

December 2007

# MILITARY HEALTH CARE

Cost Data Indicate  
That TRICARE  
Reserve Select  
Premiums Exceeded  
the Costs of Providing  
Program Benefits



G A O

Accountability \* Integrity \* Reliability



Highlights of [GAO-08-104](#), a report to congressional committees

## Why GAO Did This Study

The Department of Defense's (DOD) TRICARE Reserve Select (TRS) program allows most reservists to purchase coverage under TRICARE, the military health insurance program, when not on active duty. DOD intends to set premiums at a level equal to the expected costs of providing TRS benefits. The National Defense Authorization Act for 2007 required GAO to review TRS costs. As discussed with the committees of jurisdiction, GAO compared (1) the TRS premiums established by DOD to the reported costs of providing benefits under TRS in 2006 and (2) DOD's projected costs for TRS before implementation to DOD's reported costs for the program in 2005 and 2006. To do this work, GAO examined DOD analyses and interviewed DOD officials and external experts.

## What GAO Recommends

GAO recommends that DOD stop basing TRS premiums only on Blue Cross and Blue Shield (BCBS) premium adjustments and use the reported costs of providing benefits through the TRS program when adjusting TRS premiums in future years as limitations associated with the reported cost data decrease. GAO also recommends that DOD explore options for addressing instances in which premiums have been either significantly higher or lower than program costs in prior years, including seeking legislative authority as necessary. In its comments, DOD concurred with these recommendations and with GAO's conclusions.

To view the full product, including the scope and methodology, click on [GAO-08-104](#). For more information, contact Laurie Ekstrand at (202) 512-7114 or [ekstrandl@gao.gov](mailto:ekstrandl@gao.gov).

# MILITARY HEALTH CARE

## Cost Data Indicate That TRICARE Reserve Select Premiums Exceeded the Costs of Providing Program Benefits

### What GAO Found

In 2006, the premium for both individual and family coverage under TRS—which DOD based on BCBS premiums—exceeded the reported average cost per plan of providing TRICARE benefits through the program. TRS currently serves less than 1 percent of the overall TRICARE population, and unlike most other TRICARE beneficiaries, TRS enrollees pay a premium to receive health care coverage. At the time of GAO's analysis, TRS consisted of three tiers, established by law, with reservists in each tier paying different portions of the total premium, based on the tier for which they qualified. Over 90 percent of reservists who purchased TRS coverage enrolled in tier 1. The premium for individual coverage under tier 1 was 72 percent higher than the average cost per plan of providing benefits through the program. Similarly, the premium for family coverage under tier 1 was 45 percent higher than the average cost per plan of providing benefits. DOD based TRS premiums on BCBS premiums because, at the time DOD was developing TRS, actual data on the costs of TRS did not exist; however, these data are now available. Had DOD been successful in establishing premiums that were equal to the cost of providing benefits in 2006, the portion of the premium paid by enrollees in tier 1—which is set by law to cover 28 percent of the full premium—would have been lower that year. Reasons that TRS premiums did not align with benefit costs included differences between the TRS and BCBS populations and differences in the way the two programs are designed, which DOD did not consider in its methodology. According to experts, the most successful methods for aligning premiums with actual program costs involve using program cost data when setting premiums. The regulation governing TRS premium adjustments allows DOD to use either BCBS premiums or other means as the basis for TRS premiums. However, DOD officials told GAO that they plan to continue, at least for the near future, to base TRS premiums on BCBS premiums because of limitations associated with using currently available data to predict future TRS costs. However, these limitations should decrease over time as DOD gains more experience with the program and enrollment increases. Nonetheless, due to the uncertainty associated with predicting future health care costs, premiums are unlikely to exactly match program costs, even when they are based on cost data from prior years. Other insurance programs have methods to address differences between premiums and program costs, which are not provided to DOD in the law governing TRS.

DOD overestimated the total cost of providing benefits through TRS. While the department projected that its total costs would amount to about \$70 million in fiscal year 2005 and about \$442 million in fiscal year 2006, DOD's reported costs in those years were about \$5 million and about \$40 million, respectively. DOD's cost projections were too high largely because it overestimated the number of reservists who would purchase TRS and the associated cost per plan of providing TRS benefits. DOD officials told GAO that they chose not to use TRS cost and enrollment data when projecting future year program costs and enrollment levels because of uncertainty about whether they would provide an accurate indication of future experience.

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## Abbreviations

BCBS	Blue Cross and Blue Shield
CPI-W	Consumer Price Index for Urban Wage Earners and Clerical Workers
DOD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
MTF	military treatment facility
NDAA	National Defense Authorization Act
TRS	TRICARE Reserve Select

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## Congressional Committees

Since the September 11, 2001, terrorist attacks, the Department of Defense (DOD) has increasingly relied on reservists to support military operations, such as the conflicts in Iraq and Afghanistan.<sup>1</sup> In recognition of this, Congress has increased the health care benefits available to reservists and their dependents, which generally include family members such as spouses and dependent children. Specifically, the National Defense Authorization Acts (NDAA) for Fiscal Years 2005, 2006, and 2007 expanded the number of reservists and their dependents who qualify for TRICARE, the military health insurance program, and increased the period during which they qualify.<sup>2</sup> The NDAA for Fiscal Year 2005 established the program that DOD has named TRICARE Reserve Select (TRS), which currently allows most members of the Selected Reserves<sup>3</sup> to purchase TRICARE coverage for periods after the TRICARE coverage associated with active duty expires. After purchasing coverage, enrollees can obtain health care through TRICARE-authorized providers or hospitals or through DOD-operated military treatment facilities (MTF) if appointments are available. TRS currently serves a small portion of the TRICARE population—as of June 2007, only about 34,000 of the 9.1 million TRICARE beneficiaries were enrolled in TRS.

Unlike most TRICARE beneficiaries who obtain health care benefits without paying premiums, reservists who qualify for TRS must pay a monthly premium to receive benefits through the program. By statute, DOD is required to set premiums for TRS at a level that it determines to be reasonable using an appropriate actuarial basis.<sup>4</sup> DOD officials told us that

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<sup>1</sup>In this report the term reservist includes all members of the seven reserve components: the Army National Guard and the Air National Guard as well as the Army Reserve, the Naval Reserve, the Marine Corps Reserve, the Air Force Reserve, and the Coast Guard Reserve.

<sup>2</sup>Prior to these expansions, a reservist and his or her dependents were eligible for TRICARE only while the reservist was serving on active duty for more than 30 days.

<sup>3</sup>The Selected Reserves contains those units and individuals considered essential to wartime missions. In 2005, 88 percent of reservists were considered part of the Selected Reserves.

<sup>4</sup>See 10 U.S.C. § 1076d(d)(2).

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the department interpreted this to mean that TRS premiums should be set equal to the expected average costs of providing the benefit per plan.<sup>5</sup> TRS enrollees are responsible for paying a portion of the total premium set by DOD. In this report the term premium refers to the total premium—that is, the portion paid by enrollees, currently 28 percent, plus the portion covered by DOD, currently 72 percent.<sup>6</sup> DOD based the premiums for TRS on the Federal Employees Health Benefits Program’s (FEHBP) Blue Cross and Blue Shield (BCBS) Standard premiums, which the department adjusted to account for differences in age, gender, and family size between the BCBS population and the population of reservists and their family members who qualify for TRS. To keep pace with rising health care costs, DOD originally designed TRS so that the premiums are adjusted each year based on annual adjustments in BCBS Standard premiums. DOD planned to continue using this method to adjust premiums in the near future.

The NDAA for Fiscal Year 2007 required that we review DOD’s costs of implementing the TRS program.<sup>7</sup> Specifically, as discussed with the committees of jurisdiction, we compared (1) the annual TRS premiums established by DOD to the reported costs of providing benefits under TRS in 2006 and (2) DOD’s projected costs for the TRS program before implementation to DOD’s reported costs for the program in 2005 and 2006. The NDAA for Fiscal Year 2007 also required that we describe how increases in TRS premiums compare with DOD’s annual rate of medical care price inflation. This information is included in appendix I.

To compare the annual TRS premiums established by DOD to the reported costs of providing benefits under TRS in 2006, we reviewed DOD’s reported TRS enrollment data and data on the cost of providing TRS

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<sup>5</sup>In this report the term plan refers to a TRS policy purchased for individual or family coverage.

<sup>6</sup>By law, under a three-tiered premium structure in effect during fiscal year 2007, qualification criteria for TRS were set for each of three separate tiers: Members of the Selected Reserves who served in a contingency operation for 90 continuous days or more since September 11, 2001, qualified to purchase TRS coverage under tier 1 and paid 28 percent of the total premium. Members of the Selected Reserves who did not have such service but were either unemployed, self-employed, or not eligible for employer-sponsored insurance qualified to purchase TRS coverage under tier 2 and paid 50 percent of the total premium. Members of the Selected Reserves who did not qualify for tier 1 or tier 2 were qualified to purchase TRS coverage under tier 3, and paid 85 percent of the total premium. Due to a change in law, since October 1, 2007, all enrollees have paid 28 percent of the total premium.

<sup>7</sup>See Pub. L. No. 109-364, § 713(b), 120 Stat. 2083, 2289-90 (2006).

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benefits through TRICARE-authorized civilian providers or hospitals, data on the administrative costs associated with providing TRS benefits, and data on the costs of providing TRS benefits through MTFs. Using DOD's data, we calculated the average cost per TRS plan<sup>8</sup> of providing individual and family coverage as the sum of the reported costs divided by the average number of TRS plans. We also reviewed legislation relevant to the TRS program and literature on setting health insurance premiums and interviewed experts from the fields of health economics and finance and DOD officials in the TRICARE Management Activity and the Office of the Assistant Secretary for Health Affairs, which are responsible for managing the TRICARE program. We limited our analysis to calendar year 2006 because some 2007 data are still incomplete and because 2005 average cost data in some months are based on a very small number of enrollees. During the time period covered by our analysis, TRS included three tiers of eligibility with enrollees in each tier paying different portions of the premium based on the tier for which they qualified. We limited our analysis to tier 1 because it included over 90 percent of TRS plans and because tier 1 enrollee premium levels have applied to the entire TRS program since October 2007. In addition, we were unable to report the average cost per plan for tiers 2 and 3 separately, due to the low number of enrollees in these tiers.

To compare DOD's projected costs for the TRS program before implementation with DOD's reported costs for the program in 2005 and 2006, we reviewed the analyses prepared by DOD before TRS's implementation that projected (1) the number of individual and family plans in each tier of the TRS program and (2) the costs per plan of providing the TRS benefit. These projections were the two major factors used by DOD to estimate TRS costs. We compared these data with reported TRS enrollment and cost data from 2005 through 2007. In reporting the results of our comparison we use cost data through 2006 only, because some cost data for 2007 were incomplete due to the delay between when a claim is incurred and when it is paid. We also reviewed DOD internal documents and interviewed DOD officials.

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<sup>8</sup>In our analysis we calculated a separate average cost per TRS plan for individual and family coverage—not the average cost per TRS enrollee.

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While we have raised concerns about the quality of DOD cost data in previous reports,<sup>9</sup> we determined that the data used for this analysis were sufficiently reliable for our purposes based on interviews with DOD officials and an examination of the data for obvious errors and omissions. However, we did not independently verify these data.

For a complete discussion of our scope and methodology, see appendix II. We conducted our work from May 2007 through October 2007 in accordance with generally accepted government auditing standards.

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## Results in Brief

In 2006, the premium for both individual and family coverage under TRS—which DOD based on BCBS premiums—exceeded the reported average cost per plan of providing TRICARE benefits through the program. The premium for individual coverage under tier 1 was 72 percent higher than the average cost per plan of providing benefits through the program. Similarly, the premium for family coverage under tier 1 was 45 percent higher than the average cost per plan of providing benefits. DOD based TRS premiums on BCBS premiums because, at the time DOD was developing TRS, actual data on the costs of delivering TRICARE benefits for the TRS population did not exist; however, these data are now available for 2005 and 2006. Had DOD been successful in establishing premiums that were equal to the cost of providing benefits in 2006, the portion of the premium paid by enrollees in tier 1—which is set by statute to cover 28 percent of the full premium—would have been lower that year—\$566 instead of \$972 for single coverage and \$2,099 instead of \$3,036 for family coverage. Reasons that basing TRS premiums on BCBS premiums did not successfully align TRS premiums with benefit costs included certain differences between the TRS and BCBS populations and certain differences between the two programs that DOD did not consider in its methodology. According to experts, the most successful methods for aligning premiums with the actual costs of providing benefits involve using program cost data when setting premiums. The regulation governing TRS premium adjustments allows DOD to use either BCBS premiums or other means as the basis for TRS premiums. However, DOD officials told us that they plan to continue, at least for the near future, to base TRS premium

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<sup>9</sup>GAO, *Global War on Terrorism: DOD Needs to Improve the Reliability of Cost Data and Provide Additional Guidance to Control Costs*, [GAO-05-882](#) (Washington, D.C.: Sept. 21, 2005), and *Medicare Subvention Demonstration: DOD Data Limitations May Require Adjustments and Raise Broader Concern*, [GAO/HEHS-99-39](#), (Washington, D.C.: May 28, 1999).



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adjustments on BCBS premiums because of limitations associated with using currently available data to predict future TRS costs. DOD officials told us that the limitations associated with currently available data are due to the newness of the TRS program, recent changes to TRS, and the low number of enrollees. However, any limitations associated with TRS cost data should decrease over time as DOD gains more experience with the program and enrollment increases, thus enabling DOD to better project future health care costs. Nonetheless, due to the uncertainty associated with predicting future health care costs, premiums are unlikely to exactly match program costs, even when they are based on cost data from prior years. Other insurance programs have methods to address discrepancies between premiums and program costs, which are not provided to DOD in the law governing TRS.

DOD significantly overestimated the total cost of providing benefits through TRS. While the department projected that its total costs would amount to about \$70 million in fiscal year 2005 and about \$442 million in fiscal year 2006, DOD's reported costs in those years were about \$5 million and about \$40 million, respectively. DOD's cost projections were too high largely because it overestimated the number of reservists who would purchase TRS as well as the associated cost per plan of providing benefits through the program. DOD officials told us that they considered TRS cost and enrollment data when developing future year projections of program costs and enrollment levels, but they chose not to use these data as part of their projections because of uncertainty about whether they would provide an accurate indication of likely future experience.

With the goal of eventually eliminating reliance on BCBS premiums and to better align premiums with the costs of providing TRS health care benefits, we recommend that the Secretary of Defense direct the Assistant Secretary for Health Affairs to stop basing TRS premium adjustments only on BCBS premium adjustments and use the reported costs of providing benefits through the TRS program when adjusting TRS premiums in future years as limitations associated with the reported cost data decrease.

We also recommend that DOD explore options for addressing instances in which premiums have been either significantly higher or lower than program costs in prior years, including seeking legislative authority as necessary.

In its written comments on a draft of this report, DOD concurred with our conclusions and recommendations. See appendix III for DOD's comments.

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## Background

Beginning on April 27, 2005, DOD made TRICARE coverage available for purchase through TRS for certain reservists when they were not on active duty or eligible for pre- or postactivation TRICARE coverage.<sup>10</sup> Enrollees in TRS can obtain care from MTFs or from TRICARE-authorized civilian providers or hospitals. TRS enrollees can obtain prescription drugs through TRICARE's pharmacy system, which includes MTF pharmacies, network retail pharmacies, nonnetwork retail pharmacies, and the TRICARE Mail Order Pharmacy. Since 2005, Congress has made this benefit available to a growing number of members of the Selected Reserves.

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## Changes in TRS Coverage

The NDAA for Fiscal Year 2005 authorized the TRS program.<sup>11</sup> As originally authorized, TRS made TRICARE coverage available to certain members of the Selected Reserves—that is, reservists mobilized since September 11, 2001, who had continuous qualifying service on active duty for 90 days or more in support of a contingency operation. To qualify for TRS, reservists had to enter into an agreement with their respective reserve components to continue to serve in the Selected Reserves in exchange for TRS coverage. For each 90-day period of qualifying service in a contingency operation, reservists could purchase 1 year of TRS coverage.<sup>12</sup> Electing to enroll in this TRS program was a onetime opportunity, and as originally authorized, the program required reservists to sign the new service agreement and register for TRS before leaving active duty service. Reservists who qualified could also obtain coverage for their dependents by paying the appropriate premium.

The NDAA for Fiscal Year 2006 expanded the number of reservists and dependents who qualify to participate in the TRS program.<sup>13</sup> Under the

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<sup>10</sup>TRICARE coverage is generally available to reservists and their dependents at no charge for up to 90 days prior to the beginning of active duty service and 180 days after. The Transitional Assistance Management Program offers 180 days of individual or family TRICARE coverage to reserve component members separated from active duty after being called up or ordered in support of a contingency operation for more than 30 days.

<sup>11</sup>See Pub. L. No. 108-375, § 701, 118 Stat. 1811, 1980-82 (2004).

<sup>12</sup>Reservists who were ordered to active duty for a period of more than 30 days, but served less than 90 continuous days due to an injury, illness, or disease incurred or aggravated while deployed, were eligible for 1 year of TRICARE coverage under TRS as originally authorized.

<sup>13</sup>See Pub. L. No. 109-163, §§ 701-702, 119 Stat. 3136, 3339-42.

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expanded program, which became effective on October 1, 2006, almost all reservists and dependents—regardless of the reservists’ prior active duty service—had the option of purchasing TRICARE coverage. Similar to the TRS program as it was originally authorized, members of the Selected Reserves and their dependents choosing to enroll in the expanded TRS program had to pay a monthly premium to receive TRICARE coverage. The portion of the premium paid by reservists in the Selected Reserves and their dependents for TRS coverage varied based on certain qualifying conditions that had to be met, such as whether the reservist also had access to an employer-sponsored health plan. The NDAA for Fiscal Year 2006 established three levels—which DOD calls tiers—of qualification for TRS, with enrollees paying different portions of the premium based on the tier for which they qualified. Those who would have qualified under the original TRS program, because they had qualifying service in support of a contingency operation, paid the lowest premium. In another change to the program, those reservists with qualifying service in support of a contingency operation now had up to 90 days after leaving active duty to sign the new service agreement required to qualify for this lowest premium tier.

The NDAA for Fiscal Year 2007 significantly restructured the TRS program by eliminating the three-tiered premium structure.<sup>14</sup> The act also changed TRS qualification criteria for members of the Selected Reserves, generally allowing these reservists to purchase TRICARE coverage for themselves and their dependents at the lowest premium—formerly paid by enrollees in tier 1—regardless of whether they have served on active duty in support of a contingency operation. In addition, the act removed the requirement that reservists sign service agreements to be qualified for TRS. Instead, the act established that reservists in the Selected Reserves qualify for TRS for the duration of their service in the Selected Reserves. DOD implemented these changes on October 1, 2007. See table 1 for an overview of TRS qualification criteria and the monthly portion of the TRS premiums paid by reservists.

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<sup>14</sup>See Pub. L. No. 109-364, § 706, 120 Stat. 2083, 2282 (2006) (codified at 10 U.S.C. § 1076d).

**Table 1: Selected TRS Qualification Criteria and Premiums for Members of the Selected Reserves**

Qualification criteria	Percentage of TRS premium paid by enrollees	Monthly portion of the TRS premium paid by reservist		Duration of coverage
		Individual coverage	Family coverage	
<b>TRS as authorized by the NDAA for Fiscal Year 2005 (Effective April 2005 through September 2006)</b>				
Reservist must have qualifying active duty service in support of a contingency operation on or after September 11, 2001, for at least 90 days; reservist must agree to serve in the Selected Reserves for the entire period of TRS coverage. If reservist was released from active duty after April 26, 2005, reservist must execute this service agreement before release from active duty. If reservist was released from active duty on or before April 26, 2005, reservist must execute this service agreement no later than October 28, 2005.	28	\$75.00 (April 2005 through December 2005)	\$233.00 (April 2005 through December 2005)	One year of coverage for each continuous 90 days of qualifying service.
		\$81.00 (January 2006 through September 2006)	\$253.00 (January 2006 through September 2006)	
<b>TRS as authorized by the NDAA for Fiscal Year 2006 (Effective October 2006 through September 2007)</b>				
<b>Tier 1:</b> Reservist must have qualifying active duty service in support of a contingency operation on or after September 11, 2001, for at least 90 days and must agree to serve in the Selected Reserves for the entire period of TRS coverage. Reservist must execute this service agreement within 90 days after release from active duty.	28	\$81.00	\$253.00	One year of coverage for each continuous 90 days of qualifying service.

Qualification criteria	Percentage of TRS premium paid by enrollees	Monthly portion of the TRS premium paid by reservist		Duration of coverage
		Individual coverage	Family coverage	
<b>Tier 2:</b> Reservist does not qualify for tier 1; must not be eligible for employer-sponsored health insurance, or must be eligible for unemployment compensation or must be self-employed; must execute a service agreement to serve in the Selected Reserves for the entire period of TRS coverage. Reservist must qualify during open season or submit documentation establishing a qualifying life event.	50	\$145.29	\$451.42	Up to 1 year of coverage with an annual option to renew.
<b>Tier 3:</b> Reservist does not qualify for tier 1 or 2; may be eligible for employer-sponsored insurance, but must execute a service agreement to serve in the Selected Reserves for the entire period of TRS coverage. Reservist must qualify during open season or submit documentation establishing a qualifying life event.	85	\$247.00	\$767.41	Up to 1 year of coverage with an annual option to renew.
<b>TRS as authorized by the NDAA for Fiscal Year 2007 (Effective as of October 2007)</b>				
Reservist must be a member of the Selected Reserves. Reservists who are eligible for coverage under FEHBP do not qualify to purchase TRS.	28	\$81.00	\$253.00	Coverage is available as long as the reservist is a member of the Selected Reserves.

Source: GAO.

Note: The Selected Reserves contains those units and individuals considered essential to wartime missions. As of 2005, 88 percent of reservists were considered part of the Selected Reserves.

## Enrollment in TRS

Currently, reservists who qualify for TRS may purchase TRS individual or family coverage at any time. Once enrolled in TRS, reservists and their dependents are able to obtain health care through MTFs, if appointments are available, or through TRICARE-authorized civilian providers or hospitals. Enrollees who choose to use civilian providers are subject to an annual deductible, co-payments, and coinsurance. When these enrollees use providers outside TRICARE's civilian network, they pay higher cost shares and are considered to be using TRICARE Standard, the TRICARE option that is similar to a fee-for-service plan. When they use providers

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who are part of the TRICARE network, they pay discounted cost shares and are considered to be using TRICARE Extra, the TRICARE option that is similar to a preferred provider plan.<sup>15</sup>

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## DOD's Methods for Developing TRS Premiums

DOD is required by law to set premiums for TRS at a level that it determines to be reasonable using an appropriate actuarial basis.<sup>16</sup> DOD officials told us that the department interpreted this to mean that TRS premiums should be set equal to the expected average costs per plan of providing the benefit. Beginning in 2005, DOD based TRS premiums on the premiums for the BCBS Standard plan offered through FEHBP because, at the time DOD was developing TRS, actual data on the costs of delivering TRS benefits for the TRS population did not exist. To set the premiums, DOD compared characteristics of the beneficiary populations in each group and subsequently adjusted the BCBS premiums for differences in age, gender, and family size between the TRS and BCBS populations. The population that qualifies for TRS is younger, has a higher percentage of males, and has a larger number of dependents per sponsor than the BCBS population. Taken together, DOD concluded that these factors caused expected health care costs for the TRS population to be lower than expected health care costs for the BCBS population. To account for these differences, DOD set the TRS premium for individual coverage 32 percent lower than the corresponding BCBS premium and set the TRS premium for family coverage 8 percent lower than the corresponding BCBS premium.<sup>17</sup> According to DOD officials, the department based TRS premiums on BCBS premiums, rather than another health insurance plan's premiums, because BCBS offers coverage that is similar to the coverage offered under TRICARE Standard. (For a comparison of cost-sharing provisions under TRS and BCBS Standard, see table 2.) In addition, like TRS, BCBS charges a separate premium for individual coverage and for family coverage, and each of these premiums is uniform nationally and

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<sup>15</sup>TRICARE has three options, referred to as Standard (similar to fee-for-service option), Extra (similar to a preferred provider option), and Prime (similar to a health maintenance organization option). TRICARE Prime is not available under TRS.

<sup>16</sup>See 10 U.S.C. § 1076d(d)(2).

<sup>17</sup>The TRS premiums for family coverage and individual coverage were both affected by TRS's younger population. The TRS premium for family coverage was affected by the TRS population's larger number of dependents per sponsor, making its adjustment from the BCBS premium smaller. The TRS premium for individual coverage is affected by the TRS population's larger percentage of males, who generally incur lower health care costs than females, making its adjustment larger.

updated annually. Furthermore, according to DOD officials, basing TRS premiums on BCBS premiums allowed the department to account for the effect of adverse selection on the department's costs, because adverse selection is already accounted for in BCBS premiums.<sup>18</sup>

**Table 2: Comparison of Cost-Sharing Provisions under TRS and Blue Cross and Blue Shield Standard**

	TRICARE Reserve Select		Blue Cross and Blue Shield Standard	
	In-network	Out-of-network	In-network	Out-of-network
Catastrophic limit per family <sup>a</sup>	\$1,000	\$1,000	\$4,000	\$6,000
Calendar year deductible per individual/family	\$150/\$300 or \$50/\$100 (E4 and below)	\$150/\$300 or \$50/\$100 (E4 and below)	\$250	\$250
Hospital inpatient deductible or co-payment	Greater of \$14.80 per day or \$25 per admission	Greater of \$14.80 per day or \$25 per admission	\$100 per admission	\$300 per admission
Primary doctor office visits	15 percent <sup>b</sup>	20 percent <sup>b</sup>	\$15	25 percent
Specialist office visits	15 percent <sup>b</sup>	20 percent <sup>b</sup>	\$15	25 percent
Retail pharmacy co-payment for generic drugs	\$3	Greater of \$9 or 20 percent of total cost	25 percent	45 percent or higher
Mail-order pharmacy co-payment for generic drugs	\$3	N/A	\$10	N/A
Retail pharmacy co-payment for brand-name drugs	\$9	Greater of \$9 or 20 percent of total cost	25 percent	45 percent or higher
Mail-order pharmacy co-payment for brand-name drugs	\$9	N/A	\$35	N/A

Sources: DOD and the Office of Personnel Management.

<sup>a</sup>The catastrophic cap is the maximum out-of-pocket expense for which TRICARE enrollees are responsible in a given fiscal year. The catastrophic cap applies only to services covered by TRICARE.

<sup>b</sup>The in-network coinsurance rate is 15 percent of the negotiated rate, which is the rate network providers and participating nonnetwork providers have agreed to accept for covered services. The out-of-network coinsurance rate is 20 percent of the TRICARE allowable charge, which is the maximum amount TRICARE will pay for services.

<sup>18</sup>Adverse selection occurs when people who know they have a risk of incurring health care expenses buy insurance coverage, while those who have relatively less risk of incurring health care expenses decide the insurance is too expensive and therefore do not buy it. In these cases, the resulting insured population is likely to incur greater-than-average health care costs. Therefore, any premiums set to account for an insured population with average health care costs may not be sufficient to cover the claims that eventually arise.

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In order to compensate for rising health care costs, DOD originally designed TRS premiums so that they would be adjusted each year based on annual adjustments in the total BCBS Standard premiums. DOD planned to continue using this method to adjust premiums in the immediate future but allowed for the possibility that it might change the methodology at some point in the future. Thus, if BCBS premiums increased by 8.5 percent from 2005 to 2006, TRS premiums would be increased by the same percentage. New premiums are effective at the start of each calendar year. TRS premiums were increased by 8.5 percent for 2006 and scheduled to be increased by 1 percent for 2007, but a provision in the NDAA for Fiscal Year 2007 prevented this increase from being implemented for 2007.<sup>19</sup>

According to DOD officials, another reason DOD decided to use BCBS as the basis for annual TRS premium adjustments was because BCBS premiums are updated annually, and the new premiums are made public each October. DOD officials told us they did not want to use DOD data to adjust premiums because they believe that doing so would be less transparent; that is, they wanted to avoid any appearance that the data might have been manipulated to DOD's own financial advantage.

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## Basing TRS Premiums on BCBS Premiums Resulted in TRS Premiums That Exceeded the Costs of Providing Program Benefits in 2006

In 2006, the premiums for both individual and family coverage under TRS exceeded the reported costs of providing TRICARE benefits through the program. The total premium for individual coverage under tier 1 was 72 percent higher than the average cost per plan of providing benefits through the program. Similarly, the total premium for family coverage under tier 1 was 45 percent higher than the average cost per plan of providing benefits. There are several reasons that basing TRS premiums on BCBS premiums did not successfully align TRS premiums with benefit costs. These include certain differences between the TRS and BCBS populations and certain differences between the two programs that DOD did not take into account. Experts indicated that data on the costs of delivering TRS benefits would provide DOD with an improved basis for adjusting premiums in future years.

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<sup>19</sup>See Pub. L. No. 109-364, § 704, 120 Stat. 2083, 2280 (2006). This provision prevented any increase in premiums through September 30, 2007. The NDAA for Fiscal Year 2008, as passed by the House and Senate and reported on in Conference Report 110-477, contains a provision that would extend this prohibition through September 20, 2008. As of December 17, 2007, the President had not signed this bill into law.

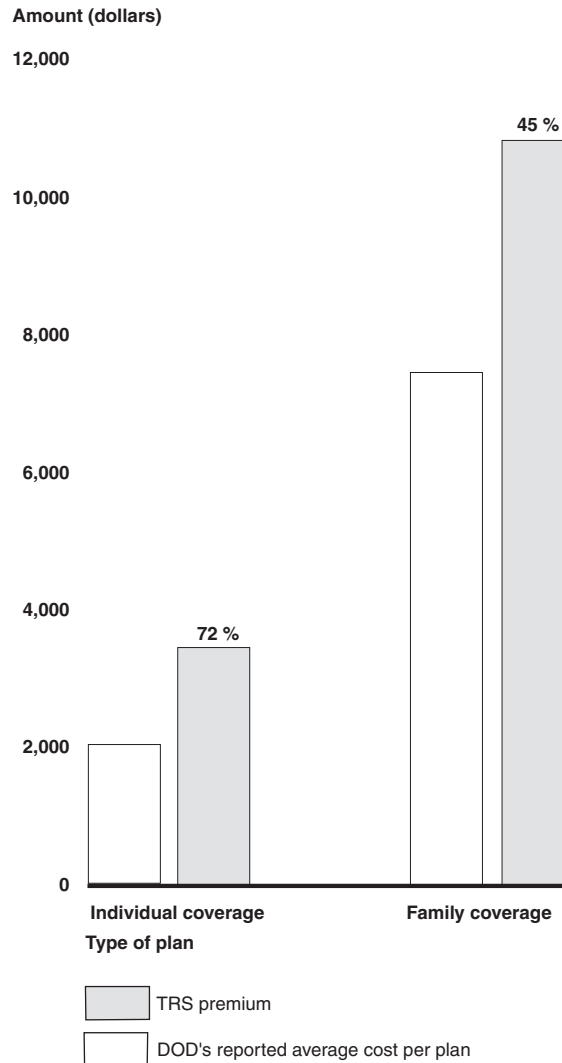


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**In 2006, the Premium for Both Individual and Family Coverage under TRS Exceeded the Reported Costs per Plan of Providing Benefits through the Program**

In 2006, the premium for both individual and family coverage under TRS exceeded the reported costs per plan of providing TRICARE benefits through the program. For tier 1, the annual premium for individual plans of \$3,471—including the share paid by enrollees and the share covered by DOD—was 72 percent higher than the average cost of providing benefits through TRS of \$2,020 per plan. Similarly, the annual premium for family plans of \$10,843 was 45 percent higher than the average cost of providing benefits through TRS of \$7,496 per plan. (See fig. 1.)

**Figure 1: Comparison of DOD's Reported Average Cost per Plan with TRS Premiums, 2006**



Source: GAO analysis of DOD data.

Note: The average cost per plan refers to tier 1 plans only.

The average costs per TRS plan do not include certain administrative costs that DOD was not able to allocate specifically to TRS, such as advertising costs and program education. However, DOD officials told us that including these costs would not be sufficient to close the gap between TRS premiums and the average costs per plan. DOD also incurred start-up costs associated with establishing the TRS program, which are not included in

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the average costs per TRS plan because DOD did not intend for them to be covered by TRS premiums.

The discrepancy between TRS premiums and reported TRS costs has implications for DOD's cost sharing with TRS enrollees. By statute, the portion of the TRS premium paid by enrollees in tier 1—and all enrollees as of October 1, 2007—is to cover 28 percent of the full premium. In 2006, TRS enrollees in tier 1 paid \$972 for individual coverage and \$3,036 for family coverage. This covered 48 percent of the average cost per individual plan and 41 percent of the average cost per family plan. Had DOD been successful in establishing TRS premiums that were equal to the average reported cost per TRS plan in 2006, enrollees' share of the premium would have been \$566 for single coverage and \$2,099 for family coverage in that year.<sup>20</sup>

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### Basing TRS Premiums on BCBS Premiums Is Unlikely to Successfully Align TRS Premiums with Benefit Costs

Basing TRS premiums on BCBS premiums is unlikely to align TRS premiums with benefit costs because of several differences between the TRS and BCBS populations and programs that DOD did not take into account. DOD based TRS premiums on BCBS premiums because at the time DOD was developing TRS, actual data on the costs of delivering TRS benefits to the TRS population did not exist. However, experts we interviewed suggested that because of demographic differences between the TRS and BCBS populations, BCBS-based premiums are unlikely to reflect TRS costs. In setting TRS premiums, DOD adjusted BCBS premiums to account for differences in age, gender, and family size between the TRS and BCBS populations. However, DOD did not take other demographic differences into account that could have potentially affected its likely success—such as enrollees' geographic distribution and health status—because accounting for these differences is very difficult. The geographic distribution of a population is an important factor in predicting health care costs and corresponding health insurance premiums, in large part because physician payment rates vary across geographic locations.<sup>21</sup> Furthermore, according to experts we interviewed, the most important

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<sup>20</sup>The average costs per TRS plan reported above apply only to tier 1 plans and are weighted by the number of plans in each month in calendar year 2006. However, including tiers 2 and 3 in our calculation of the average costs per plan does not substantially change the results, because tier 1 comprised over 90 percent of all TRS plans.

<sup>21</sup>GAO, *Federal Employees Health Benefits Program: Differences in Health Care Prices across Metropolitan Areas Linked to Competition and Other Factors*, [GAO-06-281T](#) (Washington, D.C.: Dec. 2, 2005).

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predictors of health care costs are measures related to enrollees' health status, which were not fully available to DOD when it first established TRS premiums.

Another factor that may have contributed to the disparity between TRS premiums and the program's costs is the dissimilarity in the structures of the TRS and BCBS programs. While TRS premiums are designed to cover enrollees' health care costs and certain administrative costs, BCBS premiums are designed to cover these costs and also may include contributions to or withdrawals from plan reserves<sup>22</sup> and profits. As a result, changes in BCBS premiums are generally not equal to changes in BCBS program costs.

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### TRS Cost Data Would Provide DOD with an Improved Basis for Adjusting Premiums in Future Years

Experts indicated that data on the costs of delivering TRS benefits will provide DOD with an improved basis for adjusting premiums in future years.<sup>23</sup> They informed us that there are several methods of setting health insurance premiums. The methods that are most successful in aligning premiums with the actual costs of providing benefits involve using program cost data when setting premiums. Although TRS cost data did not exist when the program was implemented, leading DOD to base TRS premiums on BCBS premiums, TRS cost data from 2005 and 2006 are now available. In DOD's description of its methodology for establishing and adjusting TRS premiums in the *Federal Register* on March 16, 2005, DOD allowed for the possibility of using other means to adjust premiums in the future.<sup>24</sup> It stated that it could base future changes in TRS premiums on actual cost data. However, DOD officials told us that the department has not used these data to adjust TRS premiums due to the limitations associated with using prior year costs to predict future costs. According to DOD officials, prior year claims data may not be indicative of future year claims costs due to the newness of the TRS program, recent changes to TRS, and the low number of enrollees. However, TRS cost data reflect actual experience with the program and any limitations associated with

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<sup>22</sup>Under 5 U.S.C. § 8909, the Office of Personnel Management administers a reserve account for each FEHBP plan, including BCBS. Funds in the reserves may be used to defray future premium increases, enhance plan benefits, reduce premiums, or cover unexpected shortfalls from higher-than-anticipated claims.

<sup>23</sup>We obtained information from experts in the fields of economics and finance.

<sup>24</sup>See 70 Fed. Reg. 12798, 12800-01 (Mar. 16, 2005).

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TRS cost data should decrease over time as DOD gains more experience with the program and more reservists enroll in it.

Nonetheless, due to the uncertainty associated with predicting future health care costs, premiums are unlikely to exactly match program costs, even when they are based on cost data from prior years. To help adjust for discrepancies between premiums and program costs, some health insurance programs have established reserve accounts, which may be used to defray future premium increases or cover unexpected shortfalls from higher-than-anticipated costs. For example, as noted earlier, the Office of Personnel Management administers a reserve account for each FEHBP plan, including BCBS. These reserve accounts are funded by a surcharge of up to 3 percent of a plan's premium. Once funds in the reserve accounts exceed certain minimum balances, they can be used to offset future year premium increases. Similarly, some health insurance programs make adjustments to premiums for subsequent years that account for any significant discrepancy between prior year premiums and program costs. The law governing TRS contains no provision for the establishment of a reserve account or for methods of increasing or decreasing premiums, after they are set, to address differences between premiums and costs in prior years.

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**TRS's Projected Costs Significantly Exceeded Reported Costs for Fiscal Years 2005 and 2006 Largely Because Enrollment Levels Were Lower Than DOD Expected**

DOD's estimated costs of providing TRS benefits were about 11 times higher than its reported costs. DOD's cost projections were too high largely because it overestimated the number of reservists who would enroll in TRS as well as the associated cost per plan of providing benefits through the program. DOD officials told us that they considered TRS cost and enrollment data when developing future year projections of program costs and enrollment levels, but they chose not to use these data as part of their projections because they are uncertain that prior year enrollment and cost data are indicative of future year costs and enrollment levels.

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**DOD's Projected Costs  
Were Significantly Higher  
Than Its Reported Costs  
for TRS in Fiscal Years  
2005 and 2006**

DOD significantly overestimated the costs of providing benefits through TRS. Prior to TRS's implementation, DOD estimated that total costs of providing benefits through the program would amount to about \$70 million in fiscal year 2005 and about \$442 million in fiscal year 2006. In contrast, reported costs in those years only amounted to about \$5 million and about \$40 million, respectively.<sup>25</sup> DOD estimated the program's likely costs by multiplying the number of TRS plans that it projected would be purchased by DOD's estimated cost per plan for individual and family plans. DOD estimated that its cost per plan would be equal to the total TRS premium minus the portion of the premium paid by enrollees.<sup>26</sup>

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**DOD's Projected Costs  
Were Higher Than  
Reported Costs for TRS  
Because It Overestimated  
the Number of TRS  
Enrollees and the Cost per  
Enrollee**

The number of reservists who purchased TRS coverage has been significantly lower than DOD projected, and as a result TRS program costs have also been lower than expected. DOD projected that about 114,000 reservists would purchase individual or family plans by 2007; however, as of June 2007 only about 11,500—or about 10 percent—of that number had purchased TRS plans. Over 90 percent of TRS enrollment had been for coverage under tier 1, which offered the lowest enrollee premium contributions of the three tiers in existence at the time covered by our analysis. Very few reservists signed up for coverage under tier 3, which had the highest enrollee premium contributions of the three tiers. (See table 3.)

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<sup>25</sup>The TRS program does not receive a separate appropriation but is funded through the lump sum appropriation for the Defense Health Program, as well as the premiums paid by reservists. Both the lump sum appropriation and the premiums are credited to the Defense Health Program account. Since amounts in this account are generally available for all medical and dental care for DOD beneficiaries, not just for TRS benefits, funds not spent on TRS are available for other components of the Defense Health Program. See 10 U.S.C. §§ 1076d(d)(5), 1100.

<sup>26</sup>Both DOD's projected and reported costs also included approximately \$25 million that DOD obligated over fiscal years 2005 and 2006 for start-up costs to be paid to the managed care support contractors and subcontractors that oversee TRICARE's civilian provider network and process TRICARE claims, and for changes to DOD's data systems. DOD officials told us that this \$25 million had been obligated over fiscal years 2005 and 2006, but that it had not been paid out in full. As of September 18, 2007, DOD officials told us that they and the contractors had not yet determined the exact amounts to be paid.

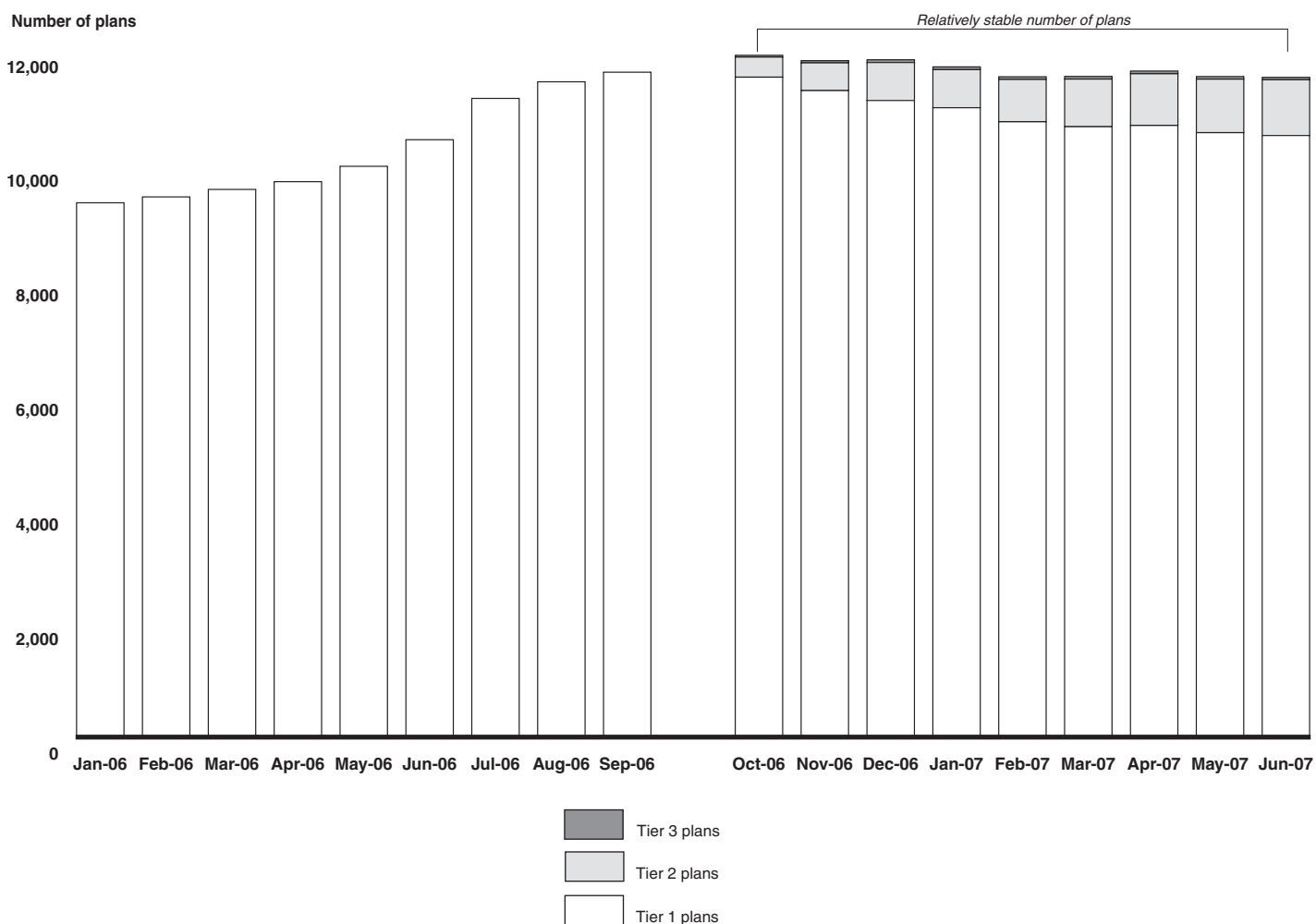
**Table 3: Comparison of the Projected Number of TRS Plans to the Reported Number of TRS Plans, June 2007**

	Projected number of plans (fiscal year 2007)		Reported number of plans (June 2007)	
	Individual coverage	Family coverage	Individual coverage	Family coverage
<b>Tier 1</b>	18,216	78,591	3,107	7,412
<b>Tier 2</b>	3,096	6,285	363	610
<b>Tier 3</b>	2,639	5,359	17	25
<b>All tiers</b>	<b>23,951</b>	<b>90,235</b>	<b>3,487</b>	<b>8,047</b>

Source: DOD.

DOD estimated the number of reservists who would purchase TRS coverage by dividing the population of reservists who qualify for each of the three tiers into several categories for which it estimated distinct participation rates, based on the premiums these reservists would likely pay for non-DOD health insurance. DOD projected lower enrollment for groups that had access to less expensive health insurance options, such as those who are offered insurance through their employers. DOD officials believe that enrollment in TRS will increase the longer the program is in place. However, while enrollment in TRS increased moderately through October 2006, it has remained relatively stable from October 2006 through June 2007. (See fig. 2.)

**Figure 2: Number of TRS Plans in Each Tier, January 2006-June 2007**



Source: GAO analysis of DOD data.

In addition to the estimated number of plans purchased, the other major factor that affected DOD's projection of overall TRS program costs was its estimate of the cost of providing benefits for each TRS plan. As previously stated, DOD based its estimated cost per plan on the total TRS premium minus the portion of the premium paid by enrollees. Because the



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premiums have been higher than DOD's reported costs, DOD's cost projections have also been too high.

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### DOD's Projection of Future TRS Enrollment Levels Is Likely Too High

DOD developed a new model to project enrollment levels and program costs under TRS's single-tiered premium structure that went into effect on October 1, 2007; however, DOD's projection of future TRS enrollment levels is likely too high. DOD projected that the total number of TRS plans for individual and family coverage would be approximately 64,000 in fiscal year 2008 at a cost to the department of about \$381 million for that year.<sup>27</sup> However, actual TRS enrollment data to date suggest that total TRS enrollment—and therefore program costs—are unlikely to be as high as DOD projected. As of June 2007, there were about 11,500 TRS plans—well below DOD's projection of about 114,000. Enrollment will almost certainly increase to some extent because reservists who previously only qualified for tier 2 or tier 3 of the program—which required enrollees to pay a larger portion of the premium—have qualified for the significantly lower tier 1 enrollee premiums since October 1, 2007. However, the degree to which it will increase is not clear. DOD officials told us that they considered TRS cost and enrollment data when developing future year projections of program costs and enrollment levels, but they chose not to use these data as part of their projections because of uncertainty about whether they would provide an accurate indication of likely future experience. DOD's past enrollment projections, made without the benefit of prior year enrollment data, were significantly higher than actual enrollment levels.

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## Conclusions

Although DOD intended that TRS premiums would be equal to the expected costs per plan of providing the benefit, DOD set premiums for the program based on BCBS premiums that proved to be significantly higher than the program's average reported costs per plan in 2006. Reservists' portion of TRS premiums would have been lower in 2006 if DOD had aligned premiums with the cost of providing TRS benefits. DOD officials told us that the department planned to continue basing TRS premium adjustments on BCBS premium adjustments in the immediate future, but the regulation governing TRS premium adjustments allows for

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<sup>27</sup>DOD's new model projects enrollment and costs through 2013 under TRS's single-tiered structure. Approximately 107,000 reservists are expected to enroll in TRS by fiscal year 2010, with enrollment levels remaining relatively constant through fiscal year 2013. Program costs are projected to increase each year and amount to approximately \$874 million in fiscal year 2013.

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the possibility that the department might change its methodology at some point in the future. However, because TRS premiums were higher than the average costs per plan in 2006, continuing to adjust TRS premiums based on BCBS premium adjustments could widen the gap between TRS premiums and the average costs per plan.

The discrepancy between TRS premiums and the reported program costs per plan results from the approach DOD used in setting TRS premiums. Basing TRS premiums on BCBS premiums is problematic because of several dissimilarities between the two programs. Most important, the average cost data now available suggest that TRS enrollees have incurred significantly lower health care costs than BCBS enrollees, even after adjusting for certain demographic characteristics. In addition, BCBS premiums may be based on more than program costs, whereas TRS premiums are intended to cover only costs. Basing TRS premiums on BCBS premiums may have been reasonable at the time that TRS was first implemented in 2005 due to the lack of available data on the cost of providing benefits through TRS. However, cost data that reflect actual experience under the program are now becoming available, and limitations associated with them should decrease over time as DOD gains more experience with the program and more reservists enroll in it. These data will provide DOD with an improved basis for setting premiums in future years, and allow the department to eventually eliminate its reliance on BCBS premiums. Nonetheless, due to the uncertainty associated with predicting future health care costs, premiums are unlikely to exactly match program costs, even when they are based on cost data from prior years. Other insurance programs have methods to address discrepancies between premiums and program costs, which are not provided to DOD in the law governing TRS.

DOD has also had difficulty accurately estimating the likely cost of providing TRS benefits in large part because it overestimated the number of reservists who would likely purchase TRS coverage. Over time, the availability of actual cost and enrollment data should help DOD improve its projections for future years.

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## Recommendations for Executive Action

With the goal of eventually eliminating reliance on BCBS premiums and to better align premiums with the costs of providing TRS health care benefits, we recommend that the Secretary of Defense direct the Assistant Secretary for Health Affairs to stop basing TRS premium adjustments only on BCBS premium adjustments and use the reported costs of providing

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benefits through the TRS program when adjusting TRS premiums in future years as limitations associated with the reported cost data decrease.

We also recommend that DOD explore options for addressing instances in which premiums have been either significantly higher or lower than program costs in prior years, including seeking legislative authority as necessary.

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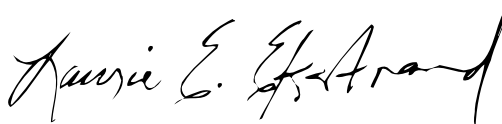
## Agency Comments

We received written comments on a draft of this report from DOD. DOD stated that it concurs with our conclusions and recommendations and that it is committed to improving the accuracy of TRS premium projections. It further stated that our recommendations are consistent with DOD's strategy to evolve the process, procedures, and analytical framework used to adjust TRS premiums as the quality and quantity of reported cost data improve. DOD's written comments are reprinted in appendix III.

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We are sending copies of this report to the Secretary of Defense and other interested parties. We will also make copies available to others on request. In addition, the report will be available at no charge on GAO's Web site at <http://www.gao.gov>.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or [ekstrandl@gao.gov](mailto:ekstrandl@gao.gov). Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.



Laurie Ekstrand  
Director, Health Care

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*List of Committees*

The Honorable Carl Levin  
Chairman  
The Honorable John McCain  
Ranking Member  
Committee on Armed Services  
United States Senate

The Honorable Daniel K. Inouye  
Chairman  
The Honorable Ted Stevens  
Ranking Member  
Subcommittee on Defense  
Committee on Appropriations  
United States Senate

The Honorable Ike Skelton  
Chairman  
The Honorable Duncan L. Hunter  
Ranking Member  
Committee on Armed Services  
House of Representatives

The Honorable John P. Murtha  
Chairman  
The Honorable C. W. Bill Young  
Ranking Member  
Subcommittee on Defense  
Committee on Appropriations  
House of Representatives

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# Appendix I: Comparison of TRS Premium Growth with DOD's Estimated Rate of Medical Care Price Inflation

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The John Warner National Defense Authorization Act (NDAA) for Fiscal Year 2007 required that we describe how increases in TRICARE Reserve Select (TRS) premiums compare with the Department of Defense's (DOD) annual rate of medical care price inflation.<sup>1</sup> As discussed with the committees of jurisdiction, this appendix compares DOD's January 2006 TRS premium increase and DOD's proposed January 2007 TRS premium increase with DOD's estimated annual rate of medical care price inflation in fiscal years 2005 and 2006 as well as the medical component of the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W).

Premiums for TRS were first established when the program was implemented in April 2005. To keep pace with rising health care costs, DOD originally designed TRS premiums so that they are adjusted each year based on annual adjustments in the Federal Employees Health Benefits Program's Blue Cross and Blue Shield (BCBS) Standard plan premiums. DOD planned to continue using this method to adjust premiums in the immediate future, although program regulations allow some flexibility in setting the premiums. Accordingly, in line with BCBS, TRS premiums increased by 8.5 percent in January 2006. Based on increases in BCBS, TRS premiums would have increased by 1 percent in January 2007. However, the NDAA for Fiscal Year 2007 froze 2007 premiums through September 30, 2007, at the rates for calendar year 2006.

DOD calculated its average annual rate of medical care inflation to be about 4.9 percent in fiscal year 2005 and about 4.7 percent in fiscal year 2006. DOD did not develop these estimates of inflation based on its own spending. Instead, DOD based the estimates on inflation rates provided annually by the Office of Management and Budget for the various components of the TRICARE operating budget, such as military personnel, private sector health care, and pharmacy. In contrast, the medical component of the CPI-W increased at lower rates than DOD's rate of medical care price inflation. The medical care component of the CPI-W increased by about 4.1 percent in 2005 and about 4.2 percent in 2006. The medical care component of the CPI-W is based on medical expenses, but it is problematic to compare to DOD's estimated rate of medical care inflation because it is based only on out-of-pocket medical expenditures paid by consumers, including health insurance premiums, and excludes the medical expenditures paid by public and private insurance programs.

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<sup>1</sup>See Pub. L. No. 109-364, § 713(b)(2)(B), 120 Stat. 2083, 2289 (2006).

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**Appendix I: Comparison of TRS Premium  
Growth with DOD's Estimated Rate of Medical  
Care Price Inflation**

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Comparing premium growth trends with DOD's annual rate of medical care price inflation and the medical care component of the CPI-W is problematic because of differences in each measurement. Unlike medical care price inflation, premium growth may reflect factors such as changes in the comprehensiveness of the policy, changes in the ratio of premiums collected to benefits paid, changes in costs because of increased utilization of health care services, contributions to or withdrawals from plan reserves, and profits.

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# Appendix II: Scope and Methodology

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To compare the annual TRS premiums established by DOD to the reported average costs per plan of providing benefits under TRS in 2006, we reviewed DOD's reported TRS enrollment data and data on the cost of providing TRS benefits through TRICARE-authorized civilian providers or hospitals, data on the administrative costs associated with providing TRS benefits, and data on the costs of providing TRS benefits through military treatment facilities (MTF). Using DOD's data, we calculated the average cost per TRS plan<sup>1</sup> of providing individual and family coverage as the sum of the reported costs divided by the average number of TRS plans. We also reviewed legislation relevant to the TRS program and literature on setting health insurance premiums and interviewed several experts from the fields of health economics and finance and DOD officials in the TRICARE Management Activity and the Office of the Assistant Secretary for Health Affairs. We limited our analysis to calendar year 2006 because some 2007 data are still incomplete and because 2005 average cost data in some months are based on a very small number of enrollees. At the time covered by our analysis, TRS included three tiers of eligibility with enrollees paying different portions of the premium based on the tier for which they qualified.<sup>2</sup> We limited our analysis to tier 1 because it included over 90 percent of TRS plans and because tier 1 enrollee premium levels have applied to the entire TRS program since October 2007. We are unable to report the average cost per plan for tiers 2 and 3 separately, due to the low number of enrollees in these tiers.

To compare DOD's projected costs for the TRS program before implementation to DOD's reported costs for the program in 2005 and 2006, we reviewed the analyses prepared by DOD before TRS's implementation that projected (1) the number of individual and family plans in each tier of the TRS program and (2) the costs per plan of providing the TRS benefit.

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<sup>1</sup>In our analysis, we calculated a separate average cost per TRS plan for individual and family coverage—not the average cost per TRS enrollee.

<sup>2</sup>By law, under a three-tiered premium structure in effect during fiscal year 2007, qualification criteria for TRS were set for each of three separate tiers: Members of the Selected Reserves who served in a contingency operation for 90 or more continuous days since September 11, 2001, qualified to purchase TRS coverage under tier 1 and paid 28 percent of the total premium. Members of the Selected Reserves who did not have such service but were either unemployed, self-employed, or not eligible for employer-sponsored insurance qualified to purchase TRS coverage under tier 2 and paid 50 percent of the total premium. Members of the Selected Reserves who did not qualify for tier 1 or tier 2 were qualified to purchase TRS coverage under tier 3 and paid 85 percent of the total premium. Due to a change in law, since October 1, 2007, all enrollees have paid 28 percent of the total premium.

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These projections were the two major factors used by DOD to estimate TRS costs. We compared these data with reported TRS enrollment and cost data from April 2005 through June 2007. In reporting the results of our comparison we use cost data through 2006 only, because some cost data for 2007 were incomplete. We also reviewed DOD internal documents and interviewed DOD officials.

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### Calculation of Average Costs per TRS Plan

To determine the average cost of providing benefits under TRS for 2006—for individual and family plans—we reviewed TRS enrollment data and TRS purchased care cost data, administrative cost data, and data on the costs of providing TRS benefits through MTFs, each of which were provided to us by DOD.

DOD officials provided TRS enrollment data to us in the form of multiple reports from the Defense Enrollment Eligibility Reporting System for each month from May 2005 through June 2007. Each report lists the number of TRS plans and enrollees in individual and family plans broken down by tier. Using these reports, we calculated the average number of TRS plans and enrollees in each month.

For each month, from May 2005 through June 2007, we calculated the total costs of providing benefits under TRS by adding the cost components reported by DOD, which consist of purchased care costs, MTF costs, and administrative costs. Administrative costs were further divided among costs associated with claims processing and separate administrative fees levied by certain TRICARE managed care support contractors for each enrollee in each month.

For each month, we calculated the average cost per TRS plan for individual and family coverage by dividing the total costs of providing benefits under TRS by the average number of TRS plans. We determined the average cost of providing benefits under TRS in 2006—for single and family plans—by summing the monthly averages and weighting them by enrollment in each month.

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### Data Reliability Tests

To ensure that the DOD data were sufficiently reliable for our analyses, we conducted detailed data reliability assessments of the data sets that we used. We restricted these assessments, however, to the specific variables that were pertinent to our analyses.



We reviewed DOD data that we determined to be relevant to our findings to assess their quality and methodological soundness. Our review consisted of (1) examining documents that describe the respective data, (2) manually and electronically checking the data for obvious errors and missing values, (3) interviewing DOD officials to inquire about concerns we uncovered, and (4) interviewing DOD officials about internal controls in place to ensure that data are complete and accurate.

Our review revealed minor inconsistencies in DOD's data that we reported to DOD officials. Overall, however, we found that all of the data sets used in this report were sufficiently reliable for use in our analyses. However, we did not independently verify DOD's figures.

We conducted our work from May 2007 through October 2007 in accordance with generally accepted government auditing standards.

# Appendix III: Comments from the Department of Defense



## THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

DEC 14 2007

Ms. Laurie E. Ekstrand  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street, N.W.  
Washington, DC 20548

Dear Ms. Ekstrand:

This is the Department of Defense (DoD) response to the U.S. Government Accountability Office (GAO) draft report; 'MILITARY HEALTH CARE: Cost Data Indicates that TRICARE Reserve Select Premiums Exceed the Costs of Providing Program Benefits,' dated October 26, 2007, (GAO Code 290632/GAO-08-104).

Thank you for the opportunity to review and comment on the draft report. Overall, the Department concurs on the subject draft report. Our response to the recommendations is enclosed.

GAO's overall finding was that the Department did not accurately estimate the costs of the TRICARE Reserve Select (TRS) program and proposed two recommendations.

As a first recommendation, GAO suggested that DoD stop basing TRS premiums only on Blue Cross Blue Shield premium adjustments and use the reported costs of providing benefits through TRS program when adjusting TRS premiums in future years, as limitations associated with the reported cost data decrease. GAO's second recommendation directed DoD to explore options for addressing instances in which premiums have been either significantly higher or lower than program costs in prior years, including seeking legislative authority as necessary.

From the outset of TRS program, the Department's strategy was to evolve the process, procedures, and analytical framework used to determine TRS premiums as the quality and quantity of actual reported data improved. Congressionally directed changes to the program, via three consecutive National Defense Authorization Acts (fiscal years 2005-2007), has slowed the data maturation process. Nonetheless, the Department remains committed to improving the accuracy of TRS premium projections. Both of GAO's recommendations are consistent with and reaffirm the Department's basic strategy.

My points of contact regarding on this audit are Mr. Sean Coyle who can be reached at (303) 676-3629 (Functional), and Mr. Gunther Zimmerman (Audit Liaison) who can be reached at (703) 681-4360.

Sincerely,



S. Ward Casscells, MD

Enclosures:  
As stated

**U.S. GOVERNMENT ACCOUNTABILITY OFFICE DRAFT  
REPORT-DATED OCTOBER 26, 2007  
(GAO CODE 290632/GAO-08-104)**

**'MILITARY HEALTH CARE: Cost Data Indicates that TRICARE Reserve Select  
Premiums Exceed the Costs of Providing Program Benefits'**

**DEPARTMENT OF DEFENSE (DoD) COMMENTS  
TO THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE  
RECOMMENDATIONS**

**RECOMMENDATION 1:** DoD stop basing TRICARE Reserve Select (TRS) premium adjustments only on Blue Cross Blue Shield premium adjustments and use the reported costs of providing benefits through TRS program when adjusting TRS premiums in future years as limitations associated with the reported cost decrease.

**DoD RESPONSE:** Concur

**U.S. GOVERNMENT ACCOUNTABILITY OFFICE DRAFT  
REPORT-DATED OCTOBER 26, 2007  
(GAO CODE 290632/GAO-08-104)**

**'MILITARY HEALTH CARE: Cost Data Indicates that TRICARE Reserve Select  
Premiums Exceed the Costs of Providing Program Benefits'**

**DEPARTMENT OF DEFENSE (DoD) COMMENTS  
TO THE U.S. GOVERNMENT ACCOUNTABILITY OFFICE  
RECOMMENDATIONS**

**RECOMMENDATION 2:** DoD explore options for addressing instances in which premiums have been either significantly higher or lower than program costs in prior years, including seeking legislative authority as necessary.

**DoD RESPONSE:** Concur

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# Appendix IV: GAO Contact and Staff Acknowledgments

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## GAO Contact

Laurie Ekstrand, (202) 512-7114 or [ekstrandl@gao.gov](mailto:ekstrandl@gao.gov)

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## Acknowledgments

In addition to the contact named above, Thomas Conahan, Assistant Director; Krister Friday; Adrienne Griffin; William Simerl; and Michael Zose made key contributions to this report.

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