

# CRS Report for Congress

## **Military Medical Care: Questions and Answers**

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**Prepared for Members and  
Committees of Congress**

# Military Medical Care: Questions and Answers

## Summary

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

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

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

The military health system currently includes some 75 hospitals and 461 clinics serving an eligible population of 8.9 million. It operates worldwide and employs some 39,000 civilians and 92,000 active duty military personnel. Calculating the total cost of military medical spending is complicated by the different categories of funds involved; DOD statistics on total medical spending indicate a growth from \$17.5 billion in FY2000 to an estimated \$37 billion in FY2008 (the latter figure includes an accrual fund for future retirees).

CHAMPUS was originally intended to provide retirees with health care benefits from the time of their retirement, usually in their mid-40s, to the time they become eligible for Medicare at age 65. In response to concerns about growing medical costs for retirees over age 65, the FY2001 Defense Authorization Act established a program, known as Tricare for Life, to serve as a second payer to Medicare for retirees and their spouses and survivors beginning in FY2002. Congress also extended a pharmacy benefit to Medicare-eligible beneficiaries.

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

This report will be updated as new information becomes available. Military health care issues are addressed in annual defense authorization and appropriations bills; for additional details and the status of current legislation, see CRS Report RL33999, *Defense: FY2008 Authorization and Appropriations*, by Pat Towell, Stephen Daggett, Amy Belasco.

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# Military Medical Care: Questions and Answers

## Most Recent Developments

Although the Administration based its budget submission for FY2008 on assumed savings from higher enrollment fees for retirees under age 65 and for pharmaceuticals, the FY2008 Defense Authorization Act (P.L. 110-181) retained current levels through the end of FY2008. (For further information, see CRS Report RL34169, *The FY2008 National Defense Authorization Act: Selected Military Personnel Issues*, by David F. Burrelli, Coordinator.)

Media reports about conditions of care provided to military personnel at Walter Reed Medical Center, especially outpatients undergoing therapy, led to leadership changes at Walter Reed and in the Army Department and to several assessments of medical care for servicemembers returning from combat. P.L. 110-181 included various “Wounded Warrior” provisions designed to encourage greater coordination between the Defense Department and the Veterans Affairs Department, reform of disability evaluation processes, and further research on Post-traumatic Stress Disorder (PTSD) and Traumatic Brain Injuries (TBI).

## Background and Analysis

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

The implementation of Tricare and other efforts to manage DOD health care more efficiently as well as downsize as part of the overall post-cold war reductions of the entire Defense Department, meant that less care was available to non-active duty beneficiaries, especially to those aged 65 and over. Informed, articulate, and well-organized, this population sought authorization to obtain health care benefits after they became eligible for Medicare. The Defense Authorization Act for FY2001

(P.L. 106-259) provided that DOD would cover costs not covered by Medicare and also established a pharmacy benefit in a program known as Tricare for Life.

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

## **Questions and Answers**

### **1. What Is the Purpose of DOD's Military Health System?**

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

In support of those in uniform, the military health system also provides, where space is available, health care services to dependents of active duty service members. Space available care is also provided to retirees and their dependents. Some former spouses are also included. Since 1966, civilian medical care for dependents of active duty personnel, and for retirees and their dependents who are under age 65, has been available (with certain limitations and co-payments) through CHAMPUS. Since October 2001, retirees and their dependents eligible for Medicare (and enrolled in Medicare Part B) have had access to Tricare for Life, which pays most charges that are not covered by Medicare. Retirees also have a pharmacy benefit.

### **2. What Is the Structure of the Military Health System?**

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

The military health system currently includes 75 hospitals and 461 clinics operating worldwide, and employs more than 39,000 civilians and 92,000 active duty military personnel. Direct care costs include the provision of medical care directly

to beneficiaries, the administrative requirements of a large medical establishment, and maintaining a capability to provide medical care to combat forces in case of hostilities. Civilian providers under contract to DOD have constituted a major portion of the defense health effort in recent years.

Even if the number of active duty personnel in DOD remained the same over the next few years, costs associated with the military health system are expected to grow. This results from general inflation in the cost of health care and an increasing percentage of care being provided to retirees and their dependents. (In 1950 retirees made up 8% of those eligible for military health care; by 1997 it was over 50%.) Reductions in direct care can actually lead to growth in overall DOD health spending because beneficiaries whose access to military medical facilities is removed through base closures may turn to more costly care from civilian providers, for which they can seek reimbursement from DOD.

Each year the Office of the Secretary of Defense (OSD) forwards a budget request to Congress for the Defense Health Program (DHP), which includes monies needed for procuring equipment, operation and maintenance, and care for civilian beneficiaries. Funding for the compensation of military medical personnel is contained in the Military Personnel appropriation accounts of the individual military departments. Additional requests are made in procurement and military construction accounts.

### **3. How Much Does Military Health Care Cost Beneficiaries?**

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

Tricare costs vary by the option selected. Active duty personnel are automatically enrolled in Tricare Prime without any premiums; their dependents may join, also without premiums. Retirees (under age 65) must pay \$230 (individual) or \$460 (family) each year in enrollment fees. Small co-payments are required for visits to civilian care providers who are part of the Tricare network.

Tricare Standard has a more complicated cost structure. There are no premiums or enrollment fees. At present, for outpatient care in civilian hospitals and clinics, there is a yearly deductible of \$150 for an individual and \$300 for a family (with lower fees for the most junior enlisted personnel). After the yearly deductible is met, dependents of active duty personnel pay 20% of CHAMPUS-approved care; all others pay 25%. For inpatient care, there is no deductible for CHAMPUS-approved care, but families of active duty service members pay a small *per diem*. Other Tricare beneficiaries will pay the lesser of 25% of the billed charges or a fixed daily amount (\$535.) of care covered by Tricare. In addition, there is a “cap” on annual care; active duty families are reimbursed for allowable expenses over \$1,000; other families are reimbursed for allowable expenses over \$3,000. These figures are generalized; there are a number of important exceptions that are explained in the Tricare Handbook and

in the underlying Federal Regulations (32 CFR 199). The Handbook urges beneficiaries to check with their Health Benefits Advisors before seeking care.

Tricare Extra, the preferred provider option, has a cost structure similar to Tricare Standard except that beneficiaries who use health care providers in the Extra network pay 5% less than they would if using non-network providers. Inpatient care costs \$14.80 per day for active duty dependents and \$250 per day (or 25% of daily hospital costs, whichever is less) for retirees and their dependents. Care may still be obtained from military facilities if space is available.

As part of the FY2007 budget submission, the Administration requested congressional authority to increase enrollment fees and co-payments for retirees and their dependents who are not eligible for Medicare and Tricare for Life. DOD, maintaining that costs of defense health care have doubled over the past decade and can be expected to reach \$64 billion by FY2015, sought to have non-Medicare eligible retirees pay a larger share of their health care costs. It also proposed that rates be adjusted annually for inflation. The Administration expressed particular concern that private employers and state and local governments have encouraged their Tricare-eligible employees to depend on DOD rather than provide a benefit. In addition to higher enrollment fees for Tricare Prime and higher deductibles for Tricare Standard, the plan included small increases in co-payments for prescriptions obtained in retail pharmacies and a few medications would not be covered; this increase would also apply to beneficiaries who are eligible for Medicare. These proposals were not accepted, but Congress established a Task Force on the Future of Military Healthcare to assess and make recommendations regarding the availability and affordability of military healthcare over the long term. In its December 2007 final report, the Task Force recommended phased-in changes in enrollment fees and deductibles for retirees under 65 “that restore cost-sharing relationships put in place when Tricare was created.” In addition, the Task Force recommended indexing the cost-sharing relationships and a modest enrollment fee for Tricare for Life beneficiaries. (See [<http://www.dodfuturehealthcare.net>].) A GAO assessment (GAO-07-647) concluded that although the DOD proposal for higher enrollment fees and deductibles might yield some \$2.3 billion in savings, it would be unlikely to save the \$9.8 billion that has been claimed. The Administration proposed higher fee levels for FY2008, but defense authorization legislation retains them at current levels, and the provision was retained in the FY2008 Defense Authorization Act (section 701, P.L. 110-181).

#### **4. In What Ways Has the Military Health System Been Changing in Recent Years?**

During the Cold War, military health care was designed to support a full-scale, extremely violent war with the Soviet Union and its allies in Europe. High casualties were anticipated along with a need for in-theater medical treatment facilities. The collapse of the Soviet Union and the end of the Warsaw Pact led to a major reassessment of U.S. defense policy. In the future, defense planners believe, the most likely conflicts will be of limited duration and involve smaller numbers of troops. The overall size of the active duty force has been reduced by one-third since the mid-1980s. Planners expect that casualties can be treated locally (with greater reliance on telemedicine) or, if necessary, evacuated to military medical facilities in

the continental United States (CONUS). This strategic planning, along with associated military personnel reductions, requires a smaller medical establishment, fewer military medical personnel, and the closure of a number of hospitals and clinics.

In the mid-1990s, the number of military medical personnel declined by 15%, and the number of military hospitals was reduced by one-third. On the other hand, the number of potential beneficiaries of military medical care who are over age 65 has grown in absolute terms to 1.2 million, and now represents about one-half of the beneficiary population. This number is expected to grow until 2009. Most retirees become eligible for Medicare when they reach age 65 although some disabled retirees become eligible for Medicare earlier. In 1991 Congress acted (in P.L. 102-190) to reestablish CHAMPUS eligibility for persons under age 65 who become eligible for Medicare, Part A because of disability. Such persons are, however, required to enroll in Medicare Part B (and pay premiums) to be eligible for Tricare.

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

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

Tricare Standard has been the military equivalent of a health insurance plan, run by DOD, for active duty dependents, military retirees and the dependents of retirees, survivors of deceased members, and certain former spouses.<sup>1</sup> Unlike private insurance plans, Tricare Standard does not require premiums. If care at a military

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<sup>1</sup> For more information on those benefits available to former spouses, see CRS Report RL31663, *Military Benefits for Former Spouses: Legislation and Policy Issues*, by David F. Burrelli.



facility cannot be provided (due to space limitations, limitations on the types of services that a facility is capable of providing, or due to the fact that a beneficiary may not live close enough to a military facility to make such travel reasonable), Tricare Standard will share responsibility with the beneficiary for the payment of care received from non-military health care providers, subject to regulations. Certain types of care, such as most dentistry and chiropractic services, are excluded.

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

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

The establishment of Tricare for Life and the current pharmaceutical benefit have contributed to significant growth in health care spending by DOD. The expanding costs of military healthcare reached \$39 billion in FY2007 with the majority of the spending going to provide care to individuals no longer on active duty or to their family members. The Congressional Budget Office has also projected that DOD's medical spending will grow by more than 80% in real terms by 2024.<sup>2</sup>

## **5. Who Is Eligible to Receive This Care?**

Current law provides that active duty personnel are entitled to receive health care at military medical facilities. In addition, active duty dependents, military retirees and their dependents, and survivors of deceased members are eligible to receive health care at military medical facilities when space and professional services are available. Also eligible to receive care for a fixed fee in these facilities are certain government officials (including the President and Members of Congress) and certain foreign military personnel on active duty in the U.S. Reserve Component (their dependents are also entitled to care in military medical facilities and participation in Tricare under certain conditions, as discussed in question 14 below).

Since 1967 DOD has funded care by civilian providers to dependents, retirees, and dependents of retirees who are under age 65 and unable to obtain access in a military health facility. After 1991 DOD began, with congressional support, moving towards managed care arrangements under the Tricare program that include greater use of civilian health care providers even for active duty personnel.

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<sup>2</sup> Congressional Budget Office, *Long-Term Implications of Current Defense Plans and Alternatives: Summary Update for Fiscal Year 2006*, October 2005.

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

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

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

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

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

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

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

The benefits available to service members or retirees, which require comparatively little or no contributions from the beneficiaries themselves, are considered by some to be a more generous benefit package than is available to civil

servants or to most people in the private sector. Retirees may also be eligible to receive medical care at Department of Veterans Affairs (VA) medical facilities.<sup>3</sup>

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

Active duty military personnel have been fully covered by Social Security and have paid Social Security taxes since January 1, 1957. Social Security coverage includes eligibility for health care coverage under Medicare at age 65. It was the legislative intent of the Congress that retired members of the uniformed services and their eligible dependents be provided with medical care after they retire from the military, usually between their late-30s and mid-40s. CHAMPUS was intended to supplement — not to replace — military health care. Likewise, Congress did not intend that CHAMPUS should replace Medicare as a supplemental benefit to military health care. For this reason, retirees became ineligible to receive CHAMPUS benefits when, at age 65, they become eligible for Medicare.

Many argued that the structure was inherently unfair because retirees lost Tricare/CHAMPUS benefits at the stage in life when they were increasingly likely to need them. It was argued that military personnel had been promised free medical care for life, not just until age 65. After considerable debate over various options for ensuring medical care to retired beneficiaries, Congress in the FY2001 Defense Authorization Act (P.L. 106-259) provided that, beginning October 1, 2001, Tricare pays out-of-pocket costs for services provided under Medicare for beneficiaries over age 64 if they are enrolled in Medicare Part B. This benefit is known as Tricare for Life (TFL). Disabled persons under 65 who are entitled to Medicare may continue to receive CHAMPUS benefits as a second payer to Medicare Parts A and B (with some restrictions).

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

Some military personnel and former military personnel maintain that they and their dependents were promised “free medical care for life” at the time of their enlistment. Such promises may have been made by military recruiters and in recruiting brochures; however, if they were made, they were not based upon laws or official regulations which provide only for access to military medical facilities for non-active duty personnel if space is available as described above. Space was not always available and Tricare options could involve significant costs to beneficiaries. Rear Admiral Harold M. Koenig, the Deputy Assistant Secretary of Defense for Health Affairs, testified in May 1993: “We have a medical care program for life for our beneficiaries, and it is pretty well defined in the law. That easily gets interpreted to, or reinterpreted into, free medical care for the rest of your life. That is a pretty easy transition for people to make in their thinking, and it is pervasive. We [DOD]

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<sup>3</sup> See CRS Report RL32975, *Veterans’ Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala.

spend an incredible amount of effort trying to re-educate people [that] that is not their benefit.”<sup>4</sup>

Dr. Stephen C. Joseph, Assistant Secretary of Defense for Health Affairs in April 1998, however, argued that because retirees believe they have had a promise of free care, the government did have an obligation. Joseph did not specify the precise extent of the obligation. The FY1998 Defense Authorization Act (P.L. 105-85) included (in Section 752) a finding that “many retired military personnel believe that they were promised lifetime health care in exchange for 20 or more years of service,” and expressed the sense of Congress that “the United States has incurred a moral obligation to provide health care to members and [retired] members of the Armed Services.” Further, it is necessary “to provide quality, affordable care to such retirees.”<sup>5</sup>

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

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

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

- **Medicare subvention** by which care would be provided by DOD to retirees age 65 and over essentially on the same basis as is provided to retirees under 65 in Tricare Prime [enrollment fees of \$230/460 (self/self+dependent) are required annually]; the legislation provides that DOD would be reimbursed for a portion of the costs of this care by Medicare. (The Medicare subvention demonstration project was established by Section 4015 of the Budget Reconciliation Act of 1998 (P.L. 105-33); it was a three-year project (termed **Tricare**

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<sup>4</sup> U.S. Congress, House of Representatives, Committee on Armed Services, Military Forces and Personnel Subcommittee, 103rd Congress, 1st session, *National Defense Authorization Act for Fiscal Year 1994 — H.R. 2401 and Oversight of Previously Authorized Programs*, Hearings, H.A.S.C. No. 103-13, April 27, 28, May 10, 11, and 13, 1993, p. 505.

<sup>5</sup> For additional background, see CRS Report 98-1006, *Military Health Care: The Issue of “Promised” Benefits*, by David F. Burrelli.

**Senior Prime**) at six sites that was phased in beginning in July 1998 and concluding in December 2001.)<sup>6</sup>

- **Access to the FEHBP** plans used by civil service retirees with DOD paying the same share of premiums that is paid by the government for civilian enrollees (approximately 72%). An FEHBP demonstration was established by Section 721 of the FY1999 Defense Authorization Act (P.L. 105-261); it was conducted at eight sites for three years, ending December 31, 2002. It did not attract a large number of enrollees.
- **Tricare as a supplement to Medicare.** Established by Section 722 of the FY1999 Defense Authorization Act (P.L. 105-261), this program was scheduled to begin in 2000 and end in December 2002 but was overtaken by the establishment of Tricare for Life.
- **A DOD-sponsored pharmaceutical benefit.** The FY2001 Defense Authorization Act (P.L. 106-398) extended pharmacy benefits to all retirees beginning in April 2001. Beneficiaries who became 65 before April 1, 2001, do not have to enroll in Medicare Part B to receive the DOD pharmacy benefit; those who turned 65 on or after April 1, 2001, have to be enrolled in Medicare Part B to use the pharmacy benefit.

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

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

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<sup>6</sup> For background on the Medicare subvention issue, see CRS Report 96-207, *Military Medical Care and Medicare Subvention Funding*, by David F. Burrelli and Tina Nunno. The project ended on December 31, 2001.

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

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

The requirement for enrollment in Medicare Part B, which will cost \$96.40 per month in 2008 for most military retirees is a source of concern to some beneficiaries, especially those who did not enroll in Part B when they became 65 and thus must pay significant penalties. Some argue that this requirement is unfair since Part B enrollment was not originally a prerequisite for access to any DOD medical care. On the other hand, waiving the penalty for military retirees could be considered unfair to other Medicare-users who did not enroll in Part B upon turning 65. The Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173), passed in December 2003, waived penalties for military retirees in certain circumstances during an open season in 2004.<sup>7</sup>

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

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

Despite objections from the Defense Department, the FY1999 Defense Authorization Act (P.L. 105-261) included a FEHBP demonstration project limited

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<sup>7</sup> See CRS Report RS21731, *Medicare: Part B Premium Penalty*, by Jennifer O'Sullivan.

to 66,000 participants in 6-10 geographic areas; enrollees had to pay the same level of premiums as paid by civil servants. The project began in January 2000 and ran for three years ending on December 31, 2002. It was evaluated by the Defense Department and the GAO, and it was evident that relatively few retirees opted for FEHBP coverage even after the initial open season was extended and additional brochures mailed out.<sup>8</sup>

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

### **11. How Are User's Fees and Fee Schedules for Medical Services Assessed?**

User's fees for medical services represent a means of generating revenues from those who use the services. In recent years user's fees, also known as co-payments, have been considered as a means of generating revenues in the military medical care system. Some observers see increased user's fees as a primary way to increase beneficiaries' cost-consciousness, arguing that far more than premiums and deductibles, cost-sharing discourages unnecessary medical services. The consideration of these fees has been subject to strong opposition from military personnel, retirees, and others who have viewed free or inexpensive health care as an important benefit of military service. To these individuals, user's fees represent an "erosion of earned benefits." Specifically, these benefits are not viewed by some beneficiaries as an insurance program paid for in a market context, but rather as a benefit that is earned by the unique nature of demands inherent in performing military service. The Defense Department's FY2007 and FY2008 budget submissions included provisions that would raise enrollment fees, co-payments, and deductibles for retirees under age 65 and makes small increases in deductibles for pharmaceuticals for all retirees. This proposal has received opposition from retiree organizations.<sup>9</sup> Congress has refused to authorize such increases.

By law (P.L. 102-396) and Federal Regulation (32 CFR 199.14), health care providers treating Tricare patients cannot bill for more than 115% of charges authorized by a DOD fee schedule. In some geographic areas, providers have been unwilling to accept Tricare patients because of the limits on fees that can be charged. DOD has authority to grant exceptions. Statutes (10 U.S.C. 1079) also require that payment levels for health care services provided under Tricare be aligned with Medicare's fee schedule "to the extent practicable." Over 90% of Tricare payment

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<sup>8</sup> See U.S., General Accountability Office, Report GAO-03-547, *Military Retiree Health Benefits: Enrollment Low in Federal Employee Health Plans under DOD Demonstration*, June 2003.

<sup>9</sup> See CRS Report RS22402, *Increases in Tricare Fees: Background and Options for Congress*, by Richard A. Best Jr.

levels are now equivalent to those authorized by Medicare, about 10% are higher, and steps are being taken to adjust some to Medicare levels.

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

Base realignment and closures undertaken as part of the restructuring of the Defense Department in the post-Cold War period have prompted changes in the military health services system. As a result of base realignment and closure (BRAC) actions, 35% of the DOD medical treatment facilities providing services in 1987 were closed by the end of 1997 (although the number of eligible beneficiaries decreased by only 9%). Another BRAC round was undertaken in 2005.<sup>10</sup> Criteria for realignments and closures, established by DOD with congressional consent, include the need to deploy a force structure capable of protecting the national security, anticipated funding levels, and a number of military, fiscal, and environmental considerations that encompass community economic impact and community infrastructure.

Four BRAC Commissions have specifically considered the effect of closing DOD hospitals and clinics on active duty military personnel as well as on other beneficiaries and potential beneficiaries. The first two BRAC Commissions recommended 18 military hospital closures; the third BRAC Commission recommended an additional 10. Facilities closed include hospitals in Philadelphia, PA; Oakland, CA; Orlando, FL; San Francisco, CA; Ft. Devens, MA; Ft. Ord, CA; and Long Beach, CA. In one case, the Commission overruled a DOD proposal to close the Naval Hospital in Charleston, SC.

While DOD had commissioned a study group to examine military treatment facilities for the 1995 BRAC round, the assessment of military medical services appears to have been more comprehensive in 2005. A Medical Joint Cross-Service Group (JCSG) was established to review DOD healthcare functions and to provide BRAC recommendations. The review included healthcare education and training, healthcare services, medical and dental research, development, and acquisition. The Surgeon General of the Air Force chaired the Medical JCSG; other members included representatives from the military services, the Joint Staff, and the Office of the Secretary of Defense. The recommendations were submitted to senior DOD leadership for consideration in the preparations of the Secretary of Defense's recommended BRAC actions. Recommendations included closing Brooks City-Base, San Antonio, TX; realigning Walter Reed Medical Center, Washington, DC; realigning the inpatient medical function at Lackland Air Force Base in San Antonio, TX and other initiatives.<sup>11</sup>

With congressional encouragement, DOD has developed transition medical plans for certain closure sites. Medicare-eligible users of closed military hospitals will be encouraged to avail themselves of Tricare for Life and DOD's mail order

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<sup>10</sup> See CRS Report RL32216, *Military Base Closures: Implementing the 2005 Round*, by David E. Lockwood.

<sup>11</sup> For further information, see the DOD BRAC website, [<http://www.defenselink.mil/brac/>].



pharmacy. Nonetheless, the closure of military hospitals and clinics can be a source of anxiety, especially in communities that have attracted large numbers of residents seeking access to military medical care.

### **13. What Is the DOD Pharmacy Benefit?**

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

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

In 2004 DOD, in response to guidance in the FY2000 Defense Authorization Act (P.L. 106-65, section 701), established a uniform formulary to discourage use of expensive pharmaceuticals when others are medically appropriate. Regulations to this effect were published in the Federal Register on April 1, 2004 (vol. 69, pp. 17035-17052). Prescriptions filled by the Tricare Mail Order Pharmacy currently cost \$3 for a 90-day supply of a generic medication, \$9 for a 90-day supply of a brand-name formulary medication, and \$22 for a 30-day supply of a non-formulary medication. Section 702 of the FY2008 Defense Authorization Act (P.L. 110-181) prohibited increases in pharmacy co-payments through the end of FY2008.

### **14. What Medical Benefits are Available to Reservists?**

Reservists and National Guardsmen (members of the "Reserve Component") who are serving on active duty have the same medical benefits as regular military personnel. Reserve personnel while on active duty for training and during weekly or monthly drills also are covered for illnesses incurred while on training or traveling to or from their duty station. In recent years, especially as members of the Reserve Component have had a larger role in combat operations overseas, Congress has

broadened the medical benefits for Reservists. Those who have been notified that they are to be activated are now covered by Tricare up to 90 days before reporting. Reservists who have served more than 30 days after having been called up for active duty in a contingency are eligible for 180 days of Tricare coverage after the end of their service under the Transitional Assistance Management Program (TAMP). In addition, in 2004 Congress authorized (in P.L. 108-375, section 701) the Tricare Reserve Select (TRS) program for Reserve Component members called to active duty, under Title 10, in support of a contingency operation after September 11, 2001. To be eligible for TRS, reservists must agree to stay in the Reserves for one or more years and must pay monthly premiums (in 2008, \$81 for an individual; \$253 for a member and family coverage).

The FY2006 Defense Authorization Act (P.L. 109-163) makes Tricare Standard available to all members of the Reserve Component who continue to serve in the Selected Reserves. In addition to those already eligible for Tricare Reserve Select, those who are unemployed or have no access to employer-sponsored health care will pay fees that cover 50% of the costs of the program; other reservists will pay fees covering 85% of the costs. (Those using Tricare Reserve Select pay fees that cover approximately 28% of the costs.)

The FY2007 Defense Authorization Act, P.L. 109-364 repealed the three-tiered cost share Tricare program for reserves established in the FY2006 legislation and replaced it with a single program that would permit non-active duty reservists to obtain Tricare coverage by paying a premium of 28% of the total costs of their coverage. The **new Tricare Reserve Select program** began October 1, 2007.