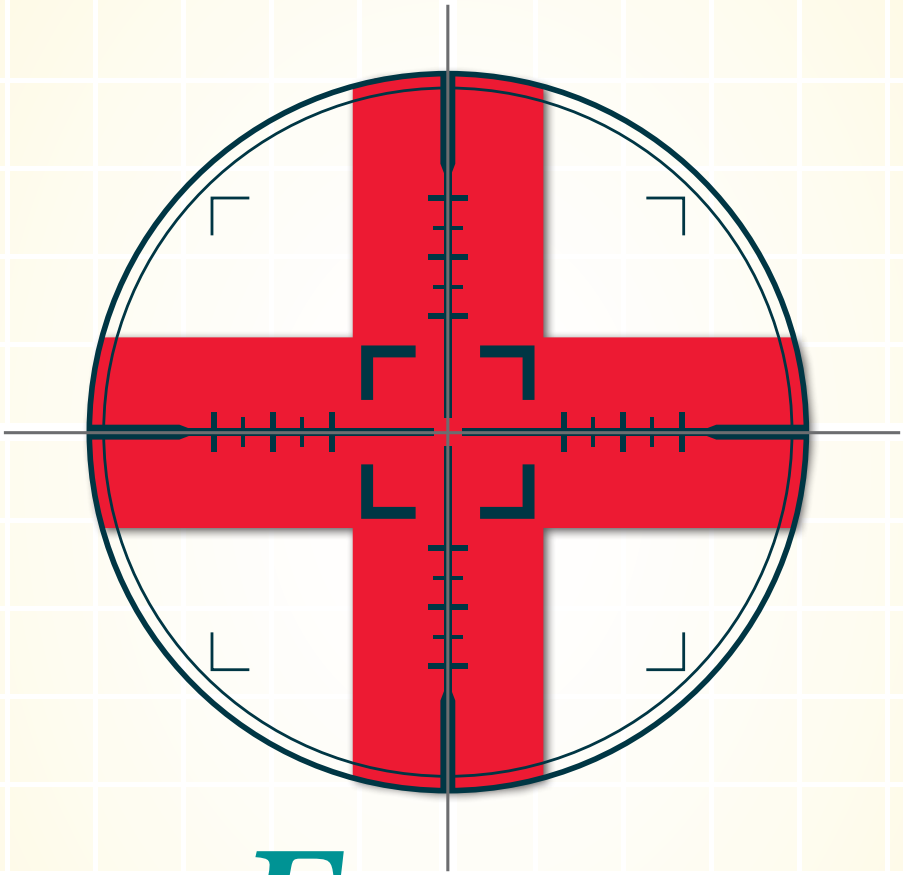
MOAA™
Military Officers Association of America



Focus *on* Military Health Care REFORM

Reform must focus on fixing documented problems with health care access, referrals, and continuity — and not just raising beneficiary fees.

FY 2017: THE YEAR OF TRICARE REFORM

In the conference report on the FY 2016 National Defense Authorization Act, conferees stated their priority for FY 2017 would be on modernizing and improving the military health care system. ■ House Armed Services Military Personnel Committee Chair Rep. Joe Heck (R-Nev.), an Army Reserve physician, said, "This process is not being driven by budgetary concerns" but by "how we can best maintain readiness and provide the best health benefit to the military community."

What's Working and What's Not in Military Health Care

MOAA agrees the military health care system is in need of reform. In that process, it will be important to retain the programs that are working well and fix those that are falling short.

Once patients access the system, the quality of care delivered is generally high. But administrative, organizational, and oversight problems often impede that delivery.

Reforming the military health system means more than just raising beneficiary fees.

While the FY 2017 defense budget proposal offers some comments about improved access to quality care, the bulk of the specifics focuses on raising existing beneficiary fees and adding new ones. It would shift $49 billion in costs to beneficiaries over the next 10 years.

MOAA believes this would place a disproportional burden on beneficiaries, when many military health system problems — and the associated costs — are due to military-unique readiness requirements, oversight shortfalls, and system inefficiencies. In other words, the problems of the system are not the fault of the beneficiaries.

Further, it's important to recognize beneficiaries have, in fact, experienced multiple benefit changes in recent years to help curtail DoD health care costs, including:

- a 23-percent increase in TRICARE Prime enrollment fees;
- a two- to three-fold increase in most pharmacy copayments;
- adding annual COLA-based adjustments to selected fees; and
- accepting a requirement to refill mainte-

What's Working

Combat Casualty Care
Quality of Care
TRICARE For Life
Pharmacy Programs
TRICARE Standard
TRICARE Overseas

What's *Not* Working

TRICARE Prime Appointing/Referrals
Guard/Reserve TRICARE Coverage
Military Provider Appointment Limits
Pediatric/Special-Needs Coverage
Medical Record Systems
Budgeting/Contracting/Oversight
Case Management

DoD Health Costs Are NOT Growing, Let Alone "Out of Control" ($ in Billions)

	FY 2010	FY 2011	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016
TRICARE For Life Deposit	**10.8**	**11.0**	**10.9**	**8.5**	**7.4**	**7.0**	**6.6**
Purchased Care	**14.3**	**14.8**	**15.4**	**14.7**	**14.8**	**14.8**	
Total Unified Medical Program	**49.9**	**51.6**	**52.9**	**48.4**	**49.3**	**48.5**	

Source: DoD reports to Congress and FY 2016 president's budget
*FY 2015 data projected in January 2015 DoD report; FY 2016 from FY 2016 budget submission

nance prescription medications through lower-cost military or mail-order venues.

Military Health Costs Are Not "Exploding"

Much of DoD's rationale for proposing significantly higher beneficiary fees is based on assertions of "exploding military health costs" that are "spiraling out of control."

The reality, as shown in the chart above, is costs have been relatively flat or declining. In many years, DoD has asked Congress to allow reprogramming of unused health care funds. In fact, the only cost areas that have been rising are pharmacy costs and in-house military care, which is under direct military control and has proven the least-efficient care system.

Currently serving families: ***MOAA supports most of the DoD proposals for active duty families,*** most of whom would see lower costs (see chart below) as long as they use military facilities or network providers.

Retired families under 65: ***The DoD proposals would raise costs for most retired families under age 65 by 42 percent to 120 percent, which MOAA believes is excessive.*** Those who live in areas where no network providers are available would face not only a new $700 annual enrollment fee but also a $600 (doubled) deductible. (See charts on the next page.) MOAA does support the rec-

DoD-Proposed Fee Impact: Currently Serving Family of Four

Fee Component	2016 TRICARE Standard	2018 TRICARE Prime	2018 TRICARE Standard
Enrollment Fee	**$0**	**$0**	**$0**
Deductible[1]	**$300**	**$0**	**$0**
Network Copays[2]	**$0**	**$0**	**$195**
Rx Cost Shares[3]	**$188**	**$260**	**$260**
Yearly Total	**$488**	**$260**	**$455**

[1] Under proposal, general deductibles apply for out-of-network care only.
[2] Assumes eight network visits a year (three primary care, two specialty care, two urgent care, one ER).
[3] Assumes two brand-name and two generic prescriptions a month (initial fill retail; refills by mail-order)

Source: FY 2017 presidential budget request

Fee Impact: Retiree Family of Four (TRICARE Prime[1])

Fee Component	2016	2018 In Network	2018 Out of Network
Annual Enrollment Fee	**$565**	**$700**	**$700**
Annual Deductible	**None**	**None**	**$600**
Doctor Visit Copayments[2]	**$72**	**$310**	**--**
Rx Copayments[3]	**$188**	**$260**	**$260**
Yearly Total	**$825**	**$1,270**	**$1,560**

Fee Impact: Retiree Family of Four (TRICARE Standard[1])

Fee Component	2016	2018 In Network	2018 Out of Network
Annual Enrollment Fee	**None**	**$900**	**$900**
Annual Deductible	**$300**	**None**	**$600**
Doctor Visit Copayments[2]	**$338**	**$355**	**--**
Rx Copayments[3]	**$188**	**$260**	**$260**
Yearly Total	**$826**	**$1,515**	**$1,760**

[1] Under proposal, TRICARE Prime will be known as TRICARE Select and TRICARE Standard will be known as TRICARE Choice.
[2] Assumes six primary care visits, three specialty-care visits, and one outpatient surgery.
[3] Assumes two brand-name and two generic prescriptions a month (initial fill retail; refills by mail-order).

Source: FY 2017 presidential budget request

ommended adjustment to hospital in-patient cost-shares.

Medicare-eligible families: TRICARE For Life (TFL)-eligibles would face a new annual enrollment fee in addition to their Medicare Part B premium. The new fee would grow to 2 percent of retired pay over the next four years.

MOAA objects to this new means-tested fee for three primary reasons:

■ DoD costs for TFL-eligibles have declined nearly 40 percent over the past five years, as DoD actuaries have gained actual experience with TFL costs versus their original pessimistic estimates.

■ TFL-eligibles already pay more for their health care coverage than any other military beneficiaries.

■ No other federal or civilian employer means-tests health care/Medicare-supplement coverage for its retired employees, which effectively would penalize longer and more successful service.

Annual adjustment mechanism: MOAA is particularly concerned DoD proposes adjusting all TRICARE fees and copayments annually by the National Health Expenditures per-capita index — which is projected to grow at about 5.2 percent a year.

The bottom chart on the next page shows how annual fees for a retired family in TRICARE Prime (in-network) would jump the first year (2018) and then would grow faster in future years than they would if fees remained indexed to the retired-pay COLA.

MOAA believes strongly military beneficiaries' health care fees should not grow faster than their military compensation does.

MOAA urges the use of the annual retired-pay COLA percentage as the basis for adjusting TRICARE fees.

DoD-Proposed TFL Annual (Family) Enrollment Fee

Means-testing fees (based on percentage of retired pay) is inappropriate. No other federal/corporate employer means-tests service-earned health benefits, as it would penalize longer and more successful service.

Retired Pay	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021
% of Gross Retired Pay	**N/A**	**0.5%**	**1%**	**1.5%**	**2%**	**2%**
Ceiling	**$0**	**$150**	**$300**	**$450**	**$600**	**$632**
Flag Officer Ceiling	**$0**	**$200**	**$400**	**$600**	**$800**	**$842**

Fee Impact on TRICARE For Life (TFL) Married Couple

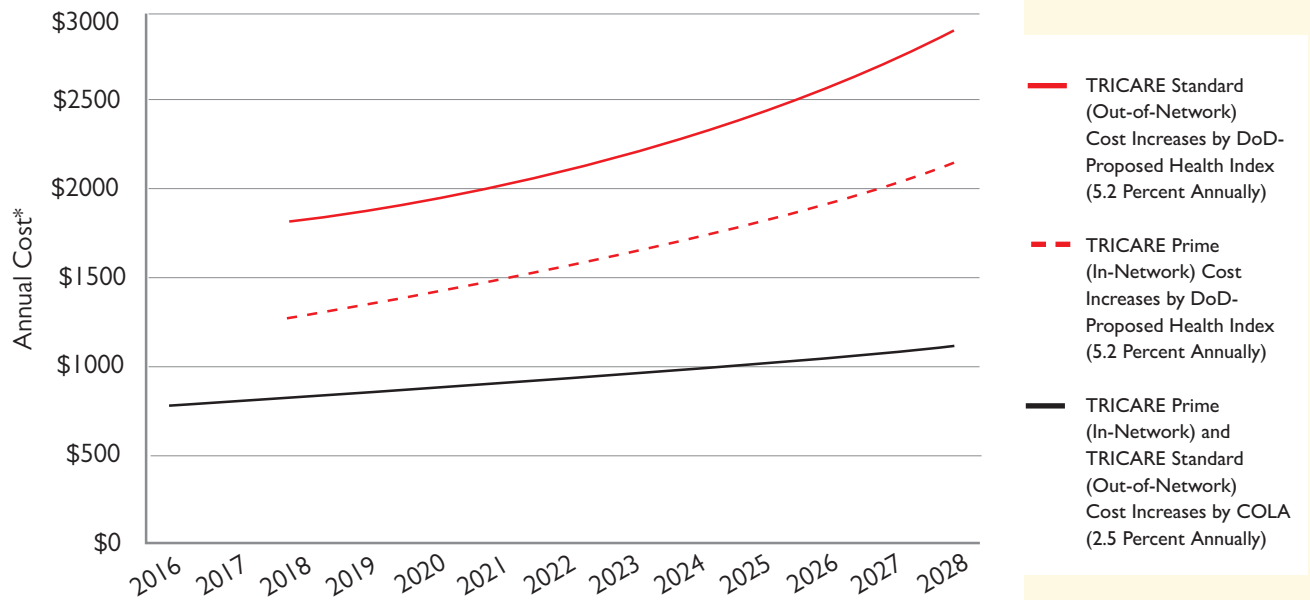
Fee Component	2016	2018
Annual Medicare Premium[1]	**$2,520**	**$2,570**
TFL Enrollment Fee[2]	**None**	**$300**
Rx Copayments[3]	**$376**	**$520**
Yearly Total	**$2,896**	**$3,390**

[1] Assumes 1-percent annual COLA. Medicare premuim based on lowest income bracket fee.
[2] O-5 with 20 years of service turning 65 in 2018 (fee would double by FY 2021).
[3] Assumes four brand-name and four generic precriptions a month (initial fill retail; refills by mail-order).

Source: FY 2017 presidential budget request

Impact of Annual Adjustments by DoD-Proposed Index vs. COLA

DoD proposals would raise retiree fees immediately, then accelerate future growth by indexing fees to annual changes in a National Health Expenditures Index, vs. current fees adjusted by annual COLA.



*Annual cost estimate for a retired family of four assumes: annual enrollment fee; annual deductible; six primary care visits, three specialty-care visits, and one outpatient surgery; and two brand-name and two generic prescriptions a month (initial fill retail; refills by mail-order).

Where MOAA Stands on Military Health System Reform

CONGRESS SHOULD FOCUS ON PRESERVING WHAT'S WORKING AND FIXING WHAT ISN'T.

MOAA understands some increases in beneficiary fees might be required but believes the proposals in the FY 2017 defense budget are excessive and, in certain cases (such as means-testing and setting up new enrollment fee requirements that could bar access to service-earned coverage), inappropriate.

Primary efforts should be focused on increasing beneficiaries' access to timely, quality care; addressing the inherent inefficiencies of current care delivery systems; and isolating costs associated with readiness and service-unique requirements.

Reform must focus on fixing documented problems with health care access, referrals, and continuity — and not just raising beneficiary fees.

MOAA Principles and Recommendations

- Means-testing is inappropriate for military health care benefits; progressively reducing benefits for longer and more successful service is a disincentive for retention of quality people.
- Annual adjustments to beneficiary fees should not exceed the percentage increase in their military compensation (i.e., the annual retired-pay COLA).
- Without guaranteed access to care, enrollment fees for TFL or TRICARE Standard are inappropriate.
- Beneficiaries should not be asked to pay any share of expenses incurred due to readiness considerations or management inefficiencies (e.g., separate service systems).
- The military health care benefit should be the "gold standard" — significantly better than the largest civilian employers provide their employees.
- Provider payments should reward quality care, not just patient visits.
- National Guard and Reserve members and their families deserve better and more consistent coverage than current TRICARE Reserve Select and Retired Reserve programs provide.
- Test the concept of unified budget and oversight authority in two or more multiservice areas (e.g., Tidewater Virginia and San Antonio).
- Focus managed-care outreach efforts on high-use/cost beneficiaries of all ages.
- Pursue partnerships with Medicare Advantage programs to attract/refer TFL-eligibles to military facilities for procedures that promote medical staff readiness.
- Most important, ensure military health care fees continue to appropriately reflect career servicemembers' decades of pre-paid, in-kind premiums of arduous service and sacrifice.

FOR MORE INFORMATION, CONTACT:
Capt. Kathy Beasley, USN (Ret)
201 N. Washington St., Alexandria, VA 22314
(800) 234-MOAA (6622), ext. 164
email: kathyb@moaa.org