not required to participate in the military network, and some have purposely refused to accept TRICARE reimbursement. Those members who do accept TRICARE reimbursement must accept legislated reimbursement rates

that match MEDICARE rates. Unfortunately, these rates are often very low and do not cover some providers costs. This situation becomes particularly problematic in remote areas of the United States where the military locates for training reasons but where only few health care providers exist.[33] In these areas, if these providers refuse to accept TRICARE, members must travel long distances for care, or the TRICARE Regional Contractor must attempt to build a new provider network in this area. Provider reimbursement is a significant issue with the current TRICARE program.

Secondly, as civilian providers become necessary to care for the population, concern grows among beneficiaries that they are being forced out of the MTFs. Perhaps one of the more contentious issues is whether ADFMs and retirees are entitled to care in military treatment facilities. The way the current law reads (10 USC 1074, 1076), ADFMs, retirees, and their dependents are allowed to receive care in MTFs on a space available basis, but are not necessarily entitled to care at the MTF like the AD members.[34] Based on current law, DoD could legally reduce the medical force size to care for only AD members and require all other health care to be delivered in the local civilian health network.

An often overlooked component to the DoD health benefit is the low cost pharmacy coverage. Currently, any DoD beneficiary can go to a MTF and have their prescription filled—as long as the MTF carries that pharmaceutical. Additionally, DoD beneficiaries can utilize a mail order pharmacy or local retail pharmacies with small co-pays. The Department of Defense offers low cost pharmaceuticals because of Department of Veterans Affairs negotiated pharmaceutical contracts. These contracts offer many drugs at tremendously discounted prices. Pharmacy benefits are one of the key distinctions between private health insurance and the care offered by DoD.

The current MHS benefit is a robust product that combines produced and purchased health care. Over the past 25 years DoD increased reliance on purchased care, and developed a complex system to manage this process. With the conclusion of a description of the current military benefit, one should look at the benefit federal civilians receive.

Description of FEHBP

The current federal civilian health benefit, Federal Employees Health Benefit Program (FEHBP), began in July 1960 as a way to offer health care coverage to U.S. government employees.[35] Since this date, the U.S. Office of Personnel Management developed this program as the largest employer-sponsored health plan offered in the U.S.[36] Employer-sponsored health insurance is a way for employers to offer a health benefit as part of a compensation program and pool health cost risk of the employee, family members, and retirees.[37] In today's job market, health care coverage is a basic element of most compensation packages.

Unlike the current military health care system, FEHBP does not produce any health care. Instead of producing care, this plan is a collection of commercial health insurance products, competitively priced based on the large population served. The current FEHBP is structured similar to the TRICARE Dependent and Retiree Dental Programs where non-AD beneficiaries pay a monthly premium for commercial insurance. In FEHBP, beneficiaries choose their own providers based on those that accept payments from the insurer. The only differences between plans are the payment/reimbursement mechanisms, the amount of choice the beneficiary retains, and the co-pays/deductible for which the member is responsible. A unique feature offered by FEHBP is a variety of health plans with varying options. Based on an individual's situation, they can choose the option that best matches their needs. In addition, civilians can change type of enrollment and health plans in FEHBP during the open-enrollment period, held during a set time period once per year.[38]

Unlike TRICARE, FEHBP is a true insurance program where the companies that offer the health insurance plans bear the risk of heath care costs.[39] If the premiums do not cover the costs of health care, the insurance company assumes the financial loss—not the federal government. It is therefore essential for insurance plans that participate in FEHBP to set their premiums at a level they believe will cover their costs. The costs of these premiums are borne by two parties – the member and the federal government. The federal government pays an average of 72 percent of the premium cost of FEHBP for the members.[40] Under FEHBP, the member is responsible for the remainder of the health care premium, which is summarized in Table 1.

2007 FEHBP Premiums (Non-Postal)[41]		Total Premium		Govt. Portion		Member Portion	
		Annual	Monthly	Annual	Monthly	Annual	Monthly
FFS*	Self	$4,956	$413	$3,690	$308	$1,266	$105
	Family	$11,065	$922	$8,299	$692	$2,766	$231
HMO**	Self	$5,140	$428	$3,690	$307	$1,450	$121
	Family	$12,852	$1,071	$8,369	$697	$4,482	$374

* Nationwide Mail Handlers Benefit Plan Standard and Family Plans
** Human Health Plan of Texas, Standard Self and Family Plans

Table 1 – 2007 FEHBP Premiums, Non-Postal Rates

Premiums are set by geographical region and health plan type, but no age or pre-existing condition restrictions exist.[42] This is a very unusual feature for health care insurance since most plans charge those with higher risk factors higher premiums, since they consume more heath care on average. Placing risk with the commercial insurer and the absence of age and pre-existing condition limitations are key components to FEHBP.

FEHBP is a comprehensive plan that offers beneficiaries a choice of nationwide or locally provided plans. Nationwide, eight plans are currently offered, while over 350 plans are available depending on the local region.[43] These plans give the individual an option to match their health insurance to their particular situation and financial risk level. For example a single

young male could select a FFS plan with a high deductible and low monthly fee since he will tend to not visit the medical facility on a frequent basis. The low monthly premium allows him to use money elsewhere when he would tend to not use the medical system. On the other hand, an elderly retired couple could select a plan with a little higher monthly cost, but a lower deductible. This allows them to predict their spending and not assume a large amount of out of pocket costs when they tend to use the system more often. The amount of choice available to health consumers is a large benefit FEHBP offers.

From a beneficiary standpoint, FEHBP patients see a doctor in the private sector for most primary care needs. If this provider believes they need additional care, or if the member wishes to see a specialist, they normally will see someone in the local area to whom their primary care provider refers them. If a patient needs inpatient care or other hospitalization, the specialist has privileges at local facilities and arranges for the necessary inpatient care at one of these facilities. A beneficiary does not normally enroll in a health plan associated with a particular hospital; rather they enroll in a health plan that provides medical insurance from which most doctors, hospitals, pharmacies, ancillary services and other health care facilities accept payment. The health providers then negotiate with the health insurance company to establish a reimbursement rate they feel will adequately cover their costs. If all parties agree, the health provider "accepts" the insurance program. Insurance programs that have a large population can push for lower reimbursement rates since the insurer controls a large portion of a provider's population.

The typical pharmacy benefit in a FEHBP plan includes a small co-payment for drugs, but is similar to TRICARE with different fees for generic, local network pharmacies, and mail order pharmacy. The pharmacy benefits are summarized below in Table 2 below. This information is typical of most civilian health insurance plans which charge "twice what TRICARE does for prescription drugs."[44]

Pharmacy Co-Pay Comparison (network pharmacies)	TRICARE[45]	FEHBP[46] Mail Handler's Standard
Rx Deductible per person/family	None	None
Rx Generic, Local Pharmacy	$3	$10
Rx Generic, Mail Order Pharmacy	$3	$15
Rx Brand, Local Pharmacy	$9/$22*	$30/$50**
Rx Brand, Mail Order Pharmacy	$9/$22*	$45/$60**
Rx Size, Mail Order	90 days	90 days

* Non-formulary items must have a proven medical necessity
** Non-preferred brand name drug

Table 2 – Pharmacy Co-Pay Comparison

As evidenced by the data in Table 2, the pharmacy benefit is similar to the DoD benefit, just with higher costs.

When comparing the current TRICARE program to FEHBP, it is useful to look at benefits of outpatient care, inpatient care, and pharmacy. The outpatient and inpatient care are the same between the plans, with the caveat that FEHBP allows the member to choose their level of benefit. The TRICARE pharmacy benefit is significantly better than most commercial insurance options; so good that many retirees choose to not utilize their employer's health care insurance and use TRICARE instead. When retirees opt out of their civilian employer's health care insurance, the individual saves $2,000 per year and their employer saves an estimated $7,200 a year.[47] DoD does not realize any of these cost savings when retirees opt out of civilian health insurance.

The main differences between plans come down to the members cost share, provider reimbursement system, and the choice available to the member. Under TRICARE, members have a small cost share that occurs mainly once the member retires. Civilians that use FEHBP have monthly premiums that average approximately 25 percent of the total premium cost, and depending on the insurance plan, a small co-pay for each visit. In the TRICARE system, the

federal government dictates the provider reimbursement rates, while FEHBP sets provider rates through negotiation. Finally, TRICARE gives members the choice of three health plans: one fee for service plan, one preferred provider plan, and one HMO. FEHBP offers members a choice of eight nationwide plans and 350 local HMO options. With the completion of the descriptions of TRICARE and FEHBP, the analysis of reasons move non-AD DoD beneficiaries to FEHBP begins.

Reasons to change to FEHBP

Now that the basics of both the TRICARE and FEHBP program have been presented, an analysis can occur regarding feasibility of utilizing FEHBP for DoD. As stated earlier, since FEHBP is the health system used by all federal employees, it should be the first option investigated as an alternative to TRICARE. FEHBP offers advantages in size, reduction of administrative costs, unifying the benefit, shifting financial risk to insurers, keeping the benefit up to date, provider reimbursement, increasing health plan choice, and patient satisfaction. Each of these areas alone does not make a compelling argument, but combined present a strong case to convert non-AD members to FEHBP.

Perhaps the greatest benefit of utilizing FEHBP is the sheer size of the current program. All current and retired federal employees (9M) use FEHBP and this program has agreements at all CONUS DoD locations. In addition, any city that receives mail has some FEHBP coverage – in essence complete CONUS coverage is a reality. In total, FEHBP offers over 350 plans with many different health plan options.[48] Based on these facts, unlike many other programs, FEHBP is currently big enough to assume the large military population. Adding the 7 million ADFMs, retirees, and their family members will not overwhelm the federal system, and could provide some lower costs to current FEHBP members. Additionally because this program is so large, it offers options for all beneficiaries. No longer would three TRICARE regions be necessary—

instead the FEHBP program could manage all of the beneficiaries through the current plans offered.

Another benefit a large population offers is the creation of a larger benefit pool to reduce premium costs for everyone. Currently some providers are unwilling to accept TRICARE since the reimbursement rates are low and the population utilizing this insurance is, "small and transient."[49] If DoD utilized FEHBP, the large civilian based population mitigates the transient nature of the non-AD population and the population would be large enough to increase buying power to create lower priced health plans.[50] Finally, a unique premium feature of FEHBP is the fact that premiums for the health plans do not vary by age or risk factors. The premiums are pre-negotiated for an area based on the entire FEHBP risk pool or historical FEHBP "claims experience."[51] With the introduction of a large number of younger AD families, lower rates for the entire group could be a reality that benefits civilians as well as DoD beneficiaries. One of the benefits of a large population is lower cost premiums.

In addition to lowering premiums, DoD and OPM can combine their "purchasing clout" to design a health care reimbursement structure that better ties performance to reimbursement. The current system does not penalize providers for unnecessary care—everyone is paid the standard TRICARE reimbursement rate.[52] As mentioned earlier, health plans with a large population have the ability to better dictate terms to providers. If the provider refuses to accept the insurance company's demands, the large population will simply use a provider that will. In areas where a significant portion of the provider's beneficiaries utilize one of the insurer's plans, taking this business elsewhere can have a huge impact on the provider's business. Finally, FEHBP is unique in that they do not need to award contracts in accordance with federal minimum bid requirements.[53] This translates to not only a quicker, streamlined process to add health insurance plans, but also reduces the need for a large oversight organization. If a health

insurance company wants to join FEHBP, they can work with OPM to be included as long as they meet the minimum plan standards. A large population offers many benefits to include the ability to add new members instantly, lower premiums, and increased business "clout".

The second major benefit is the elimination of redundant infrastructure the TRICARE and FEHBP systems maintain. In order to offer health care to the entire DoD beneficiary population, DoD designed a system to monitor and manage a complex delivery network. Very little expertise existed in DoD early in the development of TRICARE, and the department continues to struggle to keep up with the latest trends in health care.[54] An entire TRICARE administrative organization exists which not only consists of a central oversight organization (TRICARE Management Activity) but also regional TRICARE offices that interact with their particular TRC. In addition, after ten years the TRICARE regional contracts must be renewed. This renewal process utilizes many additional military members for up to two years prior to structure and award of new contracts. On the FEHBP side, OPM maintains a number of personnel to oversee their health plans with a cost of managing the program estimated in FY2000 at $20 million annually.[55] This redundant structure spends duplicative money on personnel and administrative costs. Consolidation of TRICARE and FEHBP would allow for one organization to concentrate on managing health plans instead of requiring both to be experts.

A third reason to consolidate systems is to provide the same benefit for all federal employees. Many ask why members of the U.S. Congress should have a separate health care benefit than the one given to military family members.[56] FEHBP currently provides care for a population "ranging from Supreme Court justices and Presidents to Congressional staffers and Environmental Protection Agency clerks."[57] Providing a separate benefit for DoD families and retirees creates a potential dichotomy that could lead to misperceptions and inaccuracies between federal employees and DoD beneficiaries. Consolidation of non-AD care under FEHBP ensures

federal employees have a top tier health benefit—a benefit good enough for families of people risking their lives to defend the U.S.

A fourth reason to utilize FEHBP is to shift financial risk from the federal government to a commercial insurer. Under the current military FFS system called TRICARE Standard, the federal government contracted for a fiscal intermediary, not a commercial insurance plan. Only 4.7 million of the 9.1 million DoD eligible personnel are enrolled in TRICARE Prime, the HMO option.[58] This leaves DoD a population of 4.4 million eligible personnel for whom they must pay the allowable charge and assume all of the risk for the patient's health.[59] Under the current DoD system, usage increases, market driven cost increases, and inflationary increases all contribute to a growing cost of health care because DoD assumes all of the financial risk. In civilian FFS health insurance products, a health plan charges members a premium and if their costs are more than their collections, the insurer loses money.[60] By using the FEHBP model, the commercial health plan provider assumes all financial risk. Any cost increases are part of this risk and are only passed on to the member with new annual premiums rates. Shifting financial risk to an insurer is another reason to change non-AD personnel to FEHBP.

A fifth argument states DoD benefits are out of step with private sector.[61] While the private sector is trying to control health care costs, DoD has done little to increase the patients portion of cost sharing. Additionally, very few measures are in place to ensure patients receive necessary care versus higher reimbursement care. Several studies show health markets with little competition result in higher health care costs.[62] A system like TRICARE where one contractor is awarded the contract for a region severely limits competition for DoD patients. In these circumstances, health care costs are inevitably going to be higher than in a market where true competition exists. Converting non-AD patients to FEHBP allows new health care insurance products such as Consumer Directed Health Care, High Deductible Health Plans, and Health

Saving Accounts (HSAs) to be used to their maximum efficiency. In addition, using FEHBP increases the tools the government (as the employer) can use to curb health care costs. Today, DoD spends $0.55 of each $1 of cash compensation on health care, while, "In the private sector, employers have relied on changes in health care benefits and on premiums, deductibles, and co-payments to hold medical spending below nine cents per dollar of salaries and wages."[63] Shifting non-AD beneficiaries to FEHBP allows DoD to use modern health care cost management tools.

A sixth reason to use FEHBP is the improved provider reimbursement mechanisms. One of the main complaints of TRICARE is limited provider reimbursement.[64] In 2001 Congress mandated TRICARE match MEDICARE rates; however, lowering of rates has caused some providers to refuse TRICARE as an insurance payer.[65] Unfortunately MEDICARE rates are very low and many providers decided to not accept TRICARE instead of trying to provide care at a financial loss. By utilizing FEHBP, the commercial insurer and the providers negotiate reimbursement rates.[66] No minimum or maximum levels are set, and a true market economy operates. Negotiated reimbursement rates are another advantage of using the FEHBP.

A seventh reason for changing to FEHBP is creating more choice for DoD beneficiaries. Currently DoD offers one HMO plan, one PPO plan, and one FFS plan. Members of DoD cannot make choices within each plan—they only have one option. FEHBP offers individuals the choice of FFS (8 nationwide plans), PPO, Point of Service, HMO, HSA, and many others.[67] These different plans allow a beneficiary to match their health plan with their level of risk and health situation. One option available to FEHBP beneficiaries is a new health care insurance option called consumer-driven health care (CDHC). "Consumer-driven health care refers to a broad spectrum of approaches that give incentives to consumers to control their use of health services and/or ration their own health benefits."[68] To control rising health care costs, employers

have looked to shift some of the financial burden to the employees to try and limit the unnecessary usage of the health care system. One way to do this is to allow the employee to choose their type of health care coverage. If an employee chooses a robust plan with low deductibles and co-pays, the employee assumes a greater portion of the premium. A second CDHC option is to increase the employee's wages, not offer any health plan, and place the burden of procuring and managing health care costs on the consumer.[69] The main idea with all CDHC plans is to get the health care user to weigh the financial aspects when deciding what care they need. CDHC and other options could be available to DoD beneficiaries if FEHBP replaced TRICARE.

An eighth and final reason to utilize FEHBP is patient satisfaction. A Center for Naval Analyses (CNA) study demonstrated Prime patients enrolled downtown and civilian FEHBP enrollees had higher satisfaction rates than MTF beneficiaries.[70] This study shows there may be a myth some perpetuate that patients are more satisfied in the MTF. Many factors other than cost go into patient satisfaction and issues such as access to care and overall quality of care can impact overall satisfaction equally. Regardless of the reasoning, care received in the civilian economy is at least if not better than care delivered in medical facilities according to the CNA study. The potential to increase patient satisfaction is a final reason to convert non-AD beneficiaries to FEHBP.

Size, administrative costs, unifying the benefit, shifting financial risk to insurers, keeping the benefit up to date, provider reimbursement, increasing health plan choice, and patient satisfaction support a decision to convert all non-AD DoD beneficiaries to FEHBP. Before presentation of a recommendation, consideration should also be given to the reasons for not changing.

Reasons to not change to FEHBP

Opponents of changing the DoD health benefit cite concerns with benefit confusion, the appearance of a diminished retiree benefit, potential higher costs, beginning a process to outsource all DoD health care, the DoD-FEHBP demonstration project failure, and need to develop readiness skills. These concerns are all worthy of further investigation.

The first concern many have with converting non-AD beneficiaries to FEHBP is the possible confusion created between the AD health plan and the retiree/family member plan. This is particularly problematic when an AD member is physically separated from a ADFM and is trying to assist them with a health issue when deployed. The possibility exists for certain medical procedures to be available to AD members and not included in ADFM health plans. For example, chiropractic services are currently available to AD members, but are unavailable in most health plans.[71] If FEHBP were mandated to ADFMs, these occurrences could be common since there would be no link between the AD and non-AD health plans. In addition, differing administrative processes between plans can create confusion about appointing, referrals, follow-up procedures, and payments. Keeping one consistent benefit for the AD member and family members is important to streamlining a complex system for young families. The confusion created by differing health plans is one reason to not convert current DoD beneficiaries to FEHBP.

Another concern with utilizing FEHBP is the potential high premium costs. If the current health care benefit were continued under FEHBP, some method must be devised to pay for approximately 25 percent of the full premium that the government does not cover. In the current federal civilian system, the member is responsible for this portion. If DoD required all non-AD members to pay this portion, members would go from paying almost nothing to thousands of

dollars every year. Tables 3 and 4 below summarize the member's portions of enrollment fees for both our current health care system (TRICARE) and FEHBP.

2007 Member Premiums – Fee for Service	TRICARE Standard[72]	FEHBP FFS*[73]
Individual – AD Member	$0	$105/mo - $1,260/yr
Family – AD Member	$0	$230/mo - $2,760/yr
Individual – Retiree/FM <65 yrs	$0	$105/mo - $1,260/yr
Family – Retiree/FM <65 yrs	$0	$230/mo - $2,760/yr
* Nationwide Mail Handlers Benefit Plan Standard and Family Plans – Non-Postal Rates		

Table 3 – 2007 Member Premium Comparison, FFS Plans, Non-Postal Rates

2007 Premium Comparison – HMOs	TRICARE Prime[74]	FEHBP HMO*[75]
Individual – AD Member	$0	$98/mo - $1,176/yr
Family – AD Member	$0	$226/mo - $2,712/yr
Individual – Retiree/FM <65 yrs	$19/mo - $230/yr	$98/mo - $1,176/yr
Family – Retiree/FM <65 yrs	$38/mo - $460/yr	$226/mo - $2,712/yr
* Human Health Plan of Texas, Standard Self and Family Plans – Non-Postal Rates		

Table 4 – 2007 Member Premium Comparison, HMO Plans, Non-Postal Rates

If DoD utilized FEHBP, they would need to find a method to offset the members portion of the premium, or face a large political backlash. To fully fund the member's portion, a conservative estimate would cost $20B.[76] The potential for high member costs are one reason why some people are concerned about converting DoD beneficiaries to FEHBP.

In a related issue, if DoD completely paid the premiums or offset the premiums at a higher rate than federal civilians, a backlash could occur from the federal civilian unions. Many current and retired members might feel their service is less valued since their premiums are not covered at the same rate. This difference could start a movement to increase the amount of the premium the government covers for all federal employees. This in turn could lead to a potential huge bill to cover all federal employees and retirees. Current civilians could demand a greater portion of their premiums be paid by the government if DoD used FEHBP.

A third issue is pushing non-AD members into the network and limiting the health care benefits AD members were promised when they entered the military. Some military members state they have been promised "free" health care for life when entering the service.[77] These same members believe any movement to increase their cost share or limit access to care violates the promise they were given when they agreed to serve their nation. Movements to deny MTF care to non-AD beneficiaries would be seen as a direct affront to the promised care these members believe they are entitled. A shift of non-AD members to FEHBP could generate concern with members who believe their health benefits are eroding.

Along similar lines, many people are concerned that an effort to utilize FEHBP will start a process to completely outsource military medical care. Efforts to downsize the medical infrastructure are a BRAC reality, and current efforts to privatize uniformed physicians and nurses are currently underway.[78] A step to convert all non-AD members to FEHBP would continue this downward trend to completely outsourcing all military medical care. The AF is currently facing a significant shortage of family practice physicians. One way to attract and retain these doctors is to offer them a full practice so they can utilize all of their skills. If DoD implemented FEHBP for all non-AD members, these full practices would no longer exist – uniformed family practice doctors would only see AD members. This AD population should be healthier than the rest of the United States, forcing AD doctors to see only "runny noses" and "ankle sprains".[79] Taking care of such a population would not help attract physicians to the military. Shifting non-AD patients to FEHBP could begin a process to completely outsource DoD medical care.

Perhaps the strongest argument to keep non-AD beneficiaries in the MTF is the requirement to maintain readiness skills. In order to keep military medics prepared for their wartime duties, they must utilize these skills in-garrison. In many specialties, complex cases are

necessary to keep medical skills current and physicians up to date with the latest breakthroughs. In order to have a large population base to maintain medical currency, MTFs enrolled non-AD members. Previous AF Surgeon General Lieutenant General (retired) Roadman used a flying hour analogy.[80] He claimed we do not ask our pilots to fly in combat without a program where they can train and maintain these skills in peacetime. Lt Gen (ret) Roadman stated, "Clearly, we have to take care of the active-duty, but we need dependents, retired, and we need over-65 [patients] in order to get the right spectrum to maintain our clinical skills."[81] By taking all of the complex patients and sending them to the FEHBP system, some argue the wartime medic will not be prepared for their military duties when called upon.

A final argument to not implement FEHBP for all non-AD is the "failure" if the FEHBP DoD demonstration program. From 1999-2002 a demonstration program existed to enroll MEDICARE eligible DoD beneficiaries in FEHBP. The enrollment rates in the demonstration program were very low – approximately 5 percent of the eligibles when this program ended in late 2002.[82] Many argue that DoD beneficiaries will not utilize FEHBP since the majority of the members are satisfied with the current TRICARE program. These same people argue if members are satisfied with the current system, why force them to change. Key issues to point out regarding this demonstration program are that only MEDICARE eligible beneficiaries (age 65 and older) were allowed to enroll, and TRICARE For Life was implemented with the FY2001 National Defense Authorization Act, so many that might have enrolled in this program knew this demonstration program was doomed to failure. The low numbers of personnel enrolled in the DoD-FEHBP demonstration project show members may not want a change to FEHBP if given the choice.

Opponents of using FEHBP cite concerns with benefit confusion, the appearance of a diminished retiree benefit, potential higher costs, beginning a process to outsource all DoD

health care, the DoD-FEHBP demonstration project failure, and need to develop readiness skills. These issues all bring up valid counter arguments to mandating the use FEHBP for non-AD beneficiaries.

Recommendation

The final phase of this analysis is presenting recommendations for the future. These recommendations have two goals: first to establishing a system to control costs, and second to preserve the military's health care benefit. Non-AD members generate the majority of defense health care costs. As noted previously, this percentage is expected to grow to 75-80 percent of the DoD health care budget.[83] Since this group is clearly a majority of DoD beneficiaries, effective cost savings must be focused on this population. When looking at changes to impact non-AD health care costs, FEHBP is an interesting option.

First the issue of entitlement to MTF care must be addressed. Access to MTFs is not a legally required benefit for non-AD beneficiaries. This group is seen on a space available basis, and today's military health system has less and less space available. With the focus of the military on expeditionary operations, large peace-time forces will become a relic of the past. With fewer AD forces to care for, it becomes hard to justify a large military force to support the direct care system. If the direct care system will not support the ADFM and retiree populations, some sort of network care is necessary to provide health care. Based on the efficiencies outlined in the reasons to change section, the use of one health care system for all federal (military and non-military) employees would produce benefits that outweigh the costs.

In order to implement this system, a mechanism must be developed to handle member's premiums. If members are asked to cover a portion of the new health care premium, it will be considered an erosion of benefits since current health care is provided a substantially lower cost than federal civilians currently pay. Currently ADFMs do not pay any premiums and retirees

under age 65 pay a limited annual premium for TRICARE Prime (see Tables 3 and 4). If the civilian program rules were simply applied to the non-AD military population, a standard fee-for-service plan would cost the member $105 a month ($1,260 a year) for an individual or $230 a month ($2,760 a year) for a family.[84] These individual costs are significantly higher than the amounts non-AD beneficiaries pay today. For successful FEHBP implementation, DoD must devise a system to cover these health care costs or ask non-AD members to cover an increased portion.

One way to cover these costs without creating a huge political situation between military beneficiaries and federal civilian beneficiaries is to utilize the postal premium rates. The postal union successfully negotiated to have the government pay a larger portion of the premium cost share. Leaders must remind other federal employees that groups like postal employees already receive higher levels of government premium coverage based on union negotiation. DoD eligibles should be considered a different group, much like the postal employees. If the postal employee rates were used today, the member premiums for FFS and HMO plans would be approximately $276/$240 per year for an individual and $564 a year for either family plan. These rates are significant reduction from the non-postal member's premium costs. Tables 5 and 6 compare the current TRICARE member premium and the FEHBP member premiums using the 2007 postal rates.

Member Premiums – Fee for Service	TRICARE Standard[85]	FEHBP FFS*[86]
Individual – AD Member	$0	$23/mo - $276/yr
Family – AD Member	$0	$47/mo - $564/yr
Individual – Retiree/FM <65 yrs	$0	$23/mo - $276/yr
Family – Retiree/FM <65 yrs	$0	$47/mo - $564/yr
* Nationwide Mail Handlers Benefit Plan Standard and Family Plans – Postal Rates		

Table 5 – Member Premium Comparison, FFS Plans, Postal Rates

Premium Comparison – HMOs	TRICARE Prime[87]	FEHBP HMO*[88]
Individual – AD Member	$0	$20/mo - $240/yr
Family – AD Member	$0	$47/mo - $564/yr
Individual – Retiree/FM <65 yrs	$19/mo - $230/yr	$20/mo - $240/yr
Family – Retiree/FM <65 yrs	$38/mo - $460/yr	$47/mo - $564/yr

* Human Health Plan of Texas, Standard Self and Family Plans – Postal Rates

Table 6 – Member Premium Comparison, HMO Plans, Postal Rates

By using the postal FEHBP rates, DoD could closely match the current retiree TRICARE premiums. Once retiree premiums are dealt with, this leaves only the question about how to handle ADFMs premiums under FEHBP.

One alternative to ensure ADFMs have money to pay for FEHBP premiums is to create an allowance called a family health care allowance and set this at a FFS level currently comparable to TRICARE Standard. By establishing this allowance, employees will better realize their actual compensation, and can choose to allocate this to an appropriate plan. Models show the best way to recruit and retain employees is to offer attractive cash compensation.[89] To compete in the modern job market for talented personnel, DoD must find ways to demonstrate their advantages. By clearly showing this allowance to AD members, the value of their health care benefit would no longer be implicit. In addition, since this would be an allowance, it could be handled as non-taxable income—like the basic allowance for housing. Retirees would not receive this allowance; rather they could reduce their tax burden on their retirement pay by the amount they pay for medical premiums. Health Service Accounts and other new features could be used by these retired members to ensure proper monies are set aside to cover their health care costs in the future. Finally, this allowance could be adjusted based on premium increases in FEHBP as inflation and other factors increase the cost of health care. Putting measures in place to handle the inevitable cost increases is a very important aspect to this proposal since costs will

not remain stagnant. The creation of a basic allowance for health care is one way ADFM FEHBP premiums could be offset.

Revising the non-AD health benefit and devising a way to cover health care premiums are not far fetched ideas as they may initially seem. Recent health care cost increases and budgetary problems prompted DoD to propose new TRICARE fees[90] (see Table 7).

Enrollment Fees		TRICARE						FEHBP 2007 Postal Rates**[91]
		Current[92]		Proposed*[93]				
		AD	Ret	AD	Ret ≤ E6	Ret E7-E9	Ret Off	
FFS	Self	$0	$0	$0	$140	$200	$280	$276
	Family	$0	$0	$0	$280	$400	$560	$574
HMO	Self	$0	$230	$0	$325	$475	$700	$240
	Family	$0	$460	$0	$650	$950	$1,400	$574

* FY2008 rates; after this date, rates increase at the same inflation rate as FEHBP
** FFS = Nationwide Mail Handlers Benefit Plan Standard and Family Plans
HMO = Human Health Plan of Texas, Standard Self and Family Plans

Table 7 – Proposed TRICARE and FEHBP Premium Rate Comparison

These fees were DoD's attempt to address their internal cost increases before they got out of control. The proposal planned to increase fees gradually in 2006 and 2007, before reaching the ultimate fees in Table 7 by 2008. DoD proposed these ultimate fees as market equivalents for health care plans with the same benefits. Table 7 compares the proposed rates with current (2007) FEHBP postal rates and rates charged under TRICARE today. Congress resisted this proposed fee increase, but admitted some adjustment must be made if DoD health care is to continue. If DoD plans to increase enrollment fees for the current system, FEHBP should also be considered as an option – especially if member costs would be less under FEHBP. It is currently the perfect time to look at FEHBP as option while investigating new TRICARE enrollment fees.

In addition to the advantages outlined previously, switching to FEHBP would allow members to take advantage of tax laws. Current tax laws now allow members to take health care spending as a pre-tax deduction. The FEHBP program calls this "Premium Conversion."[94]

Under this program, the employees' portion of the premium is withheld from their pay and deducted as pre-tax money. This means the premium amounts are not, "subject to Federal income, Medicare, or Social Security taxes, and in most cases, state and local taxes."[95] If DoD provides health care to members at no charge, medical expenses paid for by the individual are not deductible. This pre-tax savings should be extended to retirees to reduce their tax burden on their retirement pay by the amount of their premiums.

A final benefit of using premium based health care for non-AD beneficiaries is to try and place some fiscal awareness with the member. TRICARE is a system that places almost no financial burden on the individual user. Even people with limited co-pays and premiums actually pay very little compared to private sector patients. The majority of DoD users receive what can be called "free" health care. Under this system, there is really no control or incentives for patients to only use the health system for appropriate care. To ensure the costs of health care are controlled, the consumer must have a financial stake in the medical transaction.[96] The active awareness of the health care costs a member consumes is a key benefit to converting non-AD beneficiaries to FEHBP.

To address the necessity of maintaining wartime skills, DoD should negotiate with these insurance companies to allow our providers to care for select cases as necessary to maintain wartime skills. This training could be expanded to all civilian providers to participate and see how DoD operates. This could invaluably establish a link for domestic or future international health care relief missions. As emphasized throughout the paper, the reduced force size and number of bases lowered the capability at MTFs. Even with the non-AD population enrolled to the MTFs, current limited capabilities prohibit military providers from "cracking chests" at most locations.[97] Additionally, at OCONUS locations, military health care must be provided for ADFMs. The lack of civilian providers in these regions dictates the military be able to produce

health care for members and their sponsored FMs. Retirees could utilize space available care and a contract solution should be investigated such as those available through the PACOM theater. The preservation of wartime skills could still continue, even if non-AD bases used FEHBP.

The rising health care costs in the U.S. and DoD are a fact and bold measures must be implemented to ensure these cost do not consume the entire DoD budget. One to way to address these costs is to use FEHBP for non-AD beneficiaries. The movement toward a premium based commercial health plan could be a reality with the utilization of postal rates and the establishment of an allowance for health care for ADFMs. Beneficiaries would be fiscally involved in their health care and could utilize tax deductions to reduce taxable income. If actions such as those recommended are not implemented, TRICARE enrollment fees are likely to increase and members may be asked to pay more for the same level of care they currently receive.

Conclusion

"The preservation of a soldier's health should be [the commander's] first and greatest care."

General George Washington[98]

In today's budget conscious world, tough decisions must be made between maintaining a modern military and providing first class health care. With a shrinking direct care system, uniformed providers cannot care for everyone, and DoD must look to alternatives to address providing care for beneficiaries. The challenge to DoD is to structure a system to provide cost efficient care in a world where everyone is trying to do the same. Without any changes, the current military health benefit is threatened. One possible solution is to utilize the FEHBP program offered to all federal civilians.

As the current war in Afghanistan and Iraq demonstrates, the medics have a high profile role that many value as a promise to our Soldiers, Sailors, Marines, and Airmen as they go off to war. DoD must ensure it has a system in place to care for families and retirees left behind when members deploy. If no change is made to the current system, health care costs are projected to consume the entire military budget and force a situation where DoD must choose between health care and weapons systems. Bold choices must be made today to mitigate these costs in order to save dollars in the future. The ultimate goal of any change to the current benefit is to ensure DoD has the resources to care for current and past military members and families. Without changes, DoD may no longer be able to follow through on it's promise to provide care for military families. The preservation of this benefit is the cornerstone of establishing trust in the military—an essential element for recruitment, fighting wars, retention, and confidence in the retirement system. DoD must do everything to preserve this trust and to maintain the health care system if they want future generations of Americans to voluntarily serve in the military.

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(All notes appear in shortened form. For full details, see the appropriate entry in the bibliography)

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