Order Code RL33537

CRS Report for Congress

Military Medical Care: Questions and Answers

Updated October 31, 2008

Don J. Jansen
Analyst in Defense Health Care Policy
Foreign Affairs, Defense, and Trade Division

Prepared for Members and
Committees of Congress

Military Medical Care: Questions and Answers

Summary

The primary mission of the military health system, which includes 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 health care services through either Department of Defense (DOD) medical facilities, known as "military treatment facilities" or "MTFs" as space is available, or, through private health care providers.

Known as "Tricare," this system of military and private health care offers benefits to active duty personnel and other beneficiaries, including dependents of active duty personnel, military retirees, and dependents of retirees. Tricare beneficiaries can obtain prescription drugs through a pharmacy system that includes MTF pharmacies, network retail pharmacies, non-network retail pharmacies, and the Tricare Mail Order Program (TMOP). Dependents of active duty personnel and retirees and dependents under age 65 can choose to enroll in Tricare Prime (a managed care option), or if they choose not to enroll, they can obtain care through Tricare Standard (a fee-for-service option) or Tricare Extra (preferred-provider option). Retirees who are eligible for Medicare can enroll in Tricare For Life (TFL).

The military health system currently includes some 63 hospitals and 413 clinics serving an eligible population of 9.2 million. It operates worldwide and employs some 44,100 civilians and 89,400 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 $41.6 billion in FY2009 (the latter figure includes $10.4 billion paid to an accrual fund for Medicare eligible retirees). DOD projects total medical spending to grow, perhaps reaching $64 billion in FY2015.

As of 2007, active duty military and their dependents made up 44% of Tricare beneficiaries. Thirty-six percent of beneficiaries were retirees under age 65 and their dependents, and 20% were retirees age 65 and over and their dependents. DOD estimates that care provided to retirees and their dependents will make up over 65% of DOD health care costs by 2015, up from 43% in 1999.

The Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (P.L. 110-417, October 14, 2008), prohibits fee increases proposed in the Administration's 2009 budget to help address increased defense health care costs. However, this act included measures intended to contain costs through increased use of preventive care services by Tricare beneficiaries. These provisions include waiving copayments for preventive services, and demonstration projects to provide incentives for preventive health care.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 RL34473, *Defense: FY2009 Authorization and Appropriations*, by Pat Towell, Stephen Daggett, Amy Belasco.

Contents

Most Recent Developments 1

Background 1

Questions and Answers 2

1. What Is the Purpose of DOD's Military Health System? 2
2. What Is the Structure of the Military Health System? 2
3. What is the Unified Medical Budget? 4
4. What is the Medicare Eligible Retiree Health Care Fund (MERHCF)? 6
5. How Much Does Military Health Care Cost Beneficiaries? 6
6. In What Ways Has the Military Health System Been Changing in Recent Years? 8
7. Who Is Eligible to Receive This Care? 10
8. How Are Priorities for Care in Military Medical Facilities Assigned? 11
9. What Is the Relationship of DOD Health Care to Medicare? 12
10. Have Military Personnel Been Promised Free Medical Care for Life? 13
11. How Are Private Health Care Providers Paid? 13
12. What Will Be the Effect of Base Realignment and Closure (BRAC) on Military Medical Care? 14
13. What Is the DOD Pharmacy Benefit? 15
14. What Medical Benefits are Available to Reservists? 16

List of Tables

Table 1. Tricare Fees for Active Duty Personnel, Eligible Reservists, and Dependents 7

Table 2. Tricare Fees for Retirees Under Age 65 and Their Dependents 8

Military Medical Care: Questions and Answers

Most Recent Developments

The Duncan Hunter National Defense Authorization Act for Fiscal Year 2009 (P.L. 110-417, October 14, 2008), prohibits fee increases proposed in the Administration's 2009 budget. This act includes measures intended to contain costs through increased use of preventive care services by Tricare beneficiaries. Other provisions include waiving copayments for preventive services, a health risk assessment demonstration program, a smoking cessation program, and a demonstration project that will use financial incentives to encourage service members and their families to get all of the preventive health requirements set forth by DOD.

Background

Although the Military Health System is the primary source of 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 their dependents, and survivors of deceased service members. Since 1966, civilian care to millions of dependents and retirees (and retirees' dependents) has been provided through a program still known in law as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) but more commonly known as Tricare. Tricare has four main benefit plans including a health maintenance organization option (Tricare Prime), a preferred provider option (Tricare Extra), a fee-for-service option (Tricare Standard), and a Medicare wrap-around option (Tricare for Life) for Medicare-eligible retirees. Options available to beneficiaries vary by the beneficiaries duty status and location.

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 Government 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.health.mil/].

Questions and Answers

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

In law, the purpose of the legislation authorizing the military health system is " to create and maintain high morale in the uniformed services by providing an improved and uniform program of medical and dental care for members and certain former members of those services, and for their dependents."[1] The military health system helps to maintain the health of military personnel so they can carry out their military missions. The military health system must also 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 service members involved in hostilities, and the maintenance of physical standards of those in the armed services. In addition, recruitment and retention are supported by the provision of health benefits to military retirees and their dependents.

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

The military health system consists of (1) the Defense Health Program (DHP) which is centrally directed by the Office of the Secretary of Defense and decentrally executed by the military departments, and (2) medical resources under the direction of the combatant or support command within the military departments. For DOD, the Assistant Secretary of Defense for Health Affairs (ASD(HA)) controls nondeployable medical resources, facilities and personnel. The ASD(HA) reports to the Undersecretary of Defense Personnel and Readiness who reports to the Deputy Secretary of Defense. The following all currently report to the ASD/HA:

- Deputy Assistant Secretary of Defense for Clinical and Program Policy
- Deputy Assistant Secretary of Defense for Force Health Protection and Readiness
- Deputy Assistant Secretary of Defense for Health Budget and Financial Policy
- Deputy Director Tricare Management Activity
- Chief Information Officer for Health
- Director, Strategy and Development
- Director, Communication and Media Relations
- Director, Defense Center of Excellence for Psychological Health and Traumatic Brain Injury
- President, Uniformed Services University of the Health Sciences

Other elements within the Office of the Secretary of Defense, such as the Office of the Director for Program Analysis and Evaluation and the Office of the Under Secretary of Defense (Comptroller), are also responsible for various aspects of the military health system.

---

[1] 10 U.S.C. 1071.

Within the services, the Surgeons General of the Army, Navy and Air Force retain considerable responsibility for managing military medical facilities and personnel. The Joint Staff Surgeon advises the Chairman of the Joint Chiefs of Staff.

The Surgeon General of the Army heads the U.S. Army Medical Command (MEDCOM) which along with the Office of the Surgeon General itself compose the Army Medical Department (AMEDD). The Surgeon General of the Army reports directly to the Secretary of the Army. MEDCOM commands fixed hospitals and other AMEDD commands and agencies. Field medical units, however, are under the command of the combat commanders.

The Surgeon General of the Navy reports to the Chief of Naval Operations through the Chief, Navy Staff and Vice Chief of Naval Operations and heads the Navy Bureau of Medicine and Surgery (BUMED), the headquarters command for Navy Medicine. All Defense Health Program resources allocated to the DON are administered by BUMED. Also within the Department of the Navy, the Medical Officer, U.S. Marine Corps advises the Commandant of the Marine Corps and Headquarters staff agencies on all matters about health services.

The Surgeon General of the Air Force serves as functional manager of the U.S. Air Force Medical Service, an element of Headquarters, U.S. Air Force. The Air Force Surgeon General advises the Secretary of the Air Force and Air Force Chief of Staff.

The recent Final Report of the Task Force on Future of Military Health Care noted that there has been considerable debate about the appropriate command and control structure for the military health system.[2] Alternatives to the current structure that have been suggested include a defense health agency or a unified medical command. An October 2007 Government Accountability Office report faulted DOD's analysis of these options for the lack of a comprehensive cost-benefit analysis.[3]

The military health system currently includes 63 hospitals and 413 clinics serving an eligible population of 9.2 million. It operates worldwide and employs some 44,100 civilians and 89,400 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.

The Tricare Management Activity (TMA) listed above supervises and administers the Tricare program. TMA is organized into six geographic health service regions:

---

[2] Department of Defense, *Task Force on the Future of Military Health Care*, December 2007, pp. 113-116.

[3] GAO-08-122, *Defense Health Care: DOD Needs to Address the Expected Benefits, Costs, and Risks for Its Newly Approved Medical Command Structure* October 2007, p. 15.

- Tricare North Region covering Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Kentucky, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, Wisconsin, and portions of Iowa, Missouri, and Tennessee. The Tricare North regional contractor is currently Health Net Federal Services.
- Tricare South Region covering Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, and most of Tennessee and Texas. The Tricare South regional contractor is currently Humana Military Health Services.
- Tricare West Region covering Alaska, Arizona, California, Colorado, Hawaii, Idaho, most of Iowa, Kansas, Minnesota, most of Missouri, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, portions of Texas, Utah, Washington, and Wyoming. The Tricare West regional contractor is TriWest Healthcare Alliance.
- Tricare Europe Area covering Europe, Africa, and the Middle East.
- Tricare Latin America and Canada Area covering Central and South America, the Caribbean Basin, Canada, Puerto Rico and the Virgin Islands.
- Tricare Pacific Area covering Guam, Japan, Korea, Asia, New Zealand, India and Western Pacific remote countries.

More information is available at [http://www.tricare.mil/tma/AboutTMA.aspx].

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. As of 2007, active duty military and their dependents made up 44 % of Tricare beneficiaries, 36% of beneficiaries were retirees under age 65 and their dependents and 20% were retirees age 65 and over and their dependents. DOD estimates that care provided to retirees and their dependents will make up over 65% of DOD health care costs by 2015, up from 43% in 1999[4].

3. What is the Unified Medical Budget?

ASD(HA) prepares and submits a unified medical budget which includes resources for the medical activities under his or her control within the DOD. The unified medical budget includes funding for all fixed medical treatment facilities/activities, including such costs as real property maintenance, environmental compliance, minor construction and base operations support. Funds for medical personnel and accrual payments to the Medicare Eligible Retiree Health Care Fund (MERHCF - see *What is the MERHCF?* below) are also included. The unified medical budget does not include resources associated with combat support medical units/activities. In these instances the funding responsibility is assigned to military service combatant or support command.

---

[4] Department of Defense, *Report of the The Tenth Quadrennial Review of Military Compensation: Volume II Deferred and Noncash Compensation*, July. 2008, p. 45

Unified medical budget funding has traditionally been appropriated in several places:

- The defense appropriations bill generally provides under the "Other Department of Defense Programs" title funding for Operations and Maintenance (O&M), Procurement, and Research, Development, Test and Evaluation (RDT&E) are appropriated under the heading "Defense Health Program."
- Funding for military personnel and accrual payments are. generally provided in the defense appropriations bill under the "Military Personnel"(MILPERS) title.
- Funding for medical military construction (MILCON) is generally provided under the "Department of Defense" title of the military construction and veterans affairs bill.
- A standing authorization for transfers from the MERHCF to reimburse Tricare for the cost of services provided to medicare eligible retirees is provided by 10 U.S.C. 1113.
- Costs of war related military health care is generally funded through supplemental appropriations bills.

Other resources are made available to the military health system from third party collections authorized by 10 U.S.C. 1097b(b) and a number of other reimbursable program and transfer authorities. The President's budget typically refers to the unified medical budget request as its funding request for the military health system but only includes an exhibit for the DHP in the "Department of Defense - Military" chapter and exhibits for the MERHCF in the "Other Defense — Civil Programs" chapter of the Appendix volume. Medical MILCON and MILPERS request levels are generally found in DOD's budget submissions to Congress.

The Administration's 2009 unified medical budget request[5] totaled $41.6 billion and included:

- $23.6 billion for the Defense Health program including $6.5 billion for in-house care, $12.1 billion for private sector care, $1.3 billion for consolidated health supports, and $1.1 billion for information management;
- $7.1 billion for military personnel;
- $0.5 billion for medical military construction, and;
- $10.4 billion for accrual payments to the MERHCF ($9 billion from which would be transferred to the Defense Health Program).

Much more detailed breakouts are available in budget exhibits published by the Department of Defense.

---

[5] Department of Defense, *Fiscal Year 2009 Budget Request Summary Justification*, February 4, 2008, p. 85. Available at [http://www.defenselink.mil/comptroller/defbudget/fy2009/FY2009_Budget_Request_Justification.pdf]

4. What is the Medicare Eligible Retiree Health Care Fund (MERHCF)?

The Floyd D. Spence National Defense Authorization Act for FY2001(NDAA) directed the establishment of the Medicare-Eligible Retiree Health Care Fund to pay for Medicare-eligible retiree health care beginning on October 1, 2002. Prior to this date, care for Medicare-eligible beneficiaries was space available care in MTFs. The MERHCF covers Medicare-eligible beneficiaries, regardless of age. The NDAA also established an independent three-member DoD Medicare-Eligible Retiree Health Care Board of Actuaries appointed by the Secretary of Defense. The Board is required to review the actuarial status of the fund; to report annually to the Secretary of Defense, and to report to the President and the Congress on the status of the fund at least every four years. The DoD Office of the Actuary provides all technical and administrative support to the Board.

Within DoD, the Office of the Under Secretary of Defense for Personnel and Readiness, through the Office of the Assistant Secretary of Defense (OASD) for Health Affairs (HA) has as one of its missions operational oversight of the defense health program including management of the MERHCF. The Defense Finance and Accounting Service provides accounting and investment services for the fund.

In FY2007, the MERHCF initially authorized approximately $7.7 billion in total health care services, civilian providers ($5.9 billion), military medical treatment facilities ($1.4 billion), and Military Service Personnel Accounts ($0.4 billion), on behalf of Medicare eligible retirees, retiree dependents, and survivors.[6]

5. How Much Does Military Health Care Cost Beneficiaries?

Active duty service members receive medical care at no cost. Other beneficiaries pay differing amounts depending on their status, the Tricare option enrolled in, and where they receive care. The tables below illustrate.

[6] Department of Defense, *Fiscal Year 2007 Medicare-Eligible Retiree Health Care Fund Audited Financial Statements,* November 30, 2007, page 2.

Table 1. Tricare Fees for Active Duty Personnel, Eligible Reservists, and Dependents

	Prime	Extra	Standard
Annual Deductible	None	$150/individual or $300/family for E-5 and above; $50/$100 under E-5.	$150/individual or $300/family for E-5 and above; $50/$100 under E-5.
Annual Premium	None	None	None
Civilian Outpatient Visit Cost Share	None	15% of negotiated fee.	20% of allowed charges for covered services.
Civilian Inpatient Admission Cost Share	None	Greater of $25 per admission or $14.35/day. No cost for separately billed professional charges.	Greater of $25 per admission or $14.35/day. No cost for separately billed professional charges.
Civilian Inpatient Behavioral Health Cost Share	None	Greater of $25 or $20/day. No cost for separately billed professional charges.	Greater of $25 or $20/day. No cost for separately billed professional charges.
Civilian Inpatient Skilled Nursing Facility Cost Share	None	Greater of $25 per admission or $11/day. No cost for separately billed professional charges.	Greater of $25 per admission or $11/day. No cost for separately billed professional charges.

Source: Department of Defense, *Tenth Quadrennial Review of Military Compensation*, page 44.

Table 2. Tricare Fees for Retirees Under Age 65 and Their Dependents

	Prime	Extra	Standard
Annual Deductible	None	$150/individual or $300/family.	$150/individual or $300/family.
Annual Premium	$230/individual or $460/family	None	None
Civilian Outpatient Visit Cost Share	None	20% of negotiated fee.	25% of allowed charges for covered services.
Civilian Inpatient Admission Cost Share	Greater of $25 per admission or $11/day. No cost for separately billed professional charges.	Lesser of $250/day or 25% of negotiated fee, plus 20% of negotiated professional fees.	Greater of $535/day or25% of hospital per diem plus 25% of allowable charge for separately billed professional services.
Civilian Inpatient Behavioral Health Cost Share	$40/day. No cost for separately billed professional charges.	20% of total charge plus 20% of allowable charge for separately billed professional services.	Lesser of $175/day or 25% of hospital per diem plus 25% of allowable charge for separately billed professional services.
Civilian Inpatient Skilled Nursing Facility Cost Share	Greater of $25 per admission or $11/day.	Lesser of $250/day or 20% of negotiated fee, plus 20% of separately billed professional charges..	25% of allowed charges plus 25% of allowable charges for separately billed professional services.

Source: Department of Defense, *Tenth Quadrennial Review of Military Compensation*, page 45.

6. 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. However, the collapse of the Soviet Union and the end of the Warsaw Pact led to a major reassessment of U.S. defense policy. This led defense planners to believe, the most likely conflicts will be of limited duration and involve smaller numbers of troops in the future. Indeed, the overall size of the active duty force has been reduced by one-third since the mid-1980s. Planners expected 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, required a smaller medical establishment, fewer military medical personnel, and the closure of a number of hospitals and clinics.

More recently, considerations driven by the events of September 11, 2001, and the resulting Global Ware on Terrorism(GWOT) have driven changes in DOD's planning. The 2006 edition of the Quadrennial Defense Review (QDR) focused DOD on better defining its responsibilities for homeland defense within a broader national framework including GWOT, counterterrorism, counterinserguency, and military support for stabilization and reconstruction efforts. With respect to the military health system, the QDR process identified 18 initiatives across 4 focus areas: (1) transform the force, (2) transform the infrastructure, (3) transform the business, and (4) sustain the benefit.[7] As part of this process, DOD launched a Medical Readiness Review (MRR) in August 2004. The MRR was intended to determine the optimal size of the active duty medical force. The results of the MRR led to plans for converting military health billets to civilian jobs. From FY2005 to FY2007, the Navy converted 2,676 military positions to civilian positions, created a hiring plan for 2,116 converted positions, and hired 1,349 civilian employees. The Army planned to convert 1,588 positions in fiscal years 2006 and 2007. And the Air Force planned to convert 1,216 military positions to civilian jobs.[8] These conversions have been controversial within the military services and Congress has imposed limitations on these so called "mil-civ" conversions in each of the last three NDAAs.

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 were 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,

---

[7] Office of the Assistant Secretary of Defense for Health Affairs, *Quadrennial Defensse Review: Roadmap for Medical Transformation,* April 3, 2006, pages 1-2.

[8] Department of Defense, *Task Force on the Future of Military Health Care Final Report*, December 2007, page 111.

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.[9] Unlike private insurance plans, Tricare Standard does not require premiums. If care at a military 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 an estimated $41.6 billion in FY2009 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.[10]

7. 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

---

[9] 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.

[10] Congressional Budget Office, *Long-Term Implications of Current Defense Plans and Alternatives: Summary Update for Fiscal Year 2006*, October 2005.

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.

8. 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.[11]

9. 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).

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

---

[11] See CRS Report RL32975, *Veterans' Medical Care: FY2006 Appropriations*, by Sidath Viranga Panangala.

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.[12]

10. 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] spend an incredible amount of effort trying to re-educate people [that] that is not their benefit."[13]

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."[14]

11. How Are Private Health Care Providers Paid?

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.

---

[12] See CRS Report RS21731, *Medicare: Part B Premium Penalty*, by Jennifer O'Sullivan.

[13] 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.

[14] For additional background, see CRS Report 98-1006, *Military Health Care: The Issue of "Promised" Benefits*, by David F. Burrelli.

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 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.[15] 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.[16]

---

[15] See CRS Report RL32216, *Military Base Closures: Implementing the 2005 Round*, by David E. Lockwood.

[16] For further information, see the DOD BRAC website, [http://www.defenselink.mil/brac/].

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 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?

Those with access to military treatment facilities and those who are enrolled in Tricare Prime receive prescribed pharmaceuticals free of charge. 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 703 of the FY2008 National Defense Authorization (P.L. 110-181) made pharmaceuticals purchased by Tricare beneficiaries through retail pharmacies subject to federal pricing schedules. However, to date, regulations to implement this provision have not been published. DoD expects to realize savings of $1.8 billion over the next five years through application of this rebate program.[17]

---

[17] Congressional Budget Office Cost Estimate, S. 1547 National Defense Authorization Act for FY2008 (June 21, 2007) at 12-13.

Section 702 of the FY2009 Defense Authorization Act (P.L. 110-417) prohibited increases in pharmacy co-payments for beneficiaries through the end of FY2009.

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).