



Health, Health Care, and a High-Performance Force

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Prologue

The Bipartisan Policy Center's [Task Force on Defense Personnel](#), consisting of 25 defense and national security experts, will make recommendations to strengthen U.S. national security by improving and modernizing the way that the Defense Department recruits, manages, and retains its people. During this effort, BPC is publishing a series of analytical papers examining the strengths and shortcomings of current personnel policies and practices. The first paper, [The Military Compensation Conundrum: Rising Costs, Declining Budgets, and a Stressed Force Caught in the Middle](#), explored the context in which any discussion of defense reform must occur—the current budgetary policies of the U.S. government and the challenging dynamics of today's military compensation models. The second paper, [The Building Blocks of a Ready Military: People, Funding, Tempo](#), addressed the mounting evidence that current personnel policy is degrading military readiness. The third paper, [Defense Personnel Systems: The Hidden Threat to a High-Performance Force](#), described the development of today's defense-personnel systems—covering recruitment, promotion, retention, and separation—and argued that these systems are struggling to meet national security needs and, if unchanged, will be insufficient to address the challenges of an increasingly complex global-security environment. This paper, [Health, Health Care, and a High-Performance Force](#), offers background on: the health of service members; the military health care delivery system; the challenges of maintaining a medically ready force, a ready medical force, and a sustainable health care benefit for service members, dependents, and military retirees; and recent proposals to reform military health care to better meet these needs.

To read other papers in this series, please visit bpcdc.org/DefenseResearch.

Introduction

The health of military personnel is critical to readiness and battlefield performance. The United States requires healthy soldiers, sailors, Marines, and airmen to fight and win wars. Systems and policies to promote the health of service members, therefore, are key national security functions as well as central personnel matters. Maintaining the health of each individual service member requires another personnel infrastructure—spanning uniformed service members, civilians, and contractors—to offer everything from nutritious meals to medical services.

Health care for service members is provided by one of the largest and most complex health systems in the world, with an imperative to offer high-quality, timely routine and emergency care, whether stateside or on deployment. In particular, the nation owes its service members the very best in battlefield medicine, from critical care at the site of injury through all trauma care services. All of these functions require highly trained and experienced personnel, who must be recruited and retained amid a complex, competitive, and expensive health care market.

Health care is also an important component of military-personnel compensation. Like most other large U.S. employers, the military also offers health care benefits to the families of service members and to retirees. These benefits—which are among the most generous of any government or private-sector employer—help to attract and retain service members, especially those needed for longer careers who are difficult to replace. Health care and other efforts to promote the health of service members and their families comprise a substantial portion of the defense budget as a whole and of personnel compensation in particular.

In an era of scarce resources, the tradeoffs among efforts to promote health and wellness, the design of the military health care delivery system, and the various aspects of the military health care benefit—for service members, dependents, and retirees—have attracted intense scrutiny. Much is at stake, as the nation and military need these systems to perform at a high level in many respects. A high-performing Military Health System and a well-structured military health benefit are critical to ensuring readiness of service members in general, the readiness of the medical force in particular, and the adequacy of health care benefits to attract and retain service members, while also controlling the growth of costs for the system, which affects the availability of resources for other readiness and warfighting needs.

Background

Health and its many aspects—such as strength, endurance, alertness, and the absence of illness or injury—are influenced by several factors. Genetics, the physical environment, personal behaviors, and access to quality health care services are major determinants of health. The military has special challenges in maintaining the health of service members because of the variety of operating environments, from developed, stateside installations to remote theaters of combat. Additionally, the military is unusual among large employers in that it directly provides comprehensive health care services—using its own clinics and health care providers—not just to active-duty service members, but to their families and retirees as well.

Even with these unique attributes, the military is not isolated from trends in the health of Americans and the U.S. health care system. Just like the broader American population, the proportion of service members who are overweight or obese has grown, resulting in reduced readiness, increased separations, and higher costs for the military as highly trained service members must be replaced. Just as the U.S. health care delivery system has become very expensive and is undergoing significant changes, the Military Health System is a major cost, the growth of which threatens other defense priorities, attracting criticism and proposals to reform military health care.

Despite these challenges, the military has significant strengths and, in many instances, has performed well in fostering good health outcomes. The Defense Department has the infrastructure and resources to establish an environment that promotes health and wellness, and the military command structure can direct service members to address health issues in ways that are not possible with the broader American population. Most users of the Military Health System are satisfied with the health care services they receive at home.¹ And combat casualty and rehabilitative care have become more effective than ever, saving thousands of lives in recent wars.²

These achievements, however, are at risk, and in other respects, the military has underperformed in regard to health outcomes and the functioning of the health care delivery system. For example, survey results of beneficiaries fall short of civilian benchmarks for access measures (“getting needed care,” “getting an appointment with a specialist,” “getting care quickly,” and “getting timely routine appointments”), as well as for quality measures (“health care,” “primary care physician,” and “specialty care physician”—although satisfaction with the quality of the health plan exceeded the civilian benchmark).³ Operational data also provides reason for concern about system performance in certain areas. The volume of some intensive procedures performed at military hospitals—such as orthopedic surgery, coronary-artery-bypass grafting, and other cardiothoracic surgical procedures—typically are much lower than the volumes necessary to achieve the best outcomes.⁴

The growth of health care costs combined with defense-wide spending caps, as discussed in the first paper in this series, has left leadership struggling to fund and manage the Military Health System without crowding out other important defense priorities. Significant reductions in combat operations in Middle East theaters threatens the readiness of military trauma care personnel. And the military has not effectively utilized its organizational advantages to maximize a healthful environment or facilitate a coordinated, integrated psychological health care system.

Challenges to military health are compounded because the Military Health System has multiple purposes and constituencies. The primary goals are often stated by military leadership as being a medically ready force and a ready medical force. Specifically, the military's health missions encompass:

- Meeting the health care needs of active-duty service members to maintain their physical and psychological readiness for military missions;
- Building and maintaining the skills of military health care providers so they will be ready to deliver needed services—from routine care to trauma care—when deployed;
- Meeting health care needs of reserve-component service members who do not otherwise have health-insurance coverage, such as through an employer;
- Providing health care benefits to family members of active-duty service members; and
- Providing health care benefits to military retirees.

Solutions to address the needs of one group must be crafted so they do not degrade the other missions. Because of this, despite well-known shortcomings, reforming the system to address these challenges is both technically and politically difficult. Experts have made comprehensive recommendations to improve the Military Health System, with many proposals focused on personnel. For the first time in decades, lawmakers have initiated major changes to military health care. This issue brief offers background on the health of our nation's military, the design and operations of military health care, and recent reform proposals.

The Health of the U.S. Military

Compared with other large organizations, the U.S. military is especially dependent on the health of its people. Service members must be in peak condition to successfully complete the physically and psychologically demanding missions assigned to them during wartime. Even those who serve in training, administrative, and support roles—far removed from the front lines—must be in good health to ensure the overall readiness of the force. This places the burden on the U.S. military to attract enough recruits who are in good health and requires that the military help service members maintain their health for the entirety of their service so that highly trained service members do not have to be replaced—at great cost—later in their careers for preventable health reasons.

Health of Service Members: What is Health, and Why is it Important?

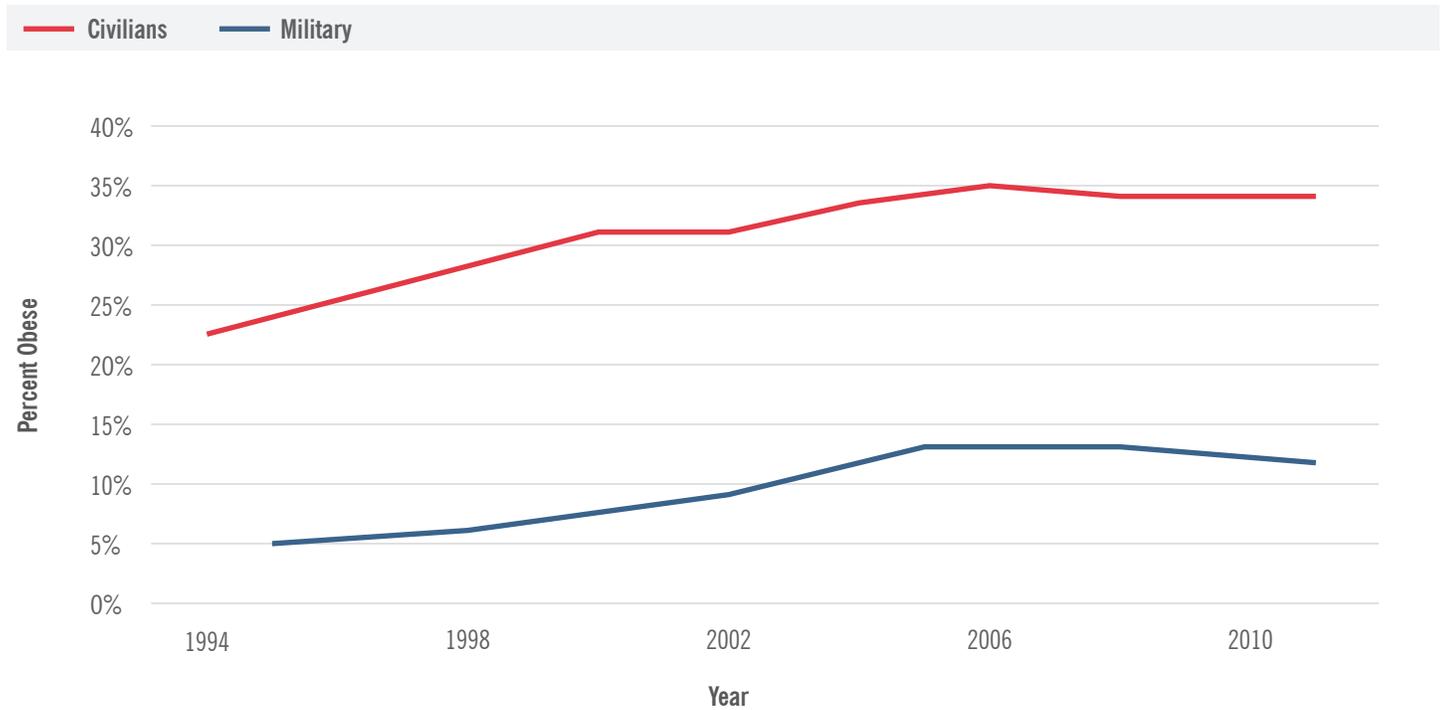
Health is a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.⁵ Health is determined by many factors, some of which include: personal behaviors, such as exercise, nutrition, tobacco use, and sleep habits; the living and working environment, such as the availability of healthful foods, the walkability of communities and workplaces, and prevailing cultural attitudes; genetics; and the availability of quality, timely health care services. In the general population, healthy behaviors and the environment account for over two-thirds of the effects on overall health.⁶ The U.S. military—in its simultaneous roles of employer, health care system operator, food-service provider, and city planner—is uniquely positioned to affect almost every determinant of health for service members.

A Medically Ready Force: America Has a Health Problem, and the U.S. Military Is No Exception

The United States currently faces a profound public health crisis, with more than 36 percent of adults meeting the definition of obese, meaning that their body mass index (BMI) is 30 or greater.⁷ An individual's BMI is based upon their height and weight; for example, someone who is 5-foot-9 and 203 pounds would have a BMI of 30 and be considered obese. People with obesity are far more likely to develop chronic diseases like diabetes, hypertension, heart disease, sleep apnea, and certain types of cancer.⁸ We also know that obesity-related illness comprises an increasingly large share of the nation's massive, and growing, health care costs and also contributes to lost productivity. Public health experts, the media, and government have paid a lot of attention to the obesity crisis in the general population, but its direct impacts on national security and the U.S. military are too often overlooked.

The military is not immune to the negative effects of this growing epidemic. Among the military-age general population, as many as 27 percent of potential candidates for military service would not qualify because of their weight.⁹ Even those who qualify for service still struggle with weight issues. In 2011, about 12 percent of active-duty service members reported a height and weight that indicated obesity (a BMI greater than or equal to 30), a 61 percent increase since 2002.¹⁰ Service members in Afghanistan with obesity were 40 percent more likely to experience an injury than those with a healthy weight.¹¹ While the military as a whole is still fitter than the rest of the population, the stakes are higher when health and fitness are key drivers of mission success.

Figure 1: Obesity Rates in Active-Duty Military and Civilian Adults

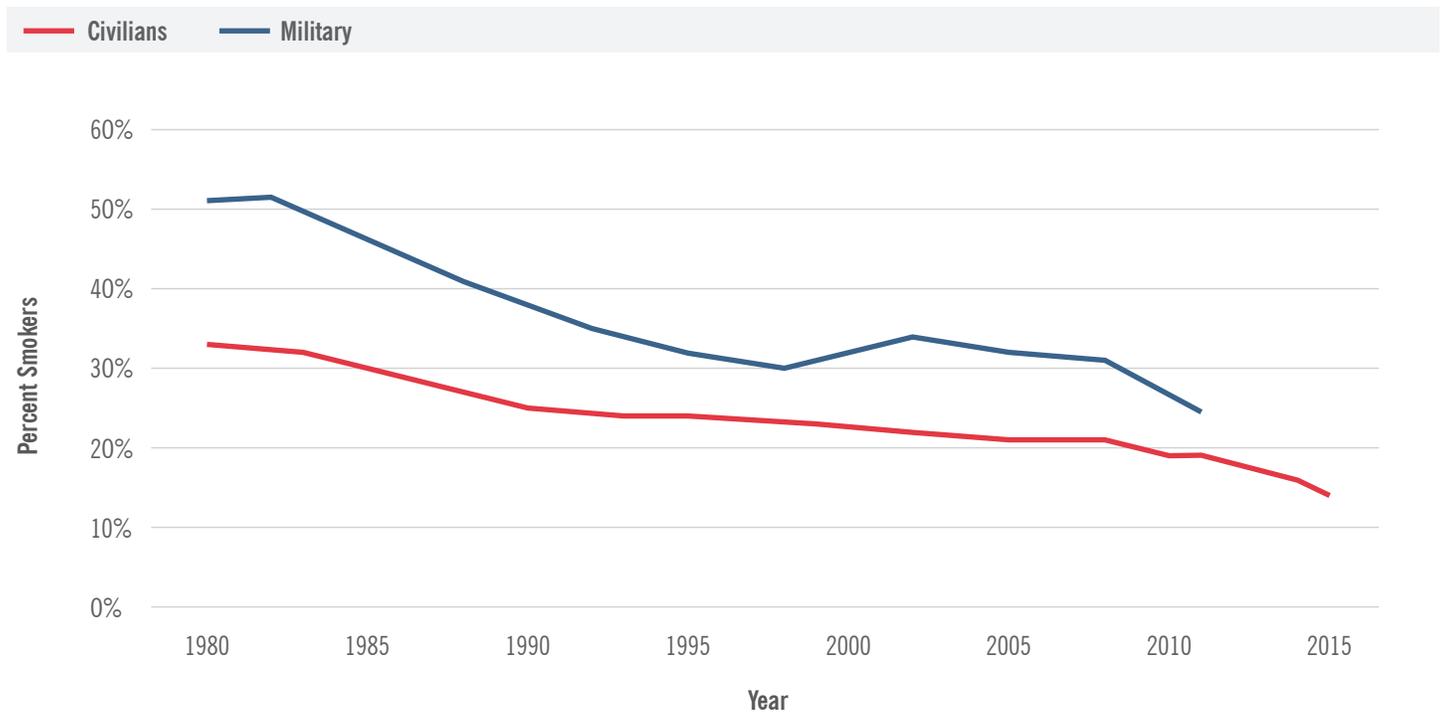


Source: Defense Department, Centers for Disease Control, and National Institute of Diabetes and Digestive and Kidney Diseases ^{12,13,14,15}

According to a 2011 study, one out of every seven male Army recruits reported that they had not exercised or played any sport in a typical week prior to basic training.¹⁶ The Army, faced with recruiting individuals who had less strength and endurance than in the past, revamped its basic-training program in 2010. To reduce injuries, the Army shifted its training from traditional sit-ups and long runs to yoga, core strengthening, and agility drills that mimic soldiers' tasks in the field, such as climbing or jumping. To complement that effort, they also revamped the food offerings during basic training to make sure that healthier choices were available. While these changes are positive steps to address health challenges in new recruits, rapid weight loss over a short period time in highly structured settings like boot camp can be difficult for recruits to maintain once they return to their usual workplaces and communities.

Tobacco use also greatly impacts the readiness of the military. Unlike with obesity rates, smoking rates among active-duty military personnel were found to be higher (24.5 percent) than among civilian populations (20.6 percent).¹⁷ Taking into account smokeless tobacco, nearly half of all service members reported using a nicotine product in the previous year.¹⁸ Long-term tobacco use contributes to increased risk for cardiovascular disease, lung disease, cancer, dental disease, and poor respiratory function.¹⁹ Service members who use tobacco experience reductions in physical fitness and endurance as well as higher absenteeism. The stressful nature of deployments also plays a role; an Institute of Medicine report states that smoking rates among military personnel returning from Iraq and Afghanistan may be as much as 50 percent higher than among non-deployed military personnel.²⁰

Figure 2: Smoking Rates in Active-Duty Military and Civilian Adults



Source: Defense Department and Centers for Disease Control ^{21,22,23,24}

Military installations typically lack the infrastructure to make healthful choices easy for service members and their families. Many of the food outlets, especially those outside of the military-run dining facilities, are dominated by high-calorie options provided by commercial contractors. Like most U.S. cities, military installations were not designed to be navigated on foot or by bicycle; driving is usually the only realistic transportation option. Tobacco products are readily available in military commissaries and exchanges, and until recently were available at lower prices than in civilian retailers. These environments enable lifestyle choices that are likely to promote weight gain and physical underperformance, which results in real readiness challenges for the military. Many involuntary separations occur because of poor fitness or excess weight. In 2012, the Army dismissed 3,000 soldiers and the Navy and Air Force each dismissed 1,300 service members for being overweight or out of shape. Recruiting, screening, and training their replacements cost almost half a billion dollars.²⁵ Service members who use tobacco are more likely to drop out of basic training, and tobacco-related costs to the department top \$1.6 billion annually.²⁶ These problems affect not only the readiness of the force, but also place a large burden on an already-constrained defense budget.

Large-scale policy changes should ideally be based on the collection, aggregation, and analysis of timely data. Since the Defense Department collects massive amounts of information on its personnel and operates a highly structured chain of command that is responsible for monitoring various aspects of service members' lives from enlistment through retirement, one would expect it to track indicators of service-member health that affect readiness and use this information to make strategic, policy, and budgetary decisions to improve the overall well-being and effectiveness of the force. It is unclear

whether the department is currently collecting data from the services about involuntary discharges due to problems with fitness or weight, or if its current data systems allow for timely analysis of any data it may collect. Evidence suggests that there are gaps in the data currently available to Pentagon decision makers in this area. For example, the publicly available data on obesity in the military comes from a series of health behavior surveys where service members *self-reported* their height and weight.²⁷ Also, the military has taken no large-scale, systematic approach to address issues related to the health and wellness of service members. Better data could help decision makers think strategically about where investments could best be directed to improve the health—and therefore the readiness—of the force. It could also foster accountability by identifying low-performance areas and creating incentives to improve them.

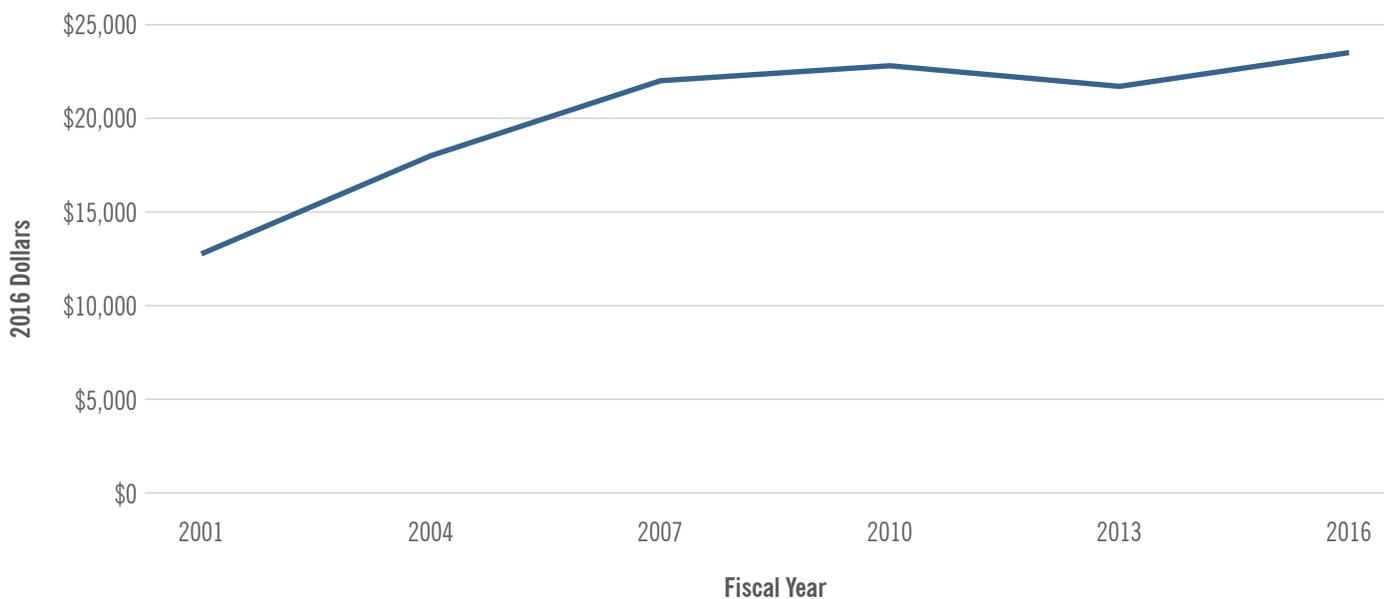
The department has taken some steps to address the health and wellness challenges faced by service members. Through military health benefits, explained in detail in the next section, military service members and their families have access to tobacco-cessation products, as well as a free telephone support line for those looking to quit tobacco. In 2016, Defense Secretary Ash Carter issued new policy guidelines to reduce tobacco use, which included raising the prices of tobacco on military bases to match local market prices. In 2013, the Pentagon launched a three-phase, long-term campaign to increase the health of the military community: Operation Live Well. The three phases are education and outreach, expansion of services and tools to support healthy lifestyles, and development of the infrastructure necessary to support permanent behavior change. As part of that effort, the department launched the Healthy Base Initiative, a pilot program designed to test and measure interventions to achieve a healthy and fit force. Fourteen pilot sites were selected from across all service branches to implement these interventions and evaluate their effectiveness over one year. Based on the resulting data, the Healthy Base Initiative made recommendations to the department on how to grow best practices. In addition to recommendations to promote healthy eating and active living, offer wellness programming to service members and their families, and discourage tobacco use, the report also includes proposals to surmount the many organizational challenges—such as inefficient food procurement systems and lack of coordinated data collection—that have stymied progress on these fronts.²⁸

Military Health Care: How It Works, Challenges, and Potential Solutions

Health care, which refers to systems and services that help to cure or manage medical, dental, and psychological conditions, is an important determinant of health and a highly visible function within the military. While, as noted above, health care is not the only factor or necessarily the most impactful cause of good or poor health across an entire population, it is the primary focus of budgeted resources to promote health in the department. Health care services are clearly critical to the maintenance and restoration of health in many situations, from recovering from traumatic injury to managing chronic disease. Whether treating an ill service member stateside or delivering lifesaving care on and near the battlefield, high-quality health care is essential for supporting the readiness of service members to fight and win wars and to meet the nation's commitment to service members who become injured during conflict.

To meet these needs, the U.S. military operates a comprehensive health care delivery and payment system, which includes military-run hospitals, physicians' offices, pharmacies, mental-health clinics, and more, as well as a system to purchase health care services from private-sector providers. This comprehensive system is known as the Military Health System, and it is charged with delivering the health benefit for service members, dependents, and retirees, which is known as TRICARE. In Fiscal Year 2016, the Military Health System provided health care for an estimated 9.4 million TRICARE beneficiaries, costing \$48 billion, roughly one in every 12 dollars in the defense budget that year.^{29,30}

Figure 3: Defense Health Program – Cost Per Active-Duty Service Member (Fiscal Years 2001 – 2016)



Note: Defense Health Program does not include spending for military personnel assigned to military treatment facilities, construction of medical facilities, and TRICARE For Life.

Source: BPC analysis of Defense Department data ³¹

The Military Health System is complex and decentralized in its organization and operation. TRICARE beneficiaries may receive care from military treatment facilities, which are staffed by uniformed physicians, nurses, dentists, and other health professionals, as well as defense civilians, or from private-sector providers included in the TRICARE network. Some functions, such as the operation of TRICARE health plans and payment to nonmilitary health care providers, are handled by the Defense Health Agency, which is supervised by the assistant secretary of defense for health affairs.³² Military treatment facilities, such as military hospitals and clinics, are managed by the separate services. For example, the Army surgeon general leads the U.S. Army Medical Command, to which all Army medical facilities report.³³

A Ready Medical Force: Prepared to Deliver Everything from Preventive Care to Battlefield Medicine

Maintaining the readiness of the medical force is one of the primary missions of the Military Health System. The medical force must be prepared to deliver comprehensive health care in a time of war—everything from typical illnesses and non-battle injuries to critical care resulting from trauma on the battlefield. Trauma care is an especially challenging competency to maintain because the intensive experience that builds proficiency for uniformed trauma care providers has been limited to wartime.

Combat casualty and rehabilitative care have become more effective than ever, saving thousands of lives; the fatality rate among wounded individuals was 9.3 percent in Iraq and Afghanistan, compared to 23 percent during the Vietnam War.³⁴ While the medical force performed very well in battlefield medicine recently, these gains are at risk as the military is decreasingly engaged in the large-scale, intensive combat that was common over the last 15 years. In the past, trauma and combat-casualty care skills have degraded during peacetime, resulting in preventable deaths and injuries when conflict returns. Absent significant changes to the strategy and operations of the Military Health System, this unwelcome trend will repeat itself.

A panel of experts convened by the National Academy of Medicine to evaluate the military trauma care system observed that most military medical personnel—even general surgeons—usually deliver beneficiary care at military treatment facilities, which does not prepare them for serving trauma patients.³⁵ The panel said:

*“ The best clinical outcomes are achieved by trauma teams that care for trauma patients on a daily basis. In much the same way that military line leadership trains for combat constantly, military trauma teams need to regularly take care of actual trauma patients to ensure the highest quality of care for combat casualties.”*³⁶

Yet, military medical professionals do not obtain this regular experience outside times of sustained combat, fueling concerns that the substantial trauma care capability developed in recent years will soon perish.

The Military Health System’s shortcomings at maintaining readiness are not limited to trauma care competency. Uniformed health care professionals devote substantial time to services that are not central to readiness, such as pediatric care. The Military Compensation and Retirement Modernization Commission reviewed the quantity of services provided at military treatment

facilities and found that, in many cases, military hospitals do not serve the volume of patients needed for providers to maintain a high level of proficiency and achieve the best outcomes for patients.³⁷ This analysis contributed to the commission's conclusion that:

“ MTFs [military treatment facilities], with their current workload and case mix, are not ideal platforms for training military medical personnel for the readiness mission. The predominance of care provided at MTFs does not provide direct training opportunities for those medical specialties most needed in wartime situations. Military medical personnel are misaligned with wartime requirements; deployment rates of medical specialties are highly inconsistent; and medical readiness funding is comingled with beneficiary care costs. Overall workload in MTFs is below commercial standards, particularly in operational specialties.”³⁸

The two analyses reinforce many of the same themes. The deficiencies that they have identified as preventing the Military Health System from maintaining maximum readiness among medical personnel have attracted widespread attention. Their recommended solutions and the efforts of lawmakers to address this structural problem are discussed below. What has become increasingly clear is that the mission of the Military Health System to maintain the readiness of the medical force has been undermined—both by the system's design and its imperative to achieve other goals.

TRICARE: The Military Health Care Benefit

In addition to its role in supporting the readiness of service members, military health care is also an important benefit of military service. Service members and their families pay little or no out-of-pocket costs for TRICARE-covered health care services, such as physicians' office visits, tests, surgeries, hospital stays, and prescription drugs. All active-duty service members and most dependents are enrolled in TRICARE Prime, which is similar to a civilian health maintenance organization (HMO), as care is limited to military treatment facilities and in-network civilian providers, and referrals are required to access a specialist. Service members enrolled in TRICARE Prime do not pay any out-of-pocket costs for covered services nor, generally, do dependents, unless they seek specialty care without a referral. Dependents of active-duty service members also have the option to enroll in TRICARE Standard and Extra, which are similar to civilian preferred provider organizations (PPOs) and cover out-of-network care. The TRICARE PPO option features some beneficiary cost-sharing, such as deductibles (up to \$150 per person or \$300 per family), copayments (for example, \$25 for outpatient surgery), and coinsurance (for example, the beneficiary pays 15 percent of the cost of a primary care office visit).^{39,40} The Fiscal Year 2017 defense-authorization law includes provisions to rename the TRICARE PPO option as TRICARE Select and establish a new cost-sharing design for dependents and future retirees (who enter the military on or after January 1, 2018), which will use copayments instead of coinsurance for most services.⁴¹

TRICARE beneficiaries are, overall, more satisfied with their health plans than civilians enrolled in private-sector health plans.⁴³ This satisfaction is likely a result of the program's broad coverage of benefits and low out-of-pocket contributions from beneficiaries. However, beneficiary satisfaction is lower when asked specifically about health care.⁴⁴ One area where TRICARE consistently underperforms private-sector health plans is in timely access to care.⁴⁵ These access problems extend to both routine appointments and specialty care, such as mental health, and access may be more challenging for reservists and

TABLE A: TRICARE Beneficiaries by Eligibility Category (Fiscal Year 2015)

	Number of Beneficiaries
Active-Duty Service Members	1.38 million
Active-Duty Family Members	1.82 million
Guard and Reserve Members	0.17 million
Guard and Reserve Family Members	0.68 million
Retirees and Family Members	5.4 million
Total	9.44 million

Source: Defense Department⁴²

military retirees who do not live near an installation with military treatment facilities. A recent survey of Air Force personnel even showed that, for a small but significant minority, difficulty obtaining access to care was a top reason to separate from the service.⁴⁶ Ironically, despite this evidence, service utilization among TRICARE beneficiaries is much higher than for the commercially insured population.⁴⁷ While some of this utilization might be due to health care needs resulting from more than 15 years of war, much could be related to poor coordination and inefficiency within the Military Health System, as well as the fact that TRICARE features relatively low, or even no, cost-sharing for beneficiaries, which promotes utilization and therefore may compound access problems given the capacity of the Military Health System.

TRICARE also provides health care benefits to military retirees, who comprise more than half of TRICARE beneficiaries.⁴⁸ Working-age military retirees (under age 65) pay more for coverage than active-duty service members but significantly less than typical out-of-pocket costs of private-sector coverage. In 2017, for example, non-Medicare-eligible military retirees enrolled in TRICARE Prime pay a \$282.60 annual enrollment fee (similar to a premium) for single coverage (\$565.20 for family coverage) and copayments when accessing certain services (for example, \$12 for a primary care or specialist office visit, \$25 for outpatient surgery, \$30 for use of a hospital emergency department).^{49,50} TRICARE Prime does not include a deductible. Future retirees (those who enter military service on or after January 1, 2018, and subsequently retire) will be subject to slightly higher enrollment fees and cost-sharing.⁵¹

To put these costs in perspective, in employer-based health plans for 2016, the average annual contribution to premiums by employees was \$1,129 for single coverage and \$5,277 for family coverage, and about half of workers covered by workplace health plans were subject to a general annual deductible of \$1,000 or more (for single coverage) before most services would be covered by the plan, along with average copayments of \$24 for a primary care office visit and \$38 for specialty care.⁵² As a result, many working-age retirees and their families use TRICARE for some or all of their health care needs, even if they have access to other health insurance from a current employer. (Many have both forms of coverage, yet the department does not know which TRICARE beneficiaries are covered by other health insurance and therefore cannot coordinate benefits and care with other health plans.) Benefits for military retirees who are not yet eligible for Medicare are funded from annual defense appropriations on a pay-as-you-go basis, meaning that TRICARE costs for current military retirees enrolled in TRICARE Prime and TRICARE PPO options are paid out of the current defense budget.

Once military retirees become eligible for Medicare (typically upon reaching age 65), they are covered by TRICARE For Life, which has no annual enrollment fee. Medicare includes substantial beneficiary cost-sharing, such as a \$1,316 deductible for most episodes of hospital care and a separate \$183 annual deductible for physician services and other medical care; once the medical deductible is met, beneficiaries must pay 20 percent of the cost of physician services.⁵³ TRICARE For Life pays for all of these out-of-pocket costs, fills in other coverage gaps within Medicare, and also offers drug coverage with no copayments for prescriptions filled at military pharmacies.⁵⁴ (Beneficiaries who do not live near a military pharmacy can obtain generic drugs for a \$10 copayment and name-brand drugs for a \$24 copayment at in-network neighborhood pharmacies.)⁵⁵ TRICARE For Life is pre-funded, meaning that funds are set aside from the current defense budget to cover the cost of TRICARE For Life for future military retirees.

Low out-of-pocket costs and broad coverage of services make TRICARE popular with beneficiaries, but they also contribute to the high cost of TRICARE relative to other workplace health plans and retiree health benefits. Inefficient delivery of care and underutilized facilities—which affect the readiness of the medical force, described above—also result in higher costs for TRICARE.

TABLE B: Selected TRICARE Prime In-Network, Out-of-Pocket Costs*

	Active-Duty Service Members and Dependents	Military Retirees (Entering Service Before 2018) and Dependents	Military Retirees (Entering Service in 2018 or later) and Dependents**
Annual Enrollment Fee	None	\$282.60 single / \$565.20 family	\$350 single / \$700 family
Annual Deductible	None	None	None
Preventive Services	\$0	\$0	\$0
Physician Office Visit (Primary Care or Specialty)	\$0	\$12 per visit	\$20 per primary care visit \$30 per specialty care visit
Emergency-Department Visit	\$0	\$30 per visit	\$60 per visit
Outpatient Surgery	\$0	\$25	\$60
Hospitalization	\$0	\$11 per day (\$25 minimum)	\$150 per admission

*Most active-duty service members, non-Medicare-eligible military retirees, and their families are enrolled in TRICARE Prime. Some are enrolled in TRICARE Standard and Extra, which feature different out-of-pocket costs not presented here.

**The soonest any retirees will be affected by these changes will be the late 2030s. Enrollment fees and copayments listed in this column are for calendar year 2018, when no retiree will be affected; in subsequent years, these out-of-pocket costs will be updated annually for growth in general consumer prices.

Source: TRICARE⁵⁶ and Public Law 114-328.

What Have Others Recommended—and What Are Policymakers Doing—to Improve the Military Health Care System?

In recent years, the Military Health System has been the focus of many analyses and attempts by administrations of both political parties to implement reforms, especially to reduce the cost of the system and improve the quality of services.⁵⁷ Despite these efforts, policymakers have made few changes to the operations of military health care and the TRICARE benefit design, in large part because changes to military health care affect many stakeholders and are usually politically controversial. But that dynamic is about to change. Recently, two respected groups of experts—the Military Compensation and Retirement Modernization Commission and the National Academy of Medicine—made comprehensive recommendations to reform the military health care delivery system to better support the readiness of uniformed medical providers, deliver higher-quality services and faster access for beneficiaries, and achieve a more-efficient system. Lawmakers have incorporated many of these delivery-system reform and personnel recommendations into the enacted version of the Fiscal Year 2017 National Defense Authorization Act legislation.⁵⁸ The commission also recommended very substantial changes to the TRICARE benefit design as well as increases to out-of-pocket costs for dependents of service members and military retirees. These recommendations have not attracted the support of lawmakers, who have proposed to preserve the existing system of TRICARE coverage for dependents and retirees, with modest tweaks and much smaller increases to out-of-pocket costs, most of which would apply only to future military retirees (those entering service in 2018 or later and retiring in the late 2030s or later).⁵⁹

The commission, which conducted a comprehensive review of service-member compensation and issued recommendations in early 2015, proposed several reforms to the Military Health System.⁶⁰ Currently, the system has decentralized management, with various functions reporting to the three different service medical organizations. The commission recommends centralizing responsibility for military health care delivery and personnel under a new joint command for readiness, which would also have duties unrelated to health care. This proposal is intended to refocus the military health care delivery system on the twin readiness goals of a medically ready force and a ready medical corps. In particular, the commission’s approach would increase the volume of treatments and procedures performed by military medical providers in order to maintain a high level of proficiency in skills that are essential to their readiness to deliver needed care when deployed. To achieve these volumes and outcomes, the commission proposes that the Military Health System be managed differently, such as by partnerships with other health systems, which could provide patient volumes that military providers need to maintain expert-level competency. These changes would also promote high-quality services for TRICARE beneficiaries and faster access to care, addressing key areas of dissatisfaction with the program.

While the National Academy of Medicine panel focused their recommended changes to military health care specifically on those necessary to maintain expert-level trauma care capabilities, their proposed approach is essentially the same as that advanced by the commission.⁶¹ In particular, the academy panel proposed that responsibility for the readiness, operation, and personnel of the military trauma care system be centralized at the Defense Health Agency and that military trauma care providers be permanently stationed at assignments where they will regularly provide a high volume of trauma care, such as at civilian Level I trauma centers.^{62,63}

The approaches to military health care delivery-system and personnel reform proposed by both expert groups were incorporated in the Fiscal Year 2017 defense-authorization law, with some modifications. For example, instead of creating a new joint command for readiness, the enacted authorization will centralize responsibility for military health care delivery and personnel in the existing Defense Health Agency.⁶⁴ The conferees included the following statement in their report to explain their rationale for this major reform:

*“ After careful study and deliberation, the conferees conclude that a single agency responsible for the administration of all MTFs would best improve and sustain operational medical force readiness and the medical readiness of the Armed Forces, improve beneficiaries’ access to care and the experience of care, improve health outcomes, and lower the total management cost of the military health system. The conferees believe that the current organizational structure of the military health system—essentially three separate health systems each managed by one of the three Services—paralyzes rapid decision-making and stifles innovation in producing a modern health care delivery system that would better serve all beneficiaries. A streamlined military health system management structure would eliminate redundancy and generate greater efficiency, yielding monetary savings to the Department while leading to true reform of the military health system and improving the experience of care for beneficiaries.”*⁶⁵

The law will also: facilitate partnerships among military treatment facilities and other health systems—including private-sector health care providers and the Veterans Health Administration—to maintain medical readiness; restructure military health care facilities—as well as establish regional centers of excellence for specialty care—to improve quality, readiness, and efficiency; expand access to care through telemedicine; promote beneficiary participation in wellness and disease-management programs; and use new contracting models that allow providers to share in savings resulting from improvement in beneficiary health outcomes—among many other provisions. Along with these changes, the law requires a comprehensive review of combat casualty care and wartime trauma systems, expansion of military-civilian trauma and combat-casualty care training sites, and other measures to improve combat care and maintain readiness for important wartime medical specialties. The law also includes provisions to establish new metrics of accountability for system leadership, including measures focused on quality of care, beneficiaries’ access to care, improvement in beneficiaries’ health outcomes, and patient safety. Put simply, the Fiscal Year 2017 defense-authorization law is the beginning of a sweeping transformation of the Military Health System.

Changes to the TRICARE benefit design and out-of-pocket costs for beneficiaries are much more controversial, and policymakers have reacted to such proposals with caution. The compensation commission recommended major changes to both the form of the TRICARE benefit and out-of-pocket costs for both dependents of current service members and military retirees. Under the commission’s proposal, TRICARE would be replaced for these beneficiaries with a new system of commercially insured health plans, similar to the health care benefit for federal employees. Dependents of service members would be charged an enrollment fee equal to 28 percent of the costs of the new program, but dependents would also receive a new allowance for health care that would offset the average beneficiary’s out-of-pocket costs under the new program. Retirees would be charged an enrollment fee equal to 20 percent of the costs of the new TRICARE option (gradually phased in over 15

years), and they would not receive the new allowance. In addition to the cost savings from the increased enrollment fee, the commission argued that the commercial health plans would improve timely access to care for beneficiaries, especially those who live far from military treatment facilities and in areas where TRICARE provider networks are not as comprehensive.

Not surprisingly, lawmakers have not embraced the commission's proposals on TRICARE costs and delivery of the benefit through commercial health plans. The Fiscal Year 2017 defense-authorization law includes provisions to modestly increase TRICARE fees for future retirees, along with a provision to launch a voluntary pilot program to test offering commercially insured health plans through TRICARE to reserve-component members, who are more likely to live in remote regions where TRICARE-provider networks may be insufficient.

Conclusion

The health of service members and their families—and the health care services available to them—are critical personnel issues. Healthy service members and a high-performing health care system are necessary to maintain readiness and maximize the performance of the force, as well as to attract and retain highly capable service members in a competitive talent marketplace.

Many aspects of military life affect the health of service members, and many groups have presented a variety of proposals to promote more healthful lifestyles and working conditions. The Pentagon is well-positioned to manage everyday systems—such as food service, facilities, and transportation—in ways that encourage wellness, from healthy eating to exercise to good sleep habits. However, these functions have not always been priorities, while statutory and cultural barriers have stymied previous efforts.

The performance of the Military Health System has attracted intense interest from expert analysts, beneficiaries, military leaders, and policymakers. Their concerns include the quality of the health care system and its impact on the readiness of service members in general; the readiness of the medical force to deliver expert-level performance when deployed in particular, with special concern for the need to maintain trauma care capabilities as the United States withdraws from Iraq and Afghanistan; and the need to improve access, quality, and value for service members, their families, and military retirees. Many stakeholders have made proposals to address these challenges, and lawmakers have initiated a serious and comprehensive effort to reform the Military Health System.

The task force is reviewing these challenges, among many other defense-personnel topics, and will propose its own recommendations in early 2017.

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Notes

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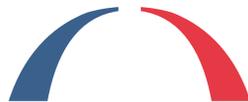
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