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WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

AUG 28 2007

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

The enclosed report responds to the request in Conference Report 109-702, accompanying the John Warner National Defense Authorization Act for Fiscal Year 2007, for the Secretary of Defense to submit a report on the advantages and disadvantages of an enrollment requirement for the TRICARE Standard option. The Department provided an interim report in February 2007.

The report presents four alternative designs for a TRICARE Standard enrollment option and it lists advantages and disadvantages of each. The most desirable alternative is identified as the one which best supports the Military Health System Strategic Plan goal to sustain the military health benefit through cost effective, patient-centered care and effective long-term patient partnerships. Achieving this goal requires a comprehensive, systems approach due to the complexity of the Military Health System with its many attributes and interrelationships. Consequently, the most desirable alternative for introducing an enrollment requirement for TRICARE Standard is one which is integrated with a complementary adjustment to other parts of the TRICARE beneficiary fee structure. The report includes an analysis of the expected financial contribution that the desired TRICARE Standard enrollment option would make to sustaining the TRICARE benefit.

Thank you for your continued support of the Military Health System.

Sincerely,

S. Ward Casscells, MD

Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

Report to Congress

Advantages and Disadvantages
of
An Enrollment Requirement
for the
TRICARE Standard Option

REPORT TO CONGRESS

ADVANTAGES AND DISADVANTAGES OF AN ENROLLMENT REQUIREMENT FOR THE TRICARE STANDARD OPTION

Introduction

Conference Report 109-702, accompanying the John Warner National Defense Authorization Act (NDAA) for Fiscal Year 2007, requests the Secretary of Defense to submit a report on the advantages and disadvantages of an enrollment requirement for the TRICARE Standard option. In February 2007, the Secretary sent to Congress an interim report about this issue. Provided herein is the final report.

Background

TRICARE is the Department of Defense (DoD) health plan for uniformed service members, family members of active duty personnel, retirees from the uniformed services, and retirees' eligible family members—a total of 9.1 million eligible beneficiaries. The DoD's TRICARE Management Activity (TMA) manages the plan. TRICARE provides three health plan options to beneficiaries under the age of 65:

1. TRICARE Prime — a managed care plan in which each participant is enrolled and is assigned a primary care manager (PCM) who provides required non-specialty care and assists the patient in accessing medically necessary specialty care. The PCM is either a member of a military treatment facility (MTF) medical staff or a medical provider in the TRICARE private sector care network. For specialty care, the TRICARE Prime enrollee must receive a referral from his/her PCM and authorization from a regional managed care support contractor. TRICARE Prime beneficiaries, except active duty service members (ADSMs) and their family members, pay an annual enrollment fee and modest, fixed copayments for care received in the private sector network. The plan also includes a TRICARE Prime point-of-service (POS) option. The POS option lets TRICARE Prime enrollees, except ADSMs, get non-emergency, TRICARE-covered services from any TRICARE-authorized provider without a PCM's referral or a regional contractor's authorization. POS annual copayments ($300 per person and $600 maximum per family) and deductibles (50 percent of the TRICARE allowable charge) will apply if the beneficiary elects the POS option.

2. TRICARE Standard — an open choice type of plan. TRICARE Standard is available to those beneficiaries, except ADSMs, under age 65 who are not enrolled in TRICARE Prime. TRICARE Standard medical providers are not members of the TRICARE private sector care network. Beneficiaries do not enroll in TRICARE Standard nor pay any annual enrollment fee, but they are subject to an

annual deductible and copayments. The latter are assessed as a percentage of the TRICARE allowable charge for services received. TRICARE Standard is the fee-for-service option that gives beneficiaries the opportunity to see any TRICARE-authorized provider--a licensed medical provider who is approved by TRICARE. Some beneficiaries' primary reason for choosing to use TRICARE Standard is the flexibility it affords in selecting medical providers as compared to TRICARE Prime. For beneficiaries living in areas where the TRICARE Prime network is not available, TRICARE Standard is their best option.

3. TRICARE Extra — a preferred provider organization (PPO) type of plan. Only TRICARE Standard beneficiaries are eligible for the TRICARE Extra option, which they use by obtaining care from a provider in the TRICARE private sector care network. Beneficiaries using TRICARE Extra pay no annual enrollment fee, but they are subject to the annual deductible and copayments. The latter are assessed as a percentage of the TRICARE allowable charge for services received, but at a lesser percentage than for care received from a provider outside the TRICARE private sector care network.

History

Currently, beneficiaries using the TRICARE Standard option do so without any enrollment requirement; introducing such a requirement has been considered at various times since the inception of the TRICARE program in 1995. In 2000, the Center for Naval Analysis (CNA) responded to a request from the Under Secretary of Defense for Personnel and Readiness to develop options for changing the TRICARE enrollment system. CNA proposed the following three options:

1. Option 1 would have affected under-age-65 retirees and was intended to make TRICARE Prime the most appealing health plan alternative while still offering the no-enrollment alternative of TRICARE Standard or an alternative of enrolling in TRICARE Extra. The TRICARE Prime annual enrollment fee was lowered from $230 per person and $460 maximum per family to $150 and $300, respectively, whereas an Extra enrollment fee was established at $150 and $300, respectively (offset by eliminating the $150/$300 TRICARE Extra per person/family annual deductible). Under this option, retirees under age 65 would have no longer been permitted to use MTFs on a space-available basis (i.e., only TRICARE Prime enrollees would have had continued access to MTF care among retirees under age 65). CNA expected modest cost increases would have resulted from implementing this option.

2. Option 2 would have imposed a mandatory enrollment requirement on all non-active duty beneficiaries. Because the CNA study was conducted before the advent of the TRICARE For Life benefit, this option would have permitted

Medicare-eligible retirees aged 65 and over to enroll in TRICARE Prime or TRICARE Standard/Extra. The TRICARE Prime annual enrollment fee would have increased from $230 per person and $460 maximum per family to $400 and $800, respectively, while a TRICARE Standard/Extra enrollment fee would have been established at $650 and $1,300, respectively. Like the first CNA option, this option would also have eliminated MTF access for beneficiaries not enrolled in TRICARE Prime. CNA expected a range of possible cost outcomes for this option, depending on the extent to which Medicare-eligible beneficiaries relied on the Military Health System (MHS).

3. Option 3 proposed a mandatory enrollment requirement for all non-active duty beneficiaries and an increase in the TRICARE Prime annual enrollment fee from $230 per person and $460 maximum per family, to $400 and $800, respectively. However, the Federal Employees Health Benefits Program (FEHBP) would have replaced TRICARE Standard/Extra. Furthermore, this option assumed that DoD would subsidize active duty family members' (ADFM) FEHBP premiums but that military retirees and their family members would pay a share of the FEHBP premium equivalent to that paid by other Federal Government retirees. Like the other options, under Option 3 only Prime enrollees would get access to MTF care. CNA estimated this option would increase MHS costs dramatically.

For all options studied, the CNA report concluded that MTF usage would decrease due to the elimination of space-available care. Further, while the report did not explicitly project cost impacts for beneficiaries, it acknowledged that the options presented might increase beneficiaries' out-of-pocket costs and would constrain beneficiary choices.

During 2001 and 2002, DoD again considered the possibility of instituting universal, mandatory enrollment for TRICARE beneficiaries. This was done in response to reporting requirements specified in the Conference Report accompanying the NDAA for FY01 (Public Law 106-945) and the House Armed Services Committee Report (106-616) regarding TRICARE enrollment. The Conference Report requested the Department submit a plan for universal, continuous enrollment for all eligible beneficiaries beginning in FY02. The House Armed Services Committee Report requested that the Department submit a report on the study of benefits to be gained by requiring eligible beneficiaries to enroll in any of the Department's TRICARE programs. In May 2002, the Department submitted to Congress a single document that addressed both of these reporting requirements. In its report, the Department presented four enrollment options:

1. **Required Selection with a Selection Fee and MTF Prime Lockout:** Under the first option, DoD would require all eligible beneficiaries to indicate whether they intend to use the MHS over the next year and to pay a nominal selection fee (e.g., $10–$50) if they do. This option would require the beneficiary to register in the Defense Enrollment Eligibility Reporting System (DEERS), to select the MHS

and, in doing so, to express their preference for MTF care or civilian care during an open season each Fall. Enrollees who selected the MHS would also have the option to enroll in TRICARE Prime where available. Those beneficiaries who chose not to select the MHS would not be permitted to enroll in TRICARE Prime and would be locked out of the MTFs for twelve months, meaning they would have to rely on TRICARE Standard/Extra or other health insurance (OHI). The Department concluded the likely level of beneficiary dissatisfaction with this option would overshadow its intended benefits.

There were several advantages noted that would result from the implementation of this option. First, it would update DEERS system information by making any necessary corrections to beneficiary addresses or other key data. This would better define the MHS-reliant population and would help to ensure the accurate receipt by beneficiaries of important TRICARE communications (e.g., marketing materials regarding benefit changes). Also, the revenue collected from the selection fee would help to defray administrative costs.

However, there were also several disadvantages noted for this option. First, the requirement that beneficiaries "select" or be locked out from the MTF would require legislative change and would be highly unusual for an entitlement program. Another disadvantage of this option is that it might not be of any tangible worth to MTF commanders since it does not definitively establish who exactly will rely on MTF care versus private sector care. In this same vein, depending on the amount of the selection fee, some beneficiaries might "select" the MHS in order to preserve their future options (particularly MTF access) even if they plan to rely on OHI for the short-term. This would dilute the informational value of the "selection" itself in assisting DoD planning efforts. Further, because even beneficiaries who do not select the MHS could rely on TRICARE Standard, the selection process would not fully define MHS reliants.

2. **Required Selection But Without a Selection Fee:** The second option was the same as the first, except that beneficiaries would not be required to pay an annual selection fee. An advantage of this option is that the lack of a selection fee would seem certain to reduce, although not eliminate, beneficiary objections. Offsetting this is the likelihood that without a selection fee many beneficiaries would select the MHS to preserve their options for MTF access, even if they did not actually intend to rely on the MHS, thus defeating the main point of the selection process as a means of defining a truly MHS-reliant, enrolled population.

3. **Required Selection with a Selection Fee and MTF Access Restricted to Prime Enrollees:** Under the third option, beneficiaries would have had to enroll in TRICARE Prime in order to retain MTF access. There would no longer be space-available care for non-enrolled beneficiaries. The main advantage of this option is

that DoD would achieve the benefits of TRICARE Prime enrollment for a larger number of beneficiaries. The primary disadvantages of this option were that beneficiaries would have less freedom of choice and would be likely to object strongly to such restrictions, that MTF specialty clinics might not get the necessary workload volume if provided care were limited to enrollees only, and that this option would require significant legislative changes.

4. **Required Selection without MTF Lockout:** Under this option, beneficiaries would have been required to select the MHS (as in Options 1, 2, and 3), but no MTF lockout would occur if the beneficiary did not select the MHS. Regardless of whether a selection fee is required, this option would not be very effective because beneficiaries are unlikely to take selection seriously in the absence of a penalty for not selecting.

Current Situation

Factors such as an aging population, rapidly increasing medical provider fees, addition of covered services to the TRICARE benefit, increased utilization by beneficiaries of covered services, and addition of beneficiary categories are contributing significantly to growth in the annual cost of military health care, which has more than doubled—from $19 billion to $39 billion—since 2001. In a recent presentation (GAO-07-766CG, April 18, 2007) to the Task Force on the Future of Military Health Care, the Comptroller General of the United States reported that in FY05, health care spending accounted for 7.5 percent of DoD's total discretionary budget and is expected to increase to 12 percent by FY15.

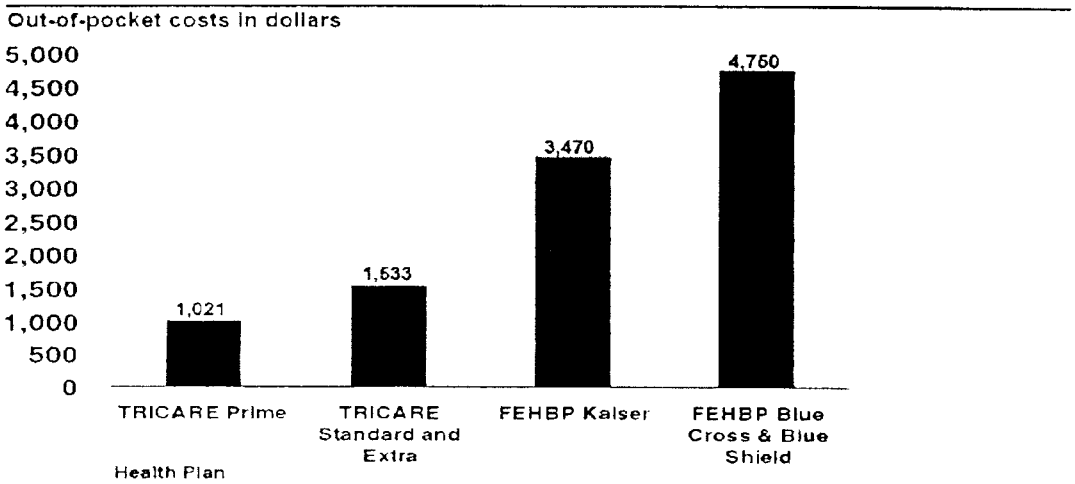
As the military health care budget continues to absorb an ever greater percentage of the Department's top line, the MHS must take steps to control costs if the TRICARE benefit is to be sustained. Included in the MHS Strategic Plan is the goal to sustain the military health benefit through cost effective, patient-centered care and effective long-term patient partnerships. The MHS has already implemented a number of initiatives directed at contributing to achievement of this goal. For example, the provision of the health care benefit in the TRICARE network is accomplished through competitively awarded contracts under which the performing contractors are provided incentives to keep costs under control while being held, under risk of financial penalty for failure to do so, to meeting various customer-centered performance standards. In another example, the TRICARE pharmacy benefit has been restructured to motivate beneficiaries to use the lowest cost medication appropriate to their treatment requirements. While these and other current initiatives may have an effect on reducing the growth in MHS costs, it is clear that much more must be done to ensure sustainment of the TRICARE benefit. Indeed, the Comptroller General, in the presentation cited above, pointed out that in the period from FY01 through FY05, DoD's spending for health care had increased at a

cumulative rate of growth that was 25 percent greater than that for DoD's total discretionary budget authority.

Sustaining the Benefit in an Environment of Increasing Costs

The Department continues to believe that a key component in any comprehensive effort to sustain the TRICARE benefit is to include the beneficiaries as partners in the effort, as indicated in the MHS Strategic Plan goal mentioned in the paragraph above. In this regard, examination of the cost contributions made by TRICARE beneficiaries for their participation in the health plan reveals opportunities for making equitable adjustment to beneficiaries' historical contribution requirements to achieve cost reductions without compromising quality of care provided. While TRICARE spending has grown dramatically over the past decade, the costs to beneficiaries have been constrained. This means that during the period, on a percentage basis, the Government/beneficiary cost sharing mix has shifted in a direction away from beneficiaries toward the Government. In FY05, under-age-65 retirees and their dependents paid just 12 percent of their TRICARE health care costs, down from 27 percent in FY96. Factors producing this shift include no increase in TRICARE Prime enrollment fees since 1995, no increase in TRICARE deductibles since 1995, reduction of the catastrophic cap (i.e., the limit on the annual cost to a beneficiary) from $7,500 to $3,000 for under-age-65 retirees and their dependents, elimination of TRICARE Prime copayments for dependents of ADSMs, and continuation of the provision that beneficiaries participate in TRICARE Standard/Extra without having to pay an enrollment fee. One result is that TRICARE beneficiaries pay much less, as displayed in the following chart, on an annual basis for their health care coverage than do participants in many other health plans, in which participation costs have typically been indexed to inflation rather than being held fixed or reduced.

Fiscal Year 2005



There are two TRICARE health plans that require enrollment and charge some participants periodic payments for plan coverage. First, TRICARE Prime programs are similar to HMOs. Retirees and their family members are charged an annual enrollment fee of $230 for individual coverage and $460 for family coverage. They are charged copayments for private sector care. ADFMs have never been charged enrollment fees, and copayments were eliminated by the NDAA for FY01. They are charged POS fees for care received without a referral that require a referral.

Originally established by Section 701 of the NDAA for FY05, TRICARE Reserve Select (TRS) is the second TRICARE health plan that requires enrollment. TRS is a premium-based TRICARE health plan. Selected Reservists who meet statutory qualifications can purchase TRS coverage. TRS members are charged monthly premiums. The three premium tiers that resulted from the NDAA for FY06 will be restructured so that all will pay only 28 percent of the total cost of the premium. Currently, those rates are $81.00 for TRS member-only coverage and $253.00 for TRS member and family coverage. Rates are subject to adjustments effective January first of each year, although they are currently under a statutory freeze. TRS members and their covered family members are charged the same deductibles and cost shares that apply to ADFMs under TRICARE Standard and TRICARE Extra. TRICARE Prime programs are not offered under TRS.

Objectives of an Enrollment Requirement

In analyzing the potential design options, features, advantages, and disadvantages of a TRICARE Standard enrollment requirement, the Department has identified three objectives such an enrollment system should seek to achieve:

1. The first objective is that the enrollment system must promote good management of the MHS. An enrollment requirement achieving this objective would (a) support reliable budget estimates, (b) improve success in addressing beneficiary preferences by aligning health care delivery to meet beneficiary needs, and (c) enhance ability to operate within the MHS and DoD budgets.

2. The second objective of an enrollment system is to retain a choice of TRICARE health plan options for beneficiaries. The enrollment system must recognize that no single plan is best for all families and that beneficiaries should be able to choose from among reasonable options. Different enrollment options should emphasize different attributes related to the circumstances and desires of varied segments of a large and diverse beneficiary population. These attributes include (a) reasonable beneficiary cost sharing, (b) access to care in MTFs, (c) broad selection of quality health care providers, (d) opportunity for the beneficiary to establish and maintain a clinical relationship with a health care manager, and

(c) minimal inconvenience to the beneficiary with regard to making appointments, payments, and general administration.

3. The third principal objective of an enrollment system would be that it complements the unique features of the MHS. Among those unique features are (a) the MHS readiness mission is paramount and requires support from a health plan with facility, staffing, and operational attributes unlike civilian health plans; (b) each MTF has a limited capacity that varies considerably among the facility's departments and clinics; and (c) a considerable number of MHS beneficiaries have access to OHI coverage that is often, by law, the primary payer.

Optimizing the degree to which each of these three objectives is achieved is the key to attaining the MHS Strategic Plan goal of sustaining the military health benefit through cost effective, patient-centered care and effective long-term patient partnerships. However, the MHS is a complex system with many attributes and interrelationships. It is driven by factors such as an absolute mandate to ensure medical readiness of the military operating forces, beneficiary choice and expectations, a demographically diverse set of covered lives, dollar and personnel resource constraints, design of the various TRICARE health plan alternative coverage options, accepted current medical practice, and congressional direction. As is usually the case with any complex system whose operation is impacted by a large set of variables, achieving optimum performance of the system demands that the contribution of the variables be controlled to the extent possible in a complementary mix. Only then can the system achieve optimum performance. This means that changing just one of the variables while holding the rest constant may not produce the desired increase in the system's performance. In fact, isolating attention to just one of the independent variables that influence system performance could actually result in system performance degradation. Applying this widely recognized system optimization concept to the topic of this paper, the Department has examined a range of alternatives for implementing such a requirement and assessed their impact upon achieving the overarching MHS strategic plan goal of sustaining the TRICARE benefit.

TRICARE Standard Enrollment Alternatives

In responding to the reporting requirement in the NDAA for FY07 (House Report 109-702), the Department has considered four alternatives for instituting a TRICARE Standard enrollment requirement. This consideration encompasses assessment of the advantages and disadvantages of each alternative, including its potential contribution to achieving sustainment of the TRICARE benefit and support of the enrollment requirement objectives listed earlier in this report. In conjunction with complementary statutory and regulatory changes as necessary, if the Department were to implement one of the alternatives, participation in it would be open to those not enrolled in TRICARE Prime who are ADFMs, under-age-65 retirees from the uniformed services, or retirees' eligible family members.

Alternative 1: Require a one-time or annual enrollment in TRICARE Standard, but without an enrollment fee, while making no adjustment to any other part of the TRICARE program beneficiary fee structure: Under this alternative, beneficiaries must first indicate in an enrollment process that they intend to use that health plan option in order to obtain TRICARE Standard benefits.

Advantages:

- Would be viewed by beneficiaries as imposing only a small increase in their administrative requirement for using TRICARE.

- Would not give beneficiaries participating in any TRICARE option a basis for objecting to an increase in the TRICARE cost-sharing structure.

- Provides at least a limited basis for targeting some TRICARE beneficiaries not enrolled in TRICARE Prime for population health management services.

- Would provide an opportunity to make an annual update in DEERS record of address and OHI information for enrolling beneficiaries.

Disadvantages:

- Does not require an effective commitment by beneficiaries to use TRICARE Standard. Many might enroll to preserve their future options but have no intent for near-term reliance on TRICARE.

- Provides at most, a limited increase in information required to support reliable TRICARE budget estimates, and at worst, very misleading information upon which to base such estimates.

- Would require an extensive communication effort to ensure beneficiaries become aware that satisfying the enrollment requirement is prerequisite for obtaining TRICARE Standard coverage of their medical costs.

- Does not provide a reliable basis for planning potential future provision of population health management services to TRICARE Standard reliants.

- Provides no increased incentive for beneficiaries to rely on OHI as primary payer.

- Does not make an equitable adjustment in beneficiaries' contribution through cost-sharing to sustaining the TRICARE benefit.

- By once again highlighting the very low cost of participating in TRICARE, this might attract even more eligible beneficiaries who do not currently use the MHS, but rely on OHI.

- Would increase cost of the TRICARE program because it provides no offset to the administrative costs of implementing this alternative.

Alternative 2: Require annual enrollment in TRICARE Standard, with only a nominal enrollment fee required, while making no adjustment to any other part of the TRICARE program beneficiary fee structure: Under this alternative, beneficiaries must first pay an annual, nominal TRICARE Standard enrollment fee (e.g., $25–$50) in order to obtain TRICARE Standard benefits.

Advantages:

- Because only a nominal enrollment fee would be charged, beneficiaries would view this as the least objectionable implementation of a fee-based, annual enrollment requirement for TRICARE Standard.

- Would not give beneficiaries participating in TRICARE Prime a basis for objecting to an increase in the TRICARE cost-sharing structure.

- Provides at least a limited basis for targeting some TRICARE beneficiaries, not enrolled in TRICARE Prime, for population health management services.

- Would provide an opportunity to make an annual update in DEERS records of address and OHI information for enrolling beneficiaries.

Disadvantages:

- Compared to Alternative 1, limiting the enrollment fee to just a "nominal" amount only marginally increases the probability that enrollees have made an effective commitment to using TRICARE Standard. Many might still enroll to preserve their future options but have no real intent of near-term reliance on TRICARE.

- Provides, at most, a limited increase in information required to support reliable TRICARE budget estimates and, at worst, very misleading information upon which to base such estimates.

- There would likely be beneficiary objection to the introduction of even a "nominal" TRICARE Standard enrollment fee.

- Would require an extensive communication effort to ensure beneficiaries become aware that satisfying the enrollment requirement is prerequisite for obtaining TRICARE Standard coverage of their medical costs.

- A "nominal" enrollment fee might not offset the associated administrative costs to the TRICARE program.

- Does not make an equitable adjustment in beneficiaries' contribution through cost-sharing to sustaining the TRICARE benefit.

- By once again highlighting the very low cost of participating in TRICARE, this might attract even more eligible beneficiaries who do not currently use the MHS but rely on OHI.

Alternative 3: Require annual enrollment in TRICARE Standard, with payment of an enrollment fee related to the current TRICARE Prime enrollment fee (e.g., 40–50 percent of Prime enrollment fee), while making no adjustment to any other part of the TRICARE program beneficiary fee structure: Under this alternative TRICARE Standard beneficiaries, in addition to remaining responsible for their historic deductible and copayment costs, would pay an annual enrollment fee, just as participants in TRICARE Prime.

Advantages:

- By requiring that beneficiaries desiring to use TRICARE Standard pay a greater than "nominal" enrollment fee, would increase the likelihood their enrollment decisions are based on intent to be TRICARE-reliant.

- Might induce current and potential TRICARE Standard users to be totally reliant on OHI.

- Provides increase in information useful for making reliable TRICARE budget estimates.

- TRICARE Standard enrollment fees likely would offset the associated administrative costs to the TRICARE program.

- Provides an improved basis for targeting some TRICARE beneficiaries not enrolled in TRICARE Prime for population health management services.

- Would provide an opportunity to make an annual update in DEERS records of address and OHI information for enrolling beneficiaries.

Disadvantages:

- Would likely elicit significant objection from TRICARE beneficiaries.

- Would increase costs to TRICARE for beneficiaries who decide, as a result of introduction of a TRICARE Standard enrollment fee, to shift from reliance on TRICARE Standard to enrollment in TRICARE Prime. Does not provide any disincentive, such as raising TRICARE Prime enrollment fees, to dissuade beneficiaries from making such shifts.

- By keeping constant all other aspects of the TRICARE program fee structure, does not make the comprehensive changes necessary to optimize the MHS's ability to sustain the TRICARE benefit.

- Would require an extensive communication effort to ensure beneficiaries become aware that satisfying the enrollment requirement is prerequisite for obtaining TRICARE Standard coverage of their medical costs.

Alternative 4: Require annual enrollment in TRICARE Standard with payment of an enrollment fee that is indexed to inflation and related to the current TRICARE Prime enrollment fee (e.g., 40–50 percent of Prime enrollment fee), while making adjustments to certain other parts of the TRICARE program beneficiary fee structure: Under this alternative, the MHS would take a "systems approach" to implementing a TRICARE Standard enrollment fee requirement. Such an approach recognizes that, in total, the various elements of the current fee structure interact to affect the contribution that TRICARE costs and beneficiary choices make to MHS operational and financial outcomes. These interactions must be controlled, to the extent possible, to produce a complementary mix that optimizes the MHS's ability to sustain the TRICARE benefit.

Advantages:

- Makes a number of the comprehensive and interrelated changes necessary to optimize the MHS's ability to sustain the TRICARE benefit.

- By requiring that beneficiaries desiring to use TRICARE Standard pay a greater than "nominal" enrollment fee, would increase the likelihood their enrollment decisions are based on intent to be TRICARE-reliant.

- Might motivate TRICARE beneficiaries who have not used the benefit to remain reliant on OHI.

- Provides increase in information useful for making reliable TRICARE budget estimates.

- TRICARE Standard enrollment fees likely would offset the associated administrative costs to the TRICARE program.

- Provides an improved basis for targeting some TRICARE beneficiaries, not enrolled in TRICARE Prime, for population health management services.

- Would provide an opportunity to make an annual update in DEERS records of address and OHI information for enrolling beneficiaries.

Disadvantages:

- Of the four alternatives considered for introducing TRICARE Standard enrollment, this one will elicit the greatest beneficiary dissatisfaction.

- Would require an extensive communication effort to convince beneficiaries that increasing a number of costs in the TRICARE beneficiary fee structure is a necessary component for ensuring sustainment of the benefit.

- Would require an extensive communication effort to ensure beneficiaries become aware that satisfying the enrollment requirement is prerequisite for obtaining TRICARE Standard coverage of their medical costs.

Summary Assessment of the Alternatives

The Department developed a summary assessment of the four alternatives displayed above for requiring enrollment in TRICARE Standard, using as assessment criteria both the enrollment objectives listed earlier in this report and the MHS Strategic Plan goal to sustain the overall TRICARE benefit. The summary assessment is presented in Table 1.

Table 1

Objective	Alternative 1	Alternative 2	Alternative 3	Alternative 4
Promote Good MHS Management	●	●	Y	●
Retain Beneficiary Choices	●	●	●	●
Complement Unique MHS Features	●	Y	●	●
Help Sustain the Overall TRICARE Benefit	●	●	Y	●

● Significantly contributes to achieving the objective.

Y Provides moderate contribution to achieving the objective.

● Provides little, if any, contribution to achieving the objective.

Of the alternatives considered, Alternative 4 (significant TRICARE Standard annual enrollment fee and increases in other TRICARE program beneficiary fees) is the one that makes the greatest overall contribution to achieving the objective criteria. The remainder of this report is devoted to presenting details of a notional potential revision to the TRICARE beneficiary fee structure that is consistent with the definition of Alternative 4. Of course, included in the revision is introduction of a TRICARE Standard enrollment fee. The analysis underlying these details was conducted in FY06 and assumed changes would first be introduced in FY07. Although the changes were never actually implemented, the results of the analysis provide useful insight to the benefits that could be realized through introduction of changes like those constituting Alternative 4.

A Potential Implementation Approach for Alternative 4

In FY06, the Department examined a package of three potential benefit changes: (1) the introduction of a premium for using TRICARE Standard/Extra, (2) increases in the outpatient deductible for Standard/Extra, and (3) increases in TRICARE Prime enrollment fees. These potential changes would apply only to retirees and retirees' eligible family members under age 65, referred to in total as non-active-duty dependents (NADDs).[1]

The potential premium and deductible increases would have three primary effects:

[1] The analysis discussed here assumes that all three changes would occur as a package. The effects would be different if only one or two of the three changes were implemented. For example, if Prime premiums were increased without similar cost sharing increases in Standard, many beneficiaries would likely simply shift from Prime to Standard rather than relying on OHI.

1. There would be fewer TRICARE users than would occur under current policy because (a) some current TRICARE users would stop using TRICARE and rely on their OHI and (b) these changes would deter some persons who have OHI from dropping their OHI and using TRICARE.

2. DoD would collect increased enrollment fee revenues and pay a lower share of the cost of TRICARE Standard services due to the higher deductibles.

3. Increasing the TRICARE Standard deductible would also reduce the utilization of services for the remaining users in TRICARE Standard.

The analysis assumed that FY07 would be the first year of changes to the enrollment premium and deductible costs and it utilized separate levels of premiums and deductibles for retired officers, senior enlisted retirees, and junior enlisted retirees. The levels are shown in Table 2 and are compared with the FY06 cost sharing amounts. The analysis assumed that the cost sharing amounts would be indexed in FY09 and beyond by the annual trend in FEHBP premiums, assumed to be a seven percent annual growth.

Table 2
Potential Premium and Deductible Levels for Retired Officers and Enlisted Retirees (Assumes Annual Indexing of 7 Percent Starting in FY 09)

	TRICARE Prime Premium	TRICARE Standard and Extra	
		Premium	Deductible
	Retired Officers		
FY 06	$230/$460	$0	$150/$300
FY 07	$500/$1,000	$150/$300	$225/$450
FY 08	$700/$1,400	$280/$560	$280/$560
FY 09+	Indexed	Indexed	Indexed
	Senior Enlisted Retired		
FY 06	$230/$460	$0	$150/$300
FY 07	$350/$700	$100/$200	$175/$350
FY 08	$475/$950	$200/$400	$185/$370
FY 09+	Indexed	Indexed	Indexed
	Junior Enlisted Retired		
FY 06	$230/$460	$0	$150/$300
FY 07	$275/$550	$75/$150	$175/$350
FY 08	$325/$650	$140/$280	$185/$370
FY 09+	Indexed	Indexed	Indexed

The analysis of these potential benefit changes is complicated by the timing of their implementation. Because some of the changes were assumed to be phased in over the FY07 to FY08 period, their full effects would not be immediate. More importantly, these potential changes would occur during a period in which the number of beneficiaries

using TRICARE rather than OHI is increasing. For the FY06 to FY11 period, the Department estimated that under current policy, the number of TRICARE users who are NADDs under the age of 65 would increase from 2.317 million to 2.675 million, a growth of 15 percent (see Table 3).

Current Policy Assumptions

In order to estimate projected savings from increases in premiums and deductibles, the analysis used current policy for NADD users and made assumptions about the mix of users by rank status (officer, senior enlisted, junior enlisted), the TRICARE Prime and non-Prime mix of users, and the Government cost per user each year.

The number of NADD users under age 65 has increased dramatically over the last six years due to a number of factors, including:

- Increases in the number of eligibles
- An increase in cost to workers of civilian health insurance relative to the cost of TRICARE coverage
- The reduced availability of civilian health insurance
- Increased benefits in TRICARE.

To project the number of future TRICARE users, a regression model was developed which related the historical number of NADD users (using quarterly data from FY99 through FY03) to historical observations of the factors noted above over the same time period.[2, 3] Using Managed Care Forecasting Analysis System (MCFAS) projections of eligible NADDs and historically-based projections of the other factors, analysts projected the number of future NADD users (see Table 3).

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[2] Users were initially measured as those beneficiaries who had at least one MTF or TRICARE private health sector visit during a given quarter. A subsequent analysis determined what the user count would be if "user" were defined as a full-time equivalent MHS-reliant person. This analysis involved two offsetting effects. First, a user count that starts with individuals who have a visit in the year understates the number of persons who rely on the MHS because it is missing those beneficiaries who are healthy enough in a given year not to need a visit and TRICARE Standard users who have one or two visits in the year but may not file a claim if their costs would be below the current deductible. Second, in the other direction, the initial user count includes individuals who have OHI and only use TRICARE as a second payer. A separate analysis was conducted of historical user data that adjusted the user counts upward to account for an estimate of healthy beneficiaries who would have used the MHS if they had needed care, while reducing the counts to credit users with OHI as only fractional users. This analysis found that these two effects almost exactly offset each other, in that the estimated "Full Time Equivalent (FTE) reliant" count was virtually equal to the original user count. Thus, for simplicity the analysis herein cites the unadjusted user counts, but with the understanding that these counts really represent estimated "FTE reliants."

[3] The model indicated very high "goodness of fit" values, including an adjusted R-squared of 0.982, F value of 175, and F significance of 1.16×10^{-11}.

Table 3 Projected Number of NADDs <65 under Current Policy			
	Users	**Eligibles**	**Users/Eligible**
FY 06	2,317,284	3,026,999	76.6%
FY 07	2,397,518	3,040,853	78.8%
FY 08	2,472,786	3,042,354	81.3%
FY 09	2,532,707	3,033,502	83.5%
FY 10	2,594,532	3,021,893	85.9%
FY 11	2,674,895	3,021,893	88.5%

To determine the mix of NADD users by rank status under current policy, analysts reviewed DEERS enrollment data and determined that 22 percent of NADDs under age 65 were retired officers, 45 percent were retired senior enlisted, and 33 percent were retired junior enlisted. The analysis assumed that these shares by rank would remain constant over the FY07 to FY11 period.

It was also determined that in FY05, 55 percent of NADD users under age 65 were enrolled in TRICARE Prime and 45 percent were non-Prime users. While the percentage of NADD users enrolled in Prime has been increasing over the last decade, the rate of increase slowed greatly during 2004 and 2005. Thus, under current policy, analysts assumed that over the FY07 to FY11 projection period, 55 percent of NADD users would be enrolled in TRICARE Prime and 45 percent would be non-Prime users. An additional assumption was that this Prime/non-Prime mix would not vary by rank status.

Analysts used DoD's M-2 database to tabulate FY05 MTF and civilian health care costs per user for NADDs under age 65 in TRICARE Prime and non-Prime. They then added costs that were not reflected in the M-2 health care data, such as TRICARE administrative costs and fees. They calculated a FY05 under-age-65 NADD cost per user in TRICARE Prime of $3,273 and a non-Prime cost per user of $2,646. After reviewing recent trends in the MHS cost per user for NADDs under age 65 and more general forecasts of cost trends in the health care sector, they estimated that these FY05 costs per user would increase by 10 percent in FY06, 9 percent in FY07, 8.5 percent in FY08, and at 8 percent annually, thereafter. The resulting estimates regarding government costs per user under current policy are presented in Table 4.

Table 4 Projected Government Cost Per User under Current Policy for NADDs <65			
	Prime	**Non-Prime**	**Difference**
FY 05	$3,273	$2,646	$627
FY 06	$3,600	$2,911	$690
FY 07	$3,924	$3,173	$752
FY 08	$4,258	$3,442	$816
FY 09	$4,599	$3,718	$881
FY 10	$4,966	$4,015	$951
FY 11	$5,364	$4,336	$1,028

Modeling User Changes Resulting From the New Premium and Deductible Policy

Increases in premiums and deductibles will reduce the number of NADD users. The literature indicates that elasticity estimates for premium increases range from -0.10 to -1.75.[4] That is, a 10 percent increase in premiums will result in a one percent to 17.5 percent reduction in enrollment. For the purpose of estimating the impacts of the types of premium increases analyzed here, an elasticity of -0.10 was assumed.[5]

In its modeling of the number of TRICARE NADD users under this option, the Department assumed that the number of users affected in TRICARE Prime versus TRICARE Standard/Extra would depend upon their respective enrollment premium and deductible increases. That is, if the option considered were to hypothetically lead to a 100 percent increase in the TRICARE Prime premium, then it was assumed the number of Prime users would be reduced by 10 percent (100 percent x -0.10). Similarly, if the combination of the TRICARE Standard/Extra enrollment premium and deductible were to hypothetically increase by 150 percent over the current deductible, then the analysts assumed that Standard/Extra users would decrease by 15 percent (150 percent x -0.10).

The projected number of users under current policy and the revised policy are presented in Table 5. The table shows a reduction in the estimated FY07 effects by 33

[4] Ringel JS and Eibner C, "Health Care Demand Elasticities and Their Implications for Military Health Cost Containment," RAND National Defense Research Institute, December 2004, PM-1761-OSD.

[5] An elasticity of -0.10 is within the range of a number of studies. An elasticity at the low end of the range in the literature was selected for two reasons specific to TRICARE. First, because TRICARE will still be less expensive to the beneficiary than most OHI plans, one would expect less elasticity than a situation in which an individual were reacting to premium changes among similarly priced plans. Second, the analysis uses the average cost per user in calculating the "user" savings, but this average cost is partly influenced by higher-cost individuals with chronic conditions, who would probably be less sensitive to a premium increase. Therefore, by using a relatively low elasticity assumption, this implicitly provides some offset for use of the average cost per user.

percent to account for the assumed time lag in beneficiaries' behavioral response (i.e., the elasticity was reduced for the first year of the policy change).

Table 5
Projected Number of NADD < 65 Users Under Current Policy and New Policy

	Current Policy Users		New Policy Users		Reduction in Users		
	TRICARE Prime	Non-Prime	TRICARE Prime	Non-Prime	TRICARE Prime	Non-Prime	Total
	All Users						
FY 06	1,274,506	1,042,778			0	0	0
FY 07	1,318,635	1,078,883	1,269,371	1,012,019	49,264	66,864	116,128
FY 08	1,360,032	1,112,754	1,215,159	924,550	144,873	188,204	333,077
FY 09	1,392,989	1,139,718	1,224,468	925,482	168,521	214,236	382,757
FY 10	1,426,992	1,167,539	1,232,284	924,538	194,708	243,001	437,709
FY 11	1,471,192	1,203,703	1,246,103	927,212	225,089	276,490	501,580
	Retired Officers						
FY 06	280,391	229,411	280,391	229,411	0	0	0
FY 07	290,100	237,354	267,283	213,500	22,817	23,854	46,671
FY 08	299,207	244,806	238,065	177,892	61,142	66,914	128,056
FY 09	306,458	250,738	237,305	175,650	69,153	75,088	144,240
FY 10	313,938	256,859	235,941	172,756	77,997	84,103	162,100
FY 11	323,662	264,815	235,355	170,183	88,308	94,631	182,939
	Senior Enlisted Retired						
FY 06	573,528	469,250	573,528	469,250	0	0	0
FY 07	593,386	485,497	572,643	458,390	20,743	27,107	47,850
FY 08	612,015	500,739	546,822	422,290	65,193	78,449	143,642
FY 09	626,845	512,873	551,010	423,308	75,835	89,565	165,399
FY 10	642,147	525,393	554,528	423,541	87,619	101,851	189,470
FY 11	662,036	541,666	560,746	425,518	101,290	116,148	217,439
	Junior Enlisted Retired						
FY 06	420,587	344,117	420,587	344,117	0	0	0
FY 07	435,150	356,031	429,445	340,129	5,704	15,903	21,607
FY 08	448,811	367,209	430,273	324,368	18,538	42,841	61,379
FY 09	459,686	376,107	436,152	326,524	23,534	49,583	73,117
FY 10	470,908	385,288	441,815	328,242	29,092	57,046	86,139
FY 11	485,493	397,222	450,002	331,511	35,491	65,711	101,202

Estimating Dollar Savings Resulting From the Policy Change

The analysis estimated the three types of savings resulting from the premium and deductible increases. The first savings category is the increased direct revenues resulting from higher premiums and deductibles. Second, there will be the savings from reducing the number of MHS users that would otherwise have occurred. Some current MHS users would shift to OHI, and some who would have dropped their OHI in the future to use the MHS instead would keep their OHI. And third, there will be the savings resulting from reduced utilization of services in Standard and Extra as a result of the higher deductible (i.e., with a higher deductible, non-enrollees would be somewhat less likely to consume health care services).

Analysts calculated direct revenues as the product of the number of users remaining in the MHS under the new policy (from Table 5) and the dollar increase in the premiums and deductibles (from Table 2), calculated on a per user basis. In the non-Prime case, three downward adjustments were made to the estimated deductible revenues:

- First, it was assumed that 5 percent of families using TRICARE Standard would have annual costs low enough that they would not pay any of the increased deductible amount.

- Second, the increased deductible revenue was offset for the coinsurance that otherwise would have been paid by the Standard and Extra users (25 percent and 20 percent, respectively); therefore, the new deductible revenue was reduced by an average coinsurance effect of 22.5 percent.

- Third, some non-Prime families (estimated at 20 percent in FY09) would exceed the $3,000 catastrophic cap limit and, thus, no additional revenues would be collected for these families.

Savings from a reduced number of users were calculated as the product of the change in the number of MHS users each year between current policy versus the proposed policy (from Table 5) times the estimated annual total government cost per user (from Table 4).

Increasing the deductible would reduce the demand for services among TRICARE Standard/Extra users. A study by Newhouse, et al.[6], which specifically addressed the effect of various deductible increases, suggests an elasticity in the neighborhood of -.075 for the effect of deductible increases on medical expenditures per covered beneficiary

[6] Newhouse, JP, et al., "The Effect of Deductibles on the Demand for Medical Care Services," *Journal of the American Statistical Association*, September 1980, Vol. 75, Number 371, pgs. 525-533.

(i.e., a hypothetical 50 percent increase in the deductible would result in a 3.75 percent reduction in medical expenditures per user). This elasticity, however, reflects the savings from two effects of an increased deductible: (1) the direct revenue effect from the beneficiary paying for more of the care, and (2) reduced demand for care because of the higher "price" (in the form of the deductible). Because the first effect (the direct revenue effect) is already credited elsewhere in the model described herein, to estimate just the utilization savings from the proposed deductible increases, DoD reduced the -.075 elasticity for the implied dollar savings in medical expenditures for the revenue portion of those savings to avoid double-counting the revenue effect. The balance of the savings represented the estimate of the utilization savings, for remaining users, resulting from the deductible increase.

Both the savings from the reduced users (relative to current policy) and the savings from reduced demand for services in the non-Prime category due to the deductible increase represent behavioral response by beneficiaries as a result of the new premiums and deductibles. Often such behavioral responses are not immediate. Therefore, for both the "users effect" elasticity and the "deductible utilization effect" elasticity, analysts assumed that only two-thirds of the elasticity responses would occur in FY07, with the full effect occurring in FY08.

The cost analysis also incorporated an estimate of the administrative costs of these policy changes. These administrative costs include an estimated one-time implementation cost of $17 million for modifying systems and procedures to implement the new enrollment premiums for TRICARE Standard users and educate beneficiaries about the new policies and procedures. Ongoing annual cost to process the new enrollments in TRICARE Standard and to collect the new Standard premiums was estimated to be $24–$25 million. This estimate reflects an assumed average cost of $25 per Standard user (plus annual inflation) for enrollment processing, premium collection, and beneficiary education related to these requirements. These estimated administrative costs are quite small relative to the savings estimates, however.

Summary of Estimated Savings

Applying the methodology outlined above, DoD estimated that the proposed premium and deductible changes would produce savings of $9.7 billion over the period FY07–FY11, as indicated in Table 6.

Table 6
Estimated Savings for Potential TRICARE Premium and Deductible Increases for NADDs <Age 65
(Dollars in Millions)

	Revenue Effect	User Reduction Effect	Deductible Utilization Response	Administrative Costs	Total
FY 07	$199	$405	$15	($41)	**$578**
FY 08	$348	$1,265	$40	($24)	**$1,629**
FY 09	$393	$1,571	$72	($24)	**$2,012**
FY 10	$442	$1,943	$100	($25)	**$2,460**
FY 11	$496	$2,406	$134	($25)	**$3,011**
Total	$1,877	$7,590	$361	($139)	**$9,690**

Conclusion

Introduction of an enrollment requirement for TRICARE Standard will produce significant cost savings if accompanied by charging an enrollment premium and if done in conjunction with upward adjustment of TRICARE Standard deductible fees and TRICARE Prime enrollment fees. Limiting revision of the TRICARE beneficiary fee structure to, at most, imposition of a TRICARE Standard enrollment fee would have limited, if any, positive impact upon the MHS's chances of sustaining the TRICARE benefit. Consequently, DoD concludes that as a means of introducing a TRICARE Standard enrollment requirement, Alternative 4 (significant TRICARE Standard annual enrollment fee and increases in other TRICARE program beneficiary fees) is the only alternative of those considered for which the advantages would clearly outweigh the disadvantages.