Budget Options

December 13, 2018

OPTION FROM: **OPTIONS FOR REDUCING THE DEFICIT: 2019 TO 2028**

Discretionary Spending

Function 050 - National Defense

Modify TRICARE Enrollment Fees and Cost Sharing for Working-Age Military Retirees

CBO periodically issues a compendium of policy options (called *Options for Reducing the Deficit*) covering a broad range of issues, as well as separate reports that include options for changing federal tax and spending policies in particular areas. This option appears in one of those publications. The options are derived from many sources and reflect a range of possibilities. For each option, CBO presents an estimate of its effects on the budget but makes *no recommendations*. Inclusion or exclusion of any particular option does not imply an endorsement or rejection by CBO.

Billions of Dollars	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2019-2023	2019-2028
Change in Discretionary Spending												
Budget authority	0	0.1	-0.9	-1.2	-1.3	-1.4	-1.6	-1.7	-1.8	-2.0	-3.4	-11.8
Outlays	0	*	-0.7	-1.1	-1.3	-1.4	-1.5	-1.7	-1.8	-1.9	-3.1	-11.4
Change in Mandatory Outlays	0	0	*	*	*	*	*	*	*	*	*	-0.1
Change in Revenues[a]	0	0	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.5	-1.9
Increase in the Deficit From Changes in Mandatory Outlays and Revenues[b]	0	0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.5	1.8

Sources: Congressional Budget Office; staff of the Joint Committee on Taxation.

This option would take effect in January 2021, although some changes to outlays would occur earlier.

* = between -$50 million and $50 million.

a. Estimates include the effects on Social Security payroll tax receipts, which are classified as off-budget.

b. Changes in discretionary spending are not included in this total because they would be realized only if future appropriations were adjusted accordingly and because the Congress uses different procedures to enforce its budgetary goals related to discretionary spending.

Background

More than 9 million people are eligible to receive health care through TRICARE, a program run by the Department of Defense's (DoD's) Military Health System. Among its beneficiaries are 1.5 million members of the active military and the other uniformed services (such as the Coast Guard), certain reservists, retired military personnel, and their qualified family members. The costs of that health care have been among the fastest-growing portions of the defense budget over the past 17

years, more than doubling in real (inflation-adjusted) terms since 2001. In 2017, DoD spent about $50 billion for health care. Much of the cost increases are attributable to new and expanded health care benefits and to financial incentives to use those benefits.

In 2017, about 20 percent of military health care spending was for working-age retirees (generally, beneficiaries who, although retired from military service, are under age 65 and thus not yet eligible for Medicare) and their family members—3.1 million beneficiaries in all. Some 1.6 million people (or about 50 percent of that group) were enrolled in TRICARE Prime, which operates like a health maintenance organization. Subscribers in 2018 pay an annual enrollment fee of $289 (for individual coverage) or $578 (for family coverage). Working-age retirees who do not enroll in TRICARE Prime may participate in TRICARE Select (a preferred provider network). Under the Select plan, a beneficiary who chooses an in-network provider for a given medical service pays lower out-of-pocket costs than one who chooses an out-of-network provider.

The National Defense Authorization Act for Fiscal Year 2017 (Public Law 114-328) made several changes to the TRICARE program, including creating the Select plan by merging two other plans and increasing cost sharing for the households of military retirees. However, those higher out-of-pocket costs will apply only to those retirees whose initial enlistment or appointment to the armed forces occurred on or after January 1, 2018. With few exceptions, the higher cost-sharing amounts will not take effect until 2038 or later, when that cohort begins to retire.

Option

Under this option, TRICARE's enrollment fees, deductibles, and copayments for working-age military retirees would increase as described below starting in January 2021. Thereafter, such costs would be indexed to nationwide growth in health care spending per person. Specifically:

- Beneficiaries with individual coverage would pay $650 annually to enroll in TRICARE Prime. The annual cost of family enrollment would be $1,300. (That family enrollment fee is about equivalent to what would result if the $460 annual fee first instituted in 1995 had grown each year by the nationwide growth in health care spending per person.)
- All beneficiaries who enroll in TRICARE Select would pay an annual enrollment fee of $485 for individual coverage and $970 for a family, which is the Congressional Budget Office's estimate of what the enrollment fees will be under current law for those retirees who joined the armed forces after January 1, 2018.
- The annual deductible for individual retirees (or surviving spouses) for TRICARE Select would rise to $300, and the annual family deductible would be $600.
- The schedule of copayments for medical treatments under TRICARE Prime and Select in 2021 would be the same for all retirees (regardless of when they joined the armed forces). In subsequent years, copayments would grow in line with nationwide growth in health care spending per person.

Those higher out-of-pocket costs would apply to most new and current retirees beginning in 2021. The only exception would be for those who retired because of disability and certain survivors (whose cost sharing would remain unchanged). DoD would incur some added costs for implementation expenses.

Effects on the Budget

CBO estimates that, combined, those changes would reduce discretionary outlays for DoD by $12.6 billion between 2020 and 2028, under the assumption that appropriations would be reduced accordingly. The increased out-of-pocket expenses for beneficiaries would reduce DoD's discretionary costs for the TRICARE program, as enrollees used fewer services and as Prime members switched to civilian care provided by their current employers or some other source of health care. Under this option, CBO estimates, about 120,000 retirees and their family members would leave TRICARE because of the higher out-of-pocket costs they would face.

Discretionary spending outside of DoD would increase slightly under the option. Some eligible retirees would obtain health care from other discretionary federal programs—such as the Veterans Health Administration or the Federal Employees Health Benefits (FEHB) program, if the person or his or her spouse was employed as a civilian by the federal government—increasing the costs of those programs. About $1.2 billion in additional spending would be needed for those programs by 2028, CBO projects, so the overall reduction in discretionary costs would be $11.4 billion between 2020 and 2028.

This option would have partially offsetting effects on mandatory spending. On the one hand, mandatory spending would increase when some retirees enrolled in other federal health care programs, such as Medicaid (for low-income retirees) or the FEHB program (for those who complete a career in the federal civil service after military retirement). On the other hand, mandatory spending would decrease as a result of the new cost sharing for retirees of the Coast Guard, the uniformed corps of the National Oceanic and Atmospheric Administration, and the Public Health Service. (TRICARE's costs for retirees from those three uniformed services are paid from mandatory appropriations; DoD's costs are paid from annual discretionary appropriations.) Overall, in CBO's estimation, mandatory spending under this option would decline by $100 million between 2021 and 2028 because spending for people in those three uniformed services would fall by a larger amount than spending for Medicaid and FEHB annuitants would rise.

CBO and the staff of the Joint Committee on Taxation estimate that, under this option, federal tax revenues would decline by $1.9 billion between 2021 and 2028 because some retirees would enroll in employment-based plans in the private sector and therefore experience a shift in compensation from taxable wages to nontaxable fringe benefits.

In general, relative to this option, increasing the share of health care costs paid by beneficiaries would further reduce federal spending, but the results would not be proportional; consequently, doubling fees or copayments would not necessarily double the savings. One reason for that relationship is that changes in some fees (such as the Prime enrollment fee) would alter beneficiaries' behavior differently than changes in other fees (such as the copayment for primary care). In addition,

the number of households that used TRICARE under different cost-sharing scenarios would not change proportionally: Relatively healthy people, who do not spend the entire deductible under the current system, for example, would be unaffected by having that deductible increase.

The largest source of uncertainty in the estimate of savings over the next 10 years relates to CBO's estimate of the number of people who would shift from TRICARE to other health care plans. Many military members retire while they are still young enough to start second careers. Studies show that over 75 percent of those working-age retirees have access to other health insurance through either an employer or a professional association (for example, Mariano and others 2007). Therefore, any significant increase in out-of-pocket costs for the military health benefit would cause some people to stop using those benefits and instead rely on other health care coverage. Nevertheless, the behavior of military retirees might differ from that of the studied populations, and changes in the cost and availability of civilian health insurance would affect the estimated amount of savings.

Other Effects

One argument in favor of this option is that the federal government established TRICARE coverage to supplement other health care for military retirees and their dependents. That was done to serve as a safety net rather than as a replacement for benefits offered by postservice civilian employers. Yet the cost sharing under the option would still be comparatively low. The Prime enrollment fee under this option, for example, would be about one-fifth that of the average premium paid by employees for employment-based health insurance in 2017. The migration of retirees from civilian coverage into TRICARE is one factor in the rapid increase in TRICARE spending since 2000.

An argument against this option is that current retirees joined and remained in the military with the understanding that they would receive free or very low-cost medical care in retirement. Imposing new cost sharing might cause some to drop their TRICARE coverage and become uninsured; it also could adversely affect military retention. Another potential disadvantage is that the health of users who remained in TRICARE might suffer if higher copayments led them to forgo some

care. However, their health might not be affected significantly if the higher copayments fostered more disciplined use of medical resources and discouraged the use of health care that did little to improve health.

Related Options

Introduce Enrollment Fees Under TRICARE for Life

Introduce Minimum Out-of-Pocket Requirements Under TRICARE for Life

Related Publications

Approaches to Changing Military Health Care
October 11, 2017

Approaches to Reducing Federal Spending on Military Health Care
January 16, 2014

Work Cited

Louis T. Mariano and others, *Civilian Health Insurance Options of Military Retirees: Findings From a Pilot Survey* (http://www.rand.org/pubs/monographs/MG583.html) (RAND Corporation, 2007)