MANAGING THE MILITARY HEALTH SYSTEM

The FY 2013 budget includes $48.7 billion for the DoD Unified Medical Budget to support our Military Health System (MHS). The MHS currently has 9.6 million eligible beneficiaries, which include active military members and their families, military retirees and their families, dependent survivors, and certain eligible Reserve Component members and their families.

Over the past decade, U.S. health care costs have grown substantially, and MHS costs have been no exception. The MHS costs have more than doubled from $19 billion in FY 2001 to this FY 2013 request of $48.7 billion, which includes $1.8 billion in estimated savings associated with several TRICARE benefit cost sharing proposals.

Figure 5-1. Military Health Care Costs[1/]
(Dollars in Billions)

Program	FY 2012 Enacted	FY 2013 Request
Defense Health (DHP)	32.5	32.5
Military Personnel[2/]	8.5	8.5
Military Construction[2/]	1.1	1.0
Health Care Accrual[3/]	10.7	6.7
Unified Medical Budget	**52.8**	**48.7**
Treasury Receipts for Current Medicare-Eligible Retirees[4/]	*9.4*	*9.7*

1/ Excludes OCO funds and other transfers. FY 2013 DHP and Health Care Accrual amounts include estimated savings from TRICARE benefit proposals of $452 million and $1,344 million, respectively.

2/ Funded in Military Personnel & Construction accounts.

3/ Includes health care accrual contributions into the Medicare-Eligible Retiree Health Care Fund to provide for the future health care costs of our personnel currently serving on active duty – and their family members – when they retire.

4/ Transfer receipts in the year of execution to support 2.2 million Medicare-eligible retirees and their family members. FY 2013 assumes $388 million in mandatory savings for TRICARE benefit proposals.

To address these rapidly rising costs, the Department has taken a comprehensive look at all facets of the MHS health care model – emphasizing the need to balance the number one priority of continuing to provide the highest quality care and service, while ensuring fiscally responsible management for long-term sustainment of the MHS benefit. The Department seeks to better manage our health benefit in a way that improves quality and satisfaction, while more responsibly managing costs by building a shared commitment to health care. The centerpiece of the MHS strategy is the Quadruple Aim:

The MHS Quadruple Aim:

- **Readiness:** Ensuring that the total military force is medically ready to deploy and that the medical force is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions.
- **Population Health:** Reducing the generators of ill health encouraging healthy behaviors and decreasing the likelihood of illness through focused prevention and the development of increased resilience.
- **Experience of Care:** Providing a care experience that is patient and family centered, compassionate, convenient, equitable, safe, and always of the highest quality.
- **Responsibly Managing the Total Cost of Health Care:** Creating value by focusing on quality, eliminating waste, and reducing un-warranted variation; considering the total cost of care over time, not just the cost of an individual health care activity.

Several initiatives support the Quadruple Aim. These include the expansion of Patient Centered Medical Home, moving from Healthcare to Health with particular focus on tobacco use and obesity, and emphasis on Patient Safety.

However, these efforts alone will not control the large increases in health care costs. In 1996, when TRICARE was fully implemented, a working age retiree's family of 3 who used civilian care contributed on average roughly 27 percent of the total cost of its health care. Today that percentage has dropped to only 11 percent. While health care costs have doubled or tripled over this time frame, a family's out of pocket expenses, including enrollment fees, deductibles and cost shares, has only grown by 20 percent – 30 percent.

With this in mind, in FY 2012, the Department proposed to implement a modest increase to TRICARE Prime enrollment fees for working age retirees and make small adjustments to retail and mail order pharmacy co-pays to incentivize the use of generic drugs and the most efficient source to fill prescriptions.

In FY 2013, the Department is seeking further changes phased over several years: (details are provided in Figure 5-2):

- Increase TRICARE Prime enrollment fee, institute an enrollment fee for TRICARE Standard/Extra, and increase Standard/Extra deductibles. It also adjusts the catastrophic cap to exclude enrollment fees. These changes will affect only retirees.
- Increase co-pays for pharmaceuticals (excludes active duty service members).
- Implement an enrollment fee for TRICARE-for-Life (TFL).
- Phase in fee changes over several years.
- Index fees/deductibles/Rx co-pays/catastrophic cap to reflect the growth in national health care costs.
- Exclude survivors of military members who died on active duty and medically retired members from any fee increases.

Despite these changes, DoD will continue to offer the most comprehensive health benefit, at lower cost to those it serves than most health plans in the nation – and deservedly so. Even after the proposed changes in TRICARE fees, the TRICARE benefit will remain one of the best medical benefits in the United States, with lower out-of-pocket costs than many other employers.

The Department will continue to invest in those programs and services critical to sustaining a strong Military Health System. These include:

- Medical readiness of the service members and military medical personnel to respond to any contingency around the globe;
- Support to wounded warriors and their families; and,
- A high quality health delivery system that offers great value, and further improves access to care and customer service for all.

Figure 5-2. TRICARE Proposals

TRICARE Prime for Working Age Retirees (under Age 65)

As part of the FY 2013 President's Budget, the Department will seek additional increases in the **TRICARE Prime** (Health Maintenance Organization (HMO) type plan) enrollment fees in order to bring the beneficiary cost share closer to the original levels mandated by Congress when the program was established. These increases will be phased-in over a 4-year period and will be tiered based on the amount of the beneficiary's military retirement pay. Table 1 displays the proposed fees by fiscal year for the three tiers of retired pay. After FY 2016, the enrollment fees will be indexed to increases in National Health Expenditures (NHE). The retired pay tiers will also be indexed to ensure beneficiaries are not pushed into a higher tier as a result of annual cost-of-living (COLA) increases. The construct and tiering are generally based on recommendations of the 2007 *Task Force on the Future of Military Health Care*.

Table 1 – TRICARE Prime Annual Family Enrollment Fees (Individual Fees = 50%)

Retired Pay	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016*	FY 2017
Tier 1: $0 – $22,589	$460/$520	$600	$680	$760	$850	$893
Tier 2: $22,590 – $45,178	$460/$520	$720	$920	$1,185	$1,450	$1,523
Tier 3: $45,179 & above	$460/$520	$820	$1,120	$1,535	$1,950	$2,048

* Indexed to medical inflation (National Health Expenditures) after FY 2016

TRICARE Standard and Extra for Working Age Retirees (under Age 65)

The **TRICARE Standard and Extra** (fee-for-service type) benefit programs currently have no enrollment fees and modest annual deductibles of $150 per individual and $300 per family. For FY 2013, the Department proposal will seek to implement an annual enrollment fee and increase deductibles. These increases displayed in Table 2 will be phased-in over a 5 year period and will then be indexed to increases in NHE.

Table 2 – TRICARE Standard/Extra Fees/Deductibles

Annual Enrollment Fees	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017*
Individual	$0	$70	$85	$100	$115	$130
Family	$0	$140	$170	$200	$230	$250
Annual Deductibles						
Individual	$150	$160	$200	$230	$260	$290
Family	$300	$320	$400	$460	$520	$580

* Indexed to medical inflation (National Health Expenditures) after FY 2017

TRICARE-for-Life Benefit (TFL) Benefit Program for Retirees age 65 and Older

Like almost all Americans, upon reaching age 65, TRICARE beneficiaries must enroll in Medicare and begin paying Medicare Part B (outpatient care coverage) premiums. With Part B coverage, Medicare typically covers only 80 percent of normal health care costs and most people choose to be covered by "Medigap" or employer-sponsored retiree health insurance to cover the additional costs as well as providing some prescription drug coverage. Enacted in 2001, the TFL program acts as a second payer plan for TRICARE beneficiaries covering the costs not paid by Medicare. While the average "Medigap" plan with comparable coverage carried premiums $2,100 per individual in 2009, there are currently no annual fees for TFL coverage. As part of the FY 2013, President's Budget, the Department is proposing to implement modest annual fees for TFL coverage. These fees will be phased in over a 4-year period and use the same tiering based on the beneficiary's retired pay along with the same indexing and exemptions as the proposed TRICARE Prime fees. Table 3 displays the proposed TFL fees by fiscal year for the three tiers of retired pay.

Table 3 – TRICARE-for-Life Annual Enrollment Fees – Per Individual

Retired Pay	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016*	FY 2017
Tier 1: $0 – $22,589	$0	$35	$75	$115	$150	$158
Tier 2: $22,590 – $45,178	$0	$75	$150	$225	$300	$317
Tier 3: $45,179 & above	$0	$115	$225	$335	$450	$475

* Indexed to medical inflation (National Health Expenditures) after FY 2016

Pharmacy Co-Pays

This proposal will adjust pharmacy co-pay structure for retirees and active duty family members to incentivize the use of mail order and generic drugs. Prescriptions will continue to be filled at no cost to beneficiaries at Military Treatment Facilities (MTFs). No fees would continue to apply to prescriptions for active duty service members. Table 4 displays the proposed co-pays for prescriptions filled through the TRICARE retail and mail order pharmacy programs.

Table 4 – Pharmacy Co-Pays

Retail – 1 month fill	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Generic	$5	$5	$6	$7	$8	$9
Brand	$12	$26	$28	$30	$32	$34
Non-Formulary*	$25	N/A	N/A	N/A	N/A	N/A
Mail-Order – 3 month fill						
Generic	$0	$0	$0	$0	$0	$9
Brand	$9	$26	$28	$30	$32	$34
Non-Formulary	$25	$51	$54	$58	$62	$66
Military Treatment Facilities	No Change – Still $0 Co-Pay					

* Non-Formulary pharmaceuticals will have limited availability in retail pharmacies

Catastrophic Cap

In order to maintain the adjusted beneficiary cost share, the annual catastrophic cap $3,000 per family will also be indexed to NHE and exclude enrollment fees.

Finally, to protect the most vulnerable, these proposals exempt survivors of members who die on active duty and medically retired and their family members from these increases. However, it should be noted that even once the proposal is fully implemented, the TRICARE Prime program remains a very generous benefit with the average beneficiary cost share well below the original 27 percent of health care costs when the program was fully implemented in 1996.

MILITARY RETIREMENT MODERNIZATION COMMISSION

The Department does not propose any changes to the military retirement system in the President's Budget for FY 2013. However, the Department requests that Congress establish a Commission to review military retirement in the context of overall military compensation. The Commission would be charged with determining whether there are cost effective changes that should be made to the current system. The President and the Secretary of Defense strongly recommend that any recommended changes be fully grandfathered – that is, they would only apply to new recruits.

The Department requests that the Commission operate under the following procedures, similar to those that govern actions by a BRAC Commission:

- The Department would make a formal recommendation to the Commission regarding changes in military retirement;
- After considering the Department's recommendation and other inputs, the Commission would make a recommendation to the President;
- The President could request that the Commission make changes in its recommendations but could not require changes;
- The President would decide whether to forward the Commission's recommendation to Congress; and
- If forwarded, Congress would have to vote up or down on the recommendation without amendment and under expedited procedures.

STRENGTHENING MILITARY FAMILIES

Support for military families is firmly established as a top priority for the Administration and has been personally endorsed repeatedly by the President, the First Lady, the Vice President, and Dr. Biden.

The Department remains fully committed to providing assistance to the All-Volunteer Force and their families particularly in light of the unprecedented demands that have been placed on them. The fact that families play a crucial role in supporting military members is not a new concept for family support policy makers or program developers. The family assistance programs serve a critical need in direct mission support for the mobilization and deployment of Active Duty military and the Guard and Reserve.

To that end, the Department has undertaken major initiatives to improve the quality of life of its military members and their families. Some initiatives focus primarily on the military member, while others – like child care and school programs – focus on their children and youth. Others are devoted to spouses. All are inextricably interwoven. All affect the family in total and are designed to reduce the burdens during all phases of deployment.