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## INSTITUTE FOR DEFENSE ANALYSES

FY 2023 NDAA Section 707 Study: Providing Benefits Under TRICARE Reserve Select and TRICARE Dental Program to Members of the Selected Reserve and Their Dependents

> Sarah K. John, Project Leader Todd C. Leroux Jamie M. Lindly EunRae Oh John S. Zhou Hilmara L. Donde John E. Whitley

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# FY 2023 NDAA Section 707 Study: Providing Benefits Under TRICARE Reserve Select and TRICARE Dental Program to Members of the Selected Reserve and Their Dependents

Sarah K. John, Project Leader Todd C. Leroux Jamie M. Lindly EunRae Oh John S. Zhou Hilmara L. Donde John E. Whitley

## **Executive Summary**

The Department of Defense (DoD) provides a comprehensive health benefit known as TRICARE to service members on active duty, and to their eligible dependents. Reserve component service member (RCSM) eligibility for the primary TRICARE benefit is tied to their activation status. When RCSMs are activated for a period of more than 30 days, they (and their dependents) become eligible for the primary premium-free TRICARE benefit—the same benefit used by active component (AC) service members. However, when they are in a non-active status (i.e., working in their civilian occupation), they do not qualify for this benefit. During non-active periods, RCSMs can opt to purchase a premiumbased TRICARE benefit known as TRICARE Reserve Select (TRS), obtain non-DoD healthcare coverage, or go uninsured. DoD-provided dental benefits work in a parallel fashion, with coverage and premium rates anchored to activation status.

The topic of RCSM health and dental benefits has received considerable attention in recent years, with reform calls focused on expanding eligibility and providing the current premium-based options "premium-free" or at "zero cost." Such calls have garnered support from military service leaders, military service organizations, and members of Congress. Those in favor of expanding RCSM health and dental benefits argue this would improve RCSM medical and dental readiness, improve recruitment and retention, address the uninsured RCSM population, and reduce difficulties RCSMs face when transitioning between health plans. Opponents argue such an expansion would be prohibitively costly, and some have also raised concerns over the feasibility of such an expansion and whether the current TRICARE program would be able to support a potentially large increase in the beneficiary population.

To address these issues, Section 707 of the fiscal year (FY) 2023 National Defense Authorization Act (NDAA) called for a study on the feasibility and potential cost of expanding TRICARE Reserve Select and the TRICARE dental program benefits under several policy scenarios, including premium-free options. To meet this requirement, the Office of the Deputy Assistant Secretary of Defense for Reserve Integration asked the Institute for Defense Analyses (IDA) to perform this study.

## **Research Approach**

The objective of this study was to examine the costs, benefits, and feasibility of the proposed benefit expansion scenarios for RCSMs. To meet these objectives, IDA

performed four key analyses: a population analysis, a cost analysis, a benefit analysis, and a feasibility analysis. We outline each below:

- **Population Analysis:** The population analysis uses data from the Defense Manpower Data Center (DMDC) to document the size and demographic composition of the eligible RCSM population (including dependents). We constructed analytic cohorts based on the RCSMs' rank group (proxy for age and income) and family status (single or with dependents). Cohorts were further subdivided based on their current healthcare (and dental) coverage status, allowing us to construct population take-up rates (the percentage of the eligible population already enrolling in the current premium-based plans). The population analysis constitutes a critical analytic foundation for the subsequent cost, feasibility, and benefit analyses.
- **Cost Analysis:** To estimate the cost of different TRICARE benefit-expansion scenarios, we developed two TRICARE cost models: a medical model, and a dental model. The cost models use data on the size of the eligible population and the average cost of covering each of the analytic cohort groups to estimate the expected total cost (and total cost increase) of the benefit-expansion scenarios relative to the status quo. Average costs were constructed from administrative data obtained from the Defense Health Agency (DHA). The expected take-up rate (i.e., how many new users will opt into the benefit once premiums are waived or reduced) constitutes a primary input into the cost model; the cost analysis provides a best estimate of take-up behavior and defines the analysis' range of possibilities.
- **Benefit Analysis:** The potential benefits of expanding RCSM health and dental benefits are often discussed but rarely quantified. We developed a framework for quantifying commonly discussed benefits (e.g., improved medical readiness, improved recruiting, etc.) by estimating the potential marginal gains (i.e., how many additional RCSMs might be made medically ready, how many additional enlistments might occur, etc.). We then calculated the marginal cost of these gains to assess their cost effectiveness. The quantitative analysis focused on three topics: improving medical readiness, potential savings in the Reserve Health Readiness Program (RHRP), and improving recruitment and retention. Data on medical readiness and the RHRP program were obtained from the DHA.
- Feasibility Analysis: The purpose of the feasibility analysis was to assess whether the existing TRICARE networks could absorb all potential new users. To do this, we built a TRICARE Network Assessment Model that uses administrative TRICARE claims to estimate whether access in a given market is high, moderate, or low, based on the current supply of TRICARE providers and demand from the

existing TRICARE beneficiary population. The feasibility analysis used family medicine, a key primary care specialty, as the main case study.

## Summary of Findings

#### **Population Analysis**

As of FY 2022, the RCSM population eligible to enroll in TRICARE benefits was just over 1.75 million, comprising approximately 789,000 RCSMs and 981,000 eligible dependents. Fifty-eight percent of this population is currently enrolled in some form of TRICARE benefit, divided as 28 percent activated and enrolled in the active-duty benefit, 7 percent in a transition status (also enrolled in the active-duty benefit), and 23 percent non-active but enrolled in the premium-based TRS benefit. The remaining 42 percent of the total population is not enrolled in a TRICARE benefit; we estimate they divide to be roughly 35 percent enrolled in civilian-based health plans, and 7 percent uninsured.

Under the status quo, RCSMs undergo multiple healthcare transitions between the primary TRICARE benefit and civilian health insurance (or TRS). We estimate the average RCSM member will experience three healthcare transitions during their military career and spend just under 22 percent of their career covered by the active-duty TRICARE benefit.

While many RCSMs are covered by TRICARE, the take-up rate for the TRS benefit is fairly low—approximately 28 percent across the eligible RCSM population (i.e., those not eligible for the active-duty benefit). This means over two thirds of the population eligible for this benefit opts to use a civilian plan (i.e., employer-sponsored plan) instead, or go uninsured. The finding of a fairly low TRS take-up rate is somewhat surprising, based on the plan's cost relative to civilian alternatives. We estimate TRS costs roughly half of the average civilian employer-sponsored plan, but that less than a third of the eligible population chooses to use the benefit. This pattern suggests there could be barriers to program participation (i.e., information problems) or a strong preference for civilian health plans. A preference for civilian health plans could be due to real (or perceived) differences in care quality and access, or a preference for care continuity. A better understanding of these possibilities should be gained before pursuing major benefit expansions.

#### **Cost Analysis**

In FY 2022 DoD spent \$3.3 billion annually on health and dental benefits for RCSMs. This expense includes the cost of benefits for activated and transitioning RCSMs and dependents (roughly \$2.2 billion) and the cost of covering those enrolled in premium-based TRS and TRICARE Dental Program (TDP) (roughly \$1.1 billion). Our best estimates suggest that a benefit expansion scenario that offers RCSMs the premium-based health and dental benefits premium-free would increase DoD's annual costs by \$1 billion to \$1.7 billion annually. If take-up behavior is higher than predicted, the annual cost could increase

to nearly \$3 billion (under 100 percent take-up rate). The following table illustrates the costs for the premium-free scenarios. The main body of the report provides a wider range of scenarios and take-up assumptions.

<b>Q</b>					
	Take-up Assumption	Medical (\$M)	Dental (\$M)	Total (\$M)	
RCSM-only Benefit	Best Estimate	935	83	1,019	
Expansion	100 Percent	2,046	224	2,270	
<b>RCSM and Dependent</b>	Best Estimate	1,575	136	1,711	
Benefit Expansion	100 Percent	2,609	379	2,988	

Estimated Annual Total Cost Increase for Premium-Free Benefit-Expansion Scenarios, in \$Millions

*Notes*: RCSM-only benefit expansion is premium-free TRS and TDP for the RCSM (dependents must pay a premium to participate). RCSM and Dependent Benefit Expansion is premium-free TRS and active-duty parity TDP for RCSMs and dependents. See Chapter 4 for a detailed explanation of each scenario. Best estimate take rates are scenario specific and differ by family status and rank group. We report averages for scenarios here: Average take rates for RCSM-only Benefit expansion: 42 percent for single; 66 percent for RCSM with dependents. Average take rates for RCSM and Dependent Benefit expansion: 42 percent for single; 71 percent for RCSMs with dependents.

The cost increases for the best estimates shown above represent a 9 to 15 percent increase in DoD's current cost of maintaining an RCSM in a non-activated status. Likewise, they would represent a 2 to 6 percent increase in the total 2022 Defense Health Program budget of roughly \$50 billion dollars.

## **Benefit Analysis**

We applied our benefit analysis framework to the following topics: medical readiness, recruiting, retention, and potential cost savings that might occur in the Reserve Health Readiness Program (RHRP). Overall, we found marginal benefits in each of these areas, but their relatively small magnitudes meant they would come at a significant marginal cost.

For instance, medical readiness rates for RCSMs, measured by individual medical readiness (IMR), are currently at historic highs, limiting their potential to improve medical readiness. We note that IMR rates may be artificially inflated by a recent change in the metric's definition. If benefit expansion guaranteed that Reserve components could lower their non-medical readiness rates to match the rates observed for the AC, roughly 2,000 RCSMs would switch from non-medically ready to medically ready status. This means the cost of the benefit expansion would be over \$500 thousand per newly ready RCSM. Likewise, while we believe the benefit expansion could offset some spending in the RHRP, the potential savings (under \$100 million annually) would be under 10 percent of the benefit-expansion costs (at least \$1 billion annually). The story is similar for recruitment

and retention; gains are expected, but their marginal cost is over \$100,000 per new recruit, or over \$50,000 per reenlistment. Overall, the analysis suggests there are more cost-effective policy instruments available for achieving readiness, recruiting, and retention objectives.

#### **Feasibility Analysis**

If all RCSMs (and dependents) who are eligible for TRS but not currently enrolled signed up tomorrow, the increase in covered lives would be just over 730,000—an increase in the total TRICARE beneficiary population of roughly 8 percent. Under the premium-free TRS scenario, our best estimate suggests an increase of 3.5 percent (or roughly 330,000 lives). Several factors complicate determining the TRICARE network's capacity to absorb this many new users. TRICARE subject matter experts generally noted capacity varies significantly by locality. While some localities could absorb new beneficiaries relatively easily, other locations that currently struggle with providing existing users sufficient access would likely experience increased stress from a benefit expansion. We built an empirical model to further investigate this topic using ZIP code level data on supply and demand. Using family medicine as a case study, we found that roughly 18 percent of all TRICARE beneficiaries live in areas we classified as low or very low access. Similarly, 28 percent lived in moderate-access areas, while 54 percent lived in high or very-high-access areas. This distribution was slightly more favorable for Prime Service Areas (PSAs) and less favorable for non-PSAs (where RCSMs are more likely to live).

When we examined the effect of increasing the TRICARE beneficiary population by 3.5 percent, we found the percentage of beneficiaries in low- or very-low-access areas would increase from 18 to 20 percent (or by roughly 10 percent) if provider supply did not increase. Our overall assessment suggested benefit expansion would likely result in a minor reduction to access in well developed areas but greater reductions to access in remote and less well-developed areas. Past research has found that the TRICARE contracting approach of having low provider reimbursement rates (lower than commercial rates paid by civilian plans) limits choice and access for beneficiaries. Shifting more beneficiaries from commercial insurance to TRICARE would further stress a system already struggling to provide sufficient access in some locations.

## Recommendations

The goal of this analysis was to help decision-makers better understand the likely costs, benefits, and feasibility issues for each of the proposed benefit-expansion scenarios. While we offer several recommendations related to the broader discussion, we do not recommend which—if any—of the proposed scenarios should be adopted over the status quo.

First, we noted that broad benefit expansions are not cost-effective policy solutions for addressing specific challenges, such as medical readiness or recruiting. Our analysis showed that other, more targeted solutions could achieve these objectives at a fraction of the cost. For instance, the RHRP is a far more cost-effective channel for providing RCSMs with medical readiness services. Likewise, hiring more recruiters would be a far more costeffective solution for targeting recruiting shortfalls. Furthermore, using more recruiters or offering recruiters cash bonus incentives would give DoD more flexibility; recruiters and bonuses can be reduced in more favorable recruiting environments, when they are no longer needed. Benefit expansions, on the other hand, are extremely difficult to take away. For these reasons, we recommend targeted policy solutions with low marginal costs over broad-based benefit expansions for achieving narrow policy objectives.

Second, care challenges facing TRICARE beneficiaries today are structural in nature; they are driven by the TRICARE program's low reimbursement rates and its model of contracting for care. Rising costs in the civilian healthcare market will put further pressure on TRICARE providers and will likely result in even narrower networks if payment rates are not increased. Without payment reform, TRICARE network access to care for beneficiaries is likely to continue its downward trend. For these reasons, we recommend that DoD address access challenges before adding a significant number of new beneficiaries to the network. If a decision is made to expand healthcare benefits for RCSMs, this could be an ideal opportunity to explore alternative methods of contracting for military healthcare benefits.

Third, if DoD expands RCSM health and dental benefits, several key factors should be considered in implementation to reduce total cost. Health and dental benefits provide many services that are also contracted for in the RHRP. If benefits are expanded, DoD should attempt to shift certain services currently delivered by the RHRP to the health and dental benefit programs. This action would require policy changes (i.e., allowing TRICARE network providers to conduct periodic health assessments) and altering incentives. For example, obtaining dental treatment through a TRICARE dental benefit would still require out-of-pocket payments, while the RHRP would provide the treatment at no cost. Without intervention, RCSMs might continue using the RHRP over their new benefit. In addition, DoD should consider how enrollment occurs (i.e., do RCSMs still have to opt in, or does enrollment become automatic?) and if TRICARE must serve as a second payer for RCSMs who opt to keep civilian coverage.

Finally, the state of Maryland has recently started providing reimbursement for National Guard medical and dental TRICARE premiums. In doing so, the state is essentially providing premium-free TRS and TDP. We discuss this case study in greater detail within this report along with a broader expansion of this scenario. Here we note that this case study offers a natural experiment and opportunity for DoD to study key aspects of benefit expansion including take-up behavior and the uninsured, potential benefits (e.g.,

gains in medical readiness, recruiting, and retention), and changes in access. Data from this experiment could prove very valuable to decision makers as they move forward in their considerations of RCSM benefit expansion.

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## 1. Introduction

## A. Background

Like many large employers, the Department of Defense (DoD) provides a comprehensive health benefit, known as TRICARE, to service members on active duty and their eligible dependents. While TRICARE benefit coverage for the active component (AC) is relatively straightforward, TRICARE coverage for the reserve component can be complicated. The complications arise from the Reserve component service members' (RCSMs') being employed by the DoD on a part-time basis. When RCSMs are activated for a period of more than 30 days, they (and their dependents) become eligible for the primary premium-free TRICARE benefit—the same benefit used by AC service members. However, when they are in an inactive status (i.e., working in their civilian occupation), they do not qualify for this benefit. During these periods, RCSMs can opt to purchase a premium-based TRICARE benefit known as TRICARE Reserve Select (TRS), obtain non-DoD healthcare coverage, or go uninsured.<sup>1</sup> Under this system, RCSMs transition back and forth between civilian-provided insurance coverage and/or different TRICARE programs. Approximately 8 percent chose to go uninsured.<sup>2</sup> DoD provides dental benefits in a parallel fashion, with coverage and premium rates anchored to activation status.

The topic of RCSM health and dental benefits has received considerable attention in recent years, with calls for reform focusing on expanding eligibility and providing the current premium-based options "premium-free" or at "zero cost." Such calls have garnered support from military service leaders, military service organizations (MSOs) like the National Guard Association of the United States (NGAUSs), Reserve Organization of America (ROA), and members of Congress. Those in favor of expanding RCSM health and dental benefits argue that it is "the right thing to do" and that it would improve RCSM medical and dental readiness, improve recruitment and retention, and address the uninsured RCSM population. Opponents argue such an expansion would be prohibitively costly. Some have also raised concerns over the feasibility of such an expansion and whether the current TRICARE program would be able to support a potentially large increase in the beneficiary population.

<sup>&</sup>lt;sup>1</sup> Chapter 2 covers the different TRICARE options available to active and Reserve component service members in greater detail, including transition benefits, which may extend eligibility for up to 180 after an activation ends.

<sup>&</sup>lt;sup>2</sup> We estimate an uninsured rate among RCSMs of 8 percent. We estimate the uninsured rate for the total RCSM population (including dependents) is 7 percent.

To address these issues, Section 707 of the fiscal year (FY) 2023 National Defense Authorization Act (NDAA) called for a study on the feasibility and potential cost impact of expanding TRICARE Reserve Select and the TRICARE dental program benefits under several policy scenarios, including premium-free options. The specific policy scenarios are discussed in greater detail in Chapter 4.

## **B.** Approach

The objective of this study was to examine the feasibility, costs, and benefits of expanding the TRICARE medical and dental benefits currently available to members of the Selected Reserve. To meet these objectives, we performed four key analyses:

- **Population Analysis:** The population analysis documents the size and demographic composition of the eligible RCSM population (including dependents). First, we split the population into analytic cohorts based on the RCSMs' rank group (proxy for age and income) and family status (single or with dependents). We then further subdivided our population cohorts based on their current healthcare (and dental) coverage status using the best available administrative and survey data, allowing us to construct population take-up rates (the percentage of the eligible population already enrolling in the current premium-based plans). The population analysis constitutes a critical analytic foundation for the subsequent cost, feasibility, and benefit analyses.
- **Cost Analysis:** To estimate the cost of different TRICARE benefit-expansion scenarios, we developed two TRICARE cost models: a medical model, and a dental model. The cost models use data on the size of the eligible population and the average cost of covering each of the analytic cohort groups (i.e., single junior enlisted RCSM, senior enlisted RCSM with dependents, etc.) to estimate the expected total cost (and total cost increase) of the benefit-expansion scenarios relative to the status quo. A primary input into the cost model is the expected take-up rate (i.e., how many new users will opt into the benefit once premiums are waived or reduced). The cost analysis provides a best estimate of take-up behavior as well as analytic ranges to illustrate a range of possibilities.
- Benefit Analysis: The potential benefits of expanding RCSM health and dental benefits are often discussed but rarely quantified. We developed a framework for quantifying commonly discussed benefits (e.g., improved medical readiness, improved recruiting, etc.) by estimating the potential marginal gains (i.e., how many additional RCSMs might be made medically ready, how many additional enlistments might occur, etc.). We then calculated the marginal cost of these gains to assess their cost effectiveness. When possible, we compared marginal costs to the marginal costs of alternative policy options (i.e., cash bonuses for recruiting) to consider relative cost effectiveness. The quantitative analysis

focused on three topics: improving medical readiness, potential savings in the Reserve Health Readiness Program (RHRP), and improving recruitment and retention.

• Feasibility Analysis: The purpose of the feasibility analysis was to assess whether the existing TRICARE networks could absorb all potential new users. To do this, we built a TRICARE Network Assessment Model that estimates whether access in a given market is high, moderate, or low, based on the current supply of TRICARE providers and demand from the existing TRICARE beneficiary population. The feasibility analysis took its data from the population analysis, which showed there are over 730,000 individuals (RCSMs and dependents) with TRS eligibility. If all of these eligible beneficiaries enrolled in TRS tomorrow, the total TRICARE population of 9.5 million would increase by roughly 8 percent. Finally, we considered how access scores would change as new beneficiaries enter the program and increase demand. The feasibility analysis uses family medicine, a key primary care specialty, as the main case study.

## C. Outline of Report

Following this introduction, an overview of the reserve component is provided, followed by chapters on the population analysis, the benefit-expansion scenarios examined, the cost analysis, the results of the cost analysis, an assessment of potential benefits from benefit expansion, and an assessment of the feasibility of expansion. The conclusion summarizes the findings of the report and provides recommendations.

## 2. **Reserve Component Overview**

The reserve components of the United States Armed Forces are an essential part of the nation's defense. Today there are seven unique reserve components—six DoD components (falling under the military departments) and one DHS component (falling under the Coast Guard). The seven components are:

- Army National Guard (ARNG)
- United States Army Reserve (USAR)
- United States Navy Reserve (USNR)
- United States Marine Corps Reserve (USMCR)
- Air National Guard (ANG)
- Air Force Reserve (USAFR)
- United States Coast Guard Reserve (USCGR)

The USAR, USNR, USMCR, USAFR, and USCGR are exclusively Federal organizations.<sup>3</sup> Their use is governed by Title 10 of the United States Code (U.S.C.). The ARNG and ANG can also be ordered to Federal service under Title 10. In addition, National Guard organizations can operate under the authority of State governors in response to natural or man-made disasters (e.g., pandemics, flooding, hurricanes, and wildfires) and civil disorder.<sup>4</sup> The use of ARNG and ANG personnel under State authority is governed by Title 32 of the U.S.C.

The status quo system of tying health benefit eligibility to activation status is one factor that contributes to RCSMs lower cost (relative to active duty). The reserve components are less costly to maintain than the ACs but are generally held to slightly lower readiness standards and require longer periods to mobilize. In this chapter we provide a

<sup>&</sup>lt;sup>3</sup> See https://crsreports.congress.gov/product/pdf/IF/IF10540 for a detailed overview of the Reserve components.

<sup>&</sup>lt;sup>4</sup> There are actually 54 different National Guard organizations (one for each State, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands). Lawrence Kapp and Barbara Salazar Torreon, "Reserve Component Personnel Issues: Questions and Answers," CRS Report RL30802 (Washington, DC: Congressional Research Service (CRS), 2020), https://fas.org/sgp/crs/natsec/RL30802.pdf. The use of ARNG and ANG personnel under State authority is governed by Title 32 of the U.S.C., Section C, which discusses use of the different Reserve components in more detail, including the various types of activations.

high-level overview of the Selected Reserve, discuss RCSM access to health and dental benefits, and costs relative to the AC, and present data on how RCSMs switch between DoD and civilian-provided health insurances. This information is foundational to understanding costs and benefits of health and dental benefit expansions from both the RCSM's and DoD's perspective.

## A. The Selected Reserve

All Reserve and Guard members are further categorized into three general categories of reserves. These include (1) the Ready Reserve, (2) the Standby Reserve, and (3) the Retired Reserve. The Ready Reserve has the highest end strength and constitutes the reserve component's (RC's) primary manpower pool.<sup>5</sup> The focus of this analysis will be the Selected Reserve (SELRES), a subgroup of the Ready Reserve. The SELRES accounts for roughly 80 percent of the Ready Reserve and comprises the most readily available units and individuals. Members of the SELRES are sometimes referred to as "drilling reservists" because they generally attend one weekend of training a month (inactive duty for training) and two full weeks of training each year (annual training with full pay). We focus on the SELRES population because members are eligible for TRS when they are not on active-duty orders. This population also has been the subject of the recent reform proposals.

Table 1 shows SELRES end strength by Service and component for FY 2022. Overall, the SELRES accounts for nearly 40 percent of total end strength. However, the SELRES's share of total end strength varies considerably by Service. The Army has over 50 percent of its end strength in the Guard and Reserve. The Air Force has just over one third of its end strength in the Guard and Reserve. The remaining Services have only a Federal Reserve component where they place roughly 15 percent of their end strength.

<sup>&</sup>lt;sup>5</sup> See IDA Document D-21567 for detail on the Ready, Standby, and Retired Reserve. https://www.ida.org/-/media/feature/publications/i/im/improving-reserve-component-medical-readiness/d-21567.ashx.

		Selecte	SELRES Share		
	AC	Guard	Reserve	Total SELRES	of Total End Strength
Army	454,759	327,358	175,733	503,091	53%
Navy	338,023		54,936	54,936	14%
Marine Corps	174,096		32,629	32,629	16%
Air Force	319,490	104,528	67,679	172,207	35%
Coast Guard	39,010		6,131	6,131	14%
Total	1,325,378	431,886	337,108	768,994	37%

Table 1. SELRES End Strength to Total End Strength by Component, FY 2022

Source: Defense Manpower Data Center, October 2022.

The large differences in the size of each Service's Reserve component and the share of total end strength that they represent has implications for the benefit-expansion proposals. Specifically, the Services that rely more heavily on RCs (and that have greater RC end strength) will face much larger total cost increases.

## B. RCSM Access to Health and Dental Benefits

In this section, we review DoD- and civilian-based options available to RCSMs for health and dental benefits, separating the discussion by activation status.

## 1. Health Options for Active RCSMs

RCSMs on orders for more than 30 consecutive days are eligible for the primary TRICARE benefit known as TRICARE Prime (or TRICARE Prime Remote for those located outside of Prime service areas). RCSMs' eligible dependents (e.g., spouses, children, etc.) are also eligible. When the RCSMs' active duty service period ends, so does eligibility for TRICARE Prime. However, an additional 180 days (6 months) of premium-free coverage is available through the Transitional Assistance Management Program (TAMP).

While RCSMs and their dependents are eligible for the premium-free TRICARE Prime (or TRICARE Prime Remote) during activations of more than 30 days, they may in some cases choose to keep additional employer-sponsored health coverage. Two laws, the Consolidated Omnibus Budget Reconciliation Act (COBRA) and the Uniformed Services Employment and Reemployment Rights Act (USERRA), generally allow individuals who leave work for military service to continue coverage for themselves and their dependents under an employment-based group health plan.<sup>6</sup>

<sup>&</sup>lt;sup>6</sup> While these provisions allow RCSMs to remain on their employer's insurance, they may be required to pay the full premium (not just the usual employee's share). Individual employers set the policy.

### 2. Health Options for Inactive RCSMs

Most members of the SELRES are eligible for the TRS program. There is one exclusion for TRS eligibility that applies to RCSMs who work for the Federal Government and have eligibility for the Federal Employees Health Benefit (FEHB). Using data from the Defense Manpower Data Center (DMDC), we estimated there are roughly 83,000 RCSMs with FEHB eligibility (with roughly 150,00 dependents). This exclusion is currently set to end in 2030, at which time all members of the SELRES will become eligible to participate in TRS. A Congressional Budget Office (CBO) analysis from 2019 estimated roughly one third of the FEHB-eligible population would switch to TRS if allowed.<sup>7</sup> Appendix A details how the FEHB-eligible population was identified.

Apart from Federal civilians, all other RCSMs are eligible to purchase TRS (unless they are activated and eligible for the Primary TRICARE benefit). In 2022, the cost of enrolling in TRS was \$47.70 per month (or \$560 annually) for an individual RCSM, or \$229.99 per month (\$2,760 annually) for a family (RCSM and their dependents). The deductibles for this plan vary by rank group: \$56 per individual and \$112 per family for E1-E4; \$168 per individual and \$336 per family for E5 and above. The catastrophic cap is \$1,120.<sup>8</sup>

While inactive RCSMs have the option to purchase TRS, they may also choose to use alternative civilian-based healthcare options. Below we outline some of the alternatives available to RCSMs:

- Employer-sponsored Health Plan: In 2022, roughly 150 million Americans were covered through employer-sponsored plans.<sup>9</sup> Under the Affordable Care Act (ACA), employers with more than 50 full-time employees must offer health insurance or pay a fine. While large firms almost always offer health insurance, many small firms do not. In 2022, roughly 51 percent of firms offered health benefits. Although new hires, part-time and temporary employees may not have been eligible, other eligible employees chose not to take up the benefit due to cost or other coverage options. Among the eligible workers, the take-up rate was just under 80 percent. Many RCSMs are eligible for a health benefit through their employer.
- The Federal Employees Health Benefit Program (FEHBP): FEHB is the employer-sponsored health program for Federal civilians. This program is used by military technicians and other SELRES members employed as Federal

<sup>&</sup>lt;sup>7</sup> https://www.cbo.gov/system/files/2019-06/hr2500.pdf.

<sup>&</sup>lt;sup>8</sup> These numbers were obtained from the TRICARE website cost table available at: https://tricare.mil/Costs/Compare.

<sup>&</sup>lt;sup>9</sup> https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

civilians. With roughly 8 million beneficiaries, it is similar in size to the TRICARE program and is the largest civilian employer-sponsored health program in the world.

- **Spouse's Employer-sponsored Health Plan:** Employer-sponsored plans typically offer the employee the option of purchasing an individual plan or a plan that also provides coverage for their spouse and children. RCSMs may choose to obtain coverage through a spouse's employer. This option is likely attractive to RCSMs, as it offers stability in access and continuity of care for dependents (i.e., there is no transition back and forth between TRICARE and civilian coverage).
- **Parent's Health Plan (if under 26):** Under the ACA, dependents may stay on their parent's health plan (e.g., their employer-sponsored plan) until the age of 26. Today roughly 32 percent of RCSMs are under the age of 26.<sup>10</sup> RCSMs under 26 could have coverage through their parents. We were unable to obtain an estimate of the number of RCSMs who use this option.
- ACA Health Insurance Marketplace (HealthCare.gov): Individuals may also purchase individual or family health insurance coverage through the ACA marketplaces. As of 2022, roughly 17 million Americans were covered through marketplace plans. Roughly 80 percent of enrollees are in subsidized plans (e.g., they pay reduced premiums based on their income level. Such subsidies end when an individual's income exceeds 400 percent of the poverty level).<sup>11</sup>
   Individuals who have access to an employer-sponsored plan do not qualify for subsidies. RCSMs are eligible to purchase coverage in the ACA marketplace and may be eligible for subsidies based on their income.
- Medicaid/CHIP: Medicaid is a joint Federal and State program that provides health coverage to Americans who meet eligibility requirements based on low income or disability. Roughly 73 million Americans are covered by Medicaid, and data from the Millennium Cohort Survey (MCS) suggest around 4 percent of RCSMs use Medicaid.<sup>12</sup> The income-based eligibility thresholds are Statespecific and tied to the Federal poverty level. Low-income RCSMs may qualify for Medicaid.

<sup>&</sup>lt;sup>10</sup> The vast majority of the under 26 population is single (i.e., no dependents), making it more feasible for them to remain on their parents' insurance.

<sup>&</sup>lt;sup>11</sup> https://www.kff.org/private-insurance/issue-brief/as-aca-marketplace-enrollment-reaches-record-high-fewer-are-buying-individual-market-coverage-elsewhere/.

<sup>&</sup>lt;sup>12</sup> Appendix C contains the data from the MCS. Whiles this estimate seems reasonable, we note the sample size is small and thus view results with caution.

- **Department of Veterans Affairs (VA):** The VA provides healthcare services to eligible veterans, including RCSMs with prior active-duty service. Eligibility for enrollment is based on a priority group system that factors in service-connected disability, income level, and military service history. Once enrolled, veterans may receive care for their service-connected disability, as well as other services available from VA (e.g., primary and preventative care, inpatient hospital services, urgent and emergency care). While the VA provides healthcare, it is not a comprehensive health benefit (i.e., health insurance plan), and it does not provide coverage for dependents. We do not consider VA to be health insurance. However, we estimate that 12 to 14 percent of RCSMs currently have access to VA care.<sup>13</sup>
- **Medicare:** Generally, Medicare is for people 65 years or older (or with disabilities/medical conditions that would preclude membership in the SELRES). Fewer than 200 RCSMs meet the age threshold.

Obtaining detailed data on RCSM health insurance use is difficult. By combining data from three different administrative data sources, we were able to obtain estimates of the number of RCSMs enrolled in TRICARE, the number of RCSMs enrolled in FEHB, the number of RCSMs with other health insurance (OHI)—a catchall category for all civilian options other than FEHB, and the number of uninsured.<sup>14</sup> Enrollment counts and percentages are provided in the next chapter.

Factors that influence RCSMs' health insurance choices include the choice set available to them (e.g., does their employer or spouse's employer offer a plan? do they qualify for ACA subsidies? are they under 26?), the cost of their various choices, and perceived quality and access of the various choices. The cost of an option depends on several variables: premiums, cost sharing (i.e., coinsurance rates and copays), deductibles, and out-of-pocket (OOP) maximums (or catastrophic caps). Of these variables, premium rates are often the central focus, as they are what the policyholder must pay monthly. Premium rates also tend to correlate with the quality of coverage provided by the plan, as lower premiums often require higher cost-sharing and higher deductibles when services are used.

<sup>&</sup>lt;sup>13</sup> Data from the periodic health assessment (PHA) indicate 12 percent of RCSMs report having a VA disability rating. We assume having a disability rating implies some degree of access to VA care. An alternative data source, the MCS, shows 14 percent of RCSM survey respondents reporting access to VA care. See Appendix G.

<sup>&</sup>lt;sup>14</sup> TRICARE enrollment was obtained from the Defense Enrollment Eligibility Reporting System (DEERS). FEHB enrollment estimates were derived from DMDC Reserve and civilian data files (see Appendix A). The OHI and uninsured populations were estimated from the PHA.

Table 2 compares the annual cost of enrolling in TRS relative to civilian alternatives. The alternatives include the national average for employer-sponsored plans, a select range of plans representing a low, mid, and high tier from FEHB plans, and the average cost of an ACA marketplace plan (Silver Option) for individuals at different income levels (as premiums are tied to income). The annual premium amounts shown in the table represent only the cost to the individual (the employee's share).

We believe the national average for employer-sponsored health plans is a reasonable benchmark for comparing the cost of TRS to civilian alternatives. However, we noted that premiums vary based on many employer characteristics (e.g., large vs. small, age of workforce, public vs. private, presence of unions, etc.) and plan type (e.g., health maintenance organization (HMO), preferred provider organization (PPO), point of service (POS), high-deductible health plan (HDHP), etc.). We could not observe these factors, so we relied on the national average.

		• • •	• • • •
Plan	Self	Family	Civilian Family Plan Cost relative to TRS
TRICARE Reserve Select	\$560	\$2,760	-
National Average	\$1,327	\$6,106	2.2
Select FEHB Plans			
Government Employees Health Association (GEHA) (low tier)	\$1,629	\$4,286	1.6
Blue Cross Blue Shield (BCBS) Basic (mid-tier)	\$2,085	\$5,520	2
BCBS Standard (high tier)	\$3,314	\$8,167	3
ACA Exchange*			
Income \$50K	\$2,740	\$775	.3
Income \$100K	\$4,126	\$7,930	2.9
Unsubsidized	\$4,126	\$14,540	5.3

 Table 2. TRS and Civilian Health Annual Plan Premiums (Employees Share), 2022

*Sources*: TRS data are taken from the TRICARE website (TRICARE.mil). The National Average and ACA Marketplace data come from the Kaiser Family Foundation (2022 Employer Health Benefits Survey and Health Insurance Marketplace Calculator).

\* ACA plans are based on income level. For the ACA Marketplace estimates, we assumed adults were aged 25 (and 2 children, aged 3 and 6, for the family plan). The family plan for incomes below 50K cost less because of the heavy subsidy anchored to poverty line thresholds, which are a function of family size.

Relative to commercial civilian options, TRS is generally the least expensive option. For a single RCSM, annual coverage can be obtained for under \$600 per year—less than half the cost of the national average for employer-sponsored plans and roughly one third the cost of the cheapest FEHB plans selected. The plan is also much cheaper than ACA Marketplace plans, unless the RCSM qualifies for large subsidies. Similarly, a family TRS plan is also about half the cost of the average employer-sponsored plan. A subsidized ACA plan could be cheaper than TRS if the family's income qualifies for heavy subsidy, but as income rises TRS becomes the less expensive option.

TRS OOP costs are also much lower overall than civilian options. While TRS copayments for seeing in-network providers (and coinsurance rates for out-of-network providers) appear similar to those of employer-sponsored plans, TRS deductibles are much lower.<sup>15</sup> For instance, the family deductible for an RCSM of rank E5 and above (senior enlisted, or officers) is \$336. For employer-sponsored plans, the average deductible is over \$1,700 for an individual plan. Deductibles for family plans vary widely in structure and are often person-specific (i.e., each enrolled member has their own deductible of over \$1,000). Plans that do offer an aggregate family deductible generally set them at or above \$3,000.<sup>16</sup> If the employee selects a high-deductible plan, these amounts increase even more, though premiums are generally reduced.

TRS also has a catastrophic cap of \$1,120—the most a beneficiary and their family would have to pay for covered services in a year. For employer-sponsored plans, these amounts also tend to be significantly higher. The average employer-sponsored plan has a single OOP maximum of \$4,355. The ACA mandated that health plans have an OOP maximum of no more than \$8,700 for single coverage and \$17,400 for family coverage in 2022.

In Chapter 6, we provide a more detailed comparison of RCSM OOP costs under civilian plans, the current TRS benefit, and proposed policy scenarios. But the general takeaway of this analysis is that TRS premiums and OOP costs are much lower on average than those of employer-sponsored plans.

## 3. Dental Options for Active RCSMs

RCSMs on active-duty orders of more than 30 days (and those who qualify for transitional benefits) are covered by the Active Duty Dental Program (ADDP). This program is for service members only; dependents are not eligible. However, active-duty dependents and Reserve dependents may elect to participate in the voluntary premium-based TRICARE Dental Program (TDP). The TDP premiums for RCSM dependents vary by activation status. Dependents of activated RCSMs will pay the same premium rates as

<sup>&</sup>lt;sup>15</sup> The deductible is the minimum amount the beneficiary must pay OOP for services before insurance kicks in. For example, if their deductible is \$1,700, they would pay the first \$1,700 of covered healthcare services consumed, after which they would pay only a copay or coinsurance amount (and their insurance would cover the rest).

<sup>&</sup>lt;sup>16</sup> See the Kaiser Family Foundation (KFF) Employers Health Benefit Survey for a detailed analysis of cost sharing in employer-sponsored health plans. https://www.kff.org/report-section/ehbs-2022-section-7-employee-cost-sharing/.

active-duty family members, although rates increase when their sponsor is not on activeduty orders.

#### 4. Dental Options for Inactive RCSMs

Inactive RCSMs are not eligible for the ADDP. However, they may elect to participate in the premium-based TDP. We noted that the FEHB-eligible population that is ineligible for TRS is eligible for the TDP.<sup>17</sup> In 2022, the cost of TDP enrollment for an RCSM was \$11.65 per month (or \$140 annually). For a family plan, the cost was \$87.36 dollars per month (or \$1,048 annually).<sup>18</sup>

Inactive RCSMs who do not opt to enroll in the premium-based TDP may rely on civilian alternatives, or go without dental insurance. Civilian dental alternatives largely parallel the health insurance options and include employer-sponsored dental plans (or a spouse's employer-sponsored plan), or purchasing a commercial plan from a company offering dental plans (i.e., Cigna, Humana, United, Delta Dental, etc.). Some dental coverage may be available through Medicaid for low-income families, but in many States, coverage for adults is limited. Some dental plans allow adult children to remain on a parent's plan until the age of 26, but many do not.

Dental benefits offered through employers are generally subsidized and therefore less costly than purchasing a commercial plan. Employers who offer health insurance typically also offer dental plans. As with medical, large employers are more likely than small firms to offer dental benefits.

Concerning dental coverage, it is important to note there are generally two tiers of plans: preventative, and comprehensive. Preventative plans cover routine exams, cleanings, and x-rays (along with sealants and fluoride for children). Comprehensive plans cover these services and provide coinsurance toward additional dental needs (fillings, root canal, extractions, crowns, and orthodontic services). TDP is considered a comprehensive plan. Table 3 compares the annual cost of enrolling in TDP relative to civilian alternatives; the comparison includes the national average for commercial dental plans (no employer subsidy), and the average premium rates for FEHB plans (with employer subsidy).<sup>19</sup>

<sup>&</sup>lt;sup>17</sup> https://www.health.mil/Reference-Center/Reports/2021/05/24/TRICARE-Reserve-Select-Study#:~:text=Dental%20and%20vision%20benefits%20were,status%20technicians%20are%20current ly%20eligible.

<sup>&</sup>lt;sup>18</sup> There are also options to purchase a plan for a single adult dependent (single plan \$29.12 a month) or a single adult and child dependents (i.e., no sponsor) for \$75.71 per month. We focused on the single RCSM plan or the family plan that includes the dependent, as these plans are most comparable to civilian options for this illustrative discussion. However, our cost model uses all options.

<sup>&</sup>lt;sup>19</sup> For FEHB rates, we averaged premium amounts for Region 3. https://www.opm.gov/healthcareinsurance/dental-vision/plan-information/plans/dental.

Plan	Self	Family	Cost of TDP Family Plan relative to TDP
TRICARE Dental Plan (TDP)	\$140	\$1,048	-
National Average - Comprehensive	\$564	\$1,800	1.7
National Average - Preventative Only	\$312	\$936	.9
FEHB Dental Plan Average			
FEHB Average Standard Plans (Preventative)	\$298	\$894	.9
FEHB Average High Plans (Comprehensive)	\$528	\$1,583	1.5

Table 3. TDP and Civilian Annual Health Premiums (Employee's Share), 2022

Sources: TRICARE dental data came from https://www.tricare.mil/TDP. FEHB dental premiums came from https://www.opm.gov/healthcare-insurance/dental-vision/plan-information/plans/dental. U.S. national averages came from https://www.forbes.com/advisor/health-insurance/dental-insurance/dental-insurance/coverage-and-cost/.

Relative to civilian plans, TDP premium rates appear as a less expensive option especially for single RCSMs, who receive a much larger subsidy. For instance, a single RCSM can obtain coverage through TDP at roughly a quarter of the cost of enrolling in a comprehensive FEHB plan. Civilian family coverage appears to cost 1.5 to 1.7 times more.

Comparing OOP expenditures between dental plans can be challenging, as coinsurance rates vary across plans, procedure types, and in-network versus out-of-network. In general, most diagnostic and preventative services (e.g., cleanings) are fully covered, whereas basic treatments require some cost sharing (e.g., 20 to 40 percent) and major work and orthodontics require greater cost sharing (e.g., 50 percent). Deductibles and maximum benefit amounts also need to be considered. For instance, TDP has an annual maximum benefit of \$1,500 and a lifetime orthodontic benefit of \$1,750. Table 4 compares TDP to two FEHB plans: Aetna High and Delta Dental High. Overall coverage appears similar.

Coinsurance Rate	TRICARE Dental Program	Aetna High	Delta High
Diagnostic and Preventative	0%	0%	0%
Basic Restorative	20%	30%	30%
Endodontic	30%	60%	50%
Periodontics	30%	60%	50%
Oral Surgery	50%	60%	50%
Orthodontics	50%	50%	50%
Maximums			
Annual Maximum Benefit	\$1,500	Unlimited in- Network; \$2,000 out-of-Network	Unlimited in Network; \$3,000 out-of-Network
Lifetime Maximum Orthodontic Benefit	\$1,750	\$2,000	\$3,500

 Table 4. TDP and Civilian Dental Cost OOP Cost Sharing Comparison

*Note*: Data for the FEHB plans came from OPM.gov, https://www.opm.gov/healthcareinsurance/dental-vision/plan-information/plans/dental; TRICARE data came from https://www.tricare.mil/Costs/DentalCosts/TDP/CostShares. We used in-network coinsurance rates for all plans.

### 5. Benefit Transitions and Associated Challenges

To understand the typical RCSM's pattern of transitioning in and out of DoDprovided health insurance from civilian plans (or TRS), we identified a cohort of RCSMs who entered the Reserve component in FY 2002 and followed it through FY 2022.<sup>20</sup> Appendix C describes our data sources and sample selection methodology.

Our final cohort includes 43,793 RCSMs who had over 606,922 activations. We included all forms of activations—Title 10, Title 32, activations for FTS activities, and activations for training. To account for TRICARE eligibility status, we identified the subset of activations that were for a period of more than 30 days.

By the end of our sample period, 74 percent of the cohort had finished their career, and 26 percent were still in service. Using this population, we created five key metrics to understand each RCSM's activation status changes:

• **Career Length:** The number of days an RCSM serves in the Reserve component. This variable is calculated as the difference between the last date an individual is observed and their initial entry date.

<sup>&</sup>lt;sup>20</sup> Our sample includes individuals who entered the RC from the AC and individuals who entered without prior service.

- Number of Activations: The number of activations an RCSM serves in his or her career. This variable is created by adding the number of activations with different activation begin and end dates for each RCSM. We include all forms of activations (e.g., activations for training, deployments, etc.).
- Length of Activations: The number of days an RCSM serves in each activation. This variable is calculated for each activation by subtracting the begin date of an activation from the end date.
- Length of Total Activations: The total number of days an RCSM spent activated in his or her career. This variable is created by adding the durations of all activations for each RCSM.
- Activation Intensity: The percentage of time an RCSM spent activated in his or her career. This variable is calculated by dividing the Length of Total Activations by Career Length.

Table 5 presents the metrics for the full sample (i.e., all activations) and for the activations that were over 30 days—activations that would have made the RCSM eligible for health and dental benefits. We separate the results by Guard versus Reserve, given the difference in how they are utilized.

	All Acti	vations	Activations over 30 Days Only	
Variable	Guard	Reserve	Guard	Reserve
Number of Activations	332,793	274,104	64,155	50,217
Number of RCSMs	24,913	18,880	21,358	16,072
Average Career Length in Days (in Years)	4,443 (12.2)	4,163 (11.4)	4,753 (13)	4,444 (12.2)
Average Number of Activations	13.4	14.5	2.6	2.7
Average Length of Activation in Days (in Years)	74.7 (0.2)	61.3 (0.2)	360 (1)	303.7 (0.8)
Average Length of Total Activation in Days (in Years)	997.2 (2.7)	889.5 (2.4)	927 (2.5)	807.8 (2.2)
Average Activation Intensity %	20.4%	21%	19%	19.4%

Table 5. 20-year Cohort Analysis, RCSM Activation Metrics

*Notes*: The average number of activations over 30 days is calculated for the full sample (i.e., it includes 0s for those who never activate for over 30 days). If we calculate the average number of activations over 30 days but exclude those who never activated for over 30 days, the averages rise to 3.1 for Guard and 3.0 for Reserve.

The average Guardsman in our sample had a career length of roughly 12 years, which included just over 13 activations, with an average activation length of 74 days. When we limited the analysis to activations that were more than 30 days in length (i.e., those that

turn on health and dental benefits), our sample was slightly reduced, as not all RCSMs experience an activation of over 30 days. For Guardsmen, we found the average number of activations over 30 days was 2.6, with an average length of approximately 1 year. When we summed the days the average Guardsmen spends on activations over 30 days, we got roughly 2.5 years, which translates to roughly 20 percent of their total career. This means the average Guardsman spends roughly 20 percent of their career eligible for the Primary TRICARE benefit. The numbers are similar for reservists.

These results suggest that the average RCSM will go through roughly three healthcare transitions. Box 1 discusses some of the difficulties associated with these transitions. The results also suggest that the typical RCSM spends around 2.5 years (or 20 percent of their RC career) covered by DoD-provided health and dental benefits. In reality, this is an understatement because it does not account for the transition benefits Early Alert and TAMP. Factoring in transition benefits is difficult because not all activations qualify for TAMP, and because many who do qualify may not use the full 6 months.<sup>21</sup>

If we assume all activations of over 30 days are TAMP-eligible, and that the RCSM used the full 180 days, that would increase the time the average Guardsman spends on DoD benefits by about 1.25 years (180 days x 2.5 activations), which would increase the share of career time spent on the Primary DoD benefits to nearly 30 percent. Under more conservative assumptions (e.g., supposing 50 percent of activations qualify for TAMP and the average RCSM uses 90 days), the increased time on TRICARE for the average Guardsman would be only .3 years.

<sup>&</sup>lt;sup>21</sup> To qualify for TAMP a RCSM must be activated in support of a preplanned mission, a contingency operation, or a COVID-19 support operation. https://www.tricare.mil/TAMP.

## Box 1. Transition Challenges

Transitioning between health plans imposes a burden on RCSMs. When RCSMs receive notice that they will be activated for over 30 days, their transition process will vary, depending on whether they have civilian insurance or TRS.

If the RCSM is on an employer-sponsored plan, they must first decide if they want to cancel their civilian coverage and rely on DoD insurance or maintain civilian coverage in addition to TRICARE. If they decide to drop the civilian coverage, they must determine when their TRICARE coverage begins and work with their Human Resources department to disenroll from the health plan. This process will require documentation on the activation. The member will want to ensure they will not experience a gap in coverage (e.g., turning off the civilian plan before TRICARE coverage begins). Once their activation is over, the member will need to determine when their TRICARE eligibility ends and work with their employer to re-enroll in the health benefit (again, ensuring they will not have a coverage gap).

If an RCSM is already using TRS, they will transition to active-duty TRICARE Prime, where they will no longer pay premiums and will be enrolled to a local MTF, troop medical clinic, or to medical providers within the mobilizing unit. The family members of the mobilizing service member will have a choice between TRICARE Prime or Select, where they may elect to enroll at a local MTF with no cost shares under Prime, or continue to see their current TRS network provider using TRICARE Select (not TRS) with approximately the same cost shares but no enrollment fees or premiums. The service member and dependents will need to reenroll in TRS after the activation/transition coverage ends.

While the administrative burden associated with disenrollment/reenrollment should be fairly limited, the decision-making aspect of the transition may be more difficult. RCSMs and their dependents may have concerns about access to care and care continuity (i.e., will family members be able to see their current providers if the RCSM switches to the TRICARE program?). This consideration could be an important issue for those with serious health conditions and who require specialized treatment. They may have to reach out to providers to determine if they will accept the new health plan. There may also be financial considerations, such as deductibles and health savings accounts, to consider. These factors are influenced by the timing of the enrollment cycle. For example, when enrolling in an employer's plan midway through the year, service members still need to meet the full deductible before coverage kicks in and the annual deductible amount resets at the start of the year. Transition benefits help minimize such issues, but they are only available for certain types of activations.

## C. How Much Do RCSMs Cost?

In this section, we examine what it costs DoD to employ RCSMs when they are in an active status and a non-active status and how these costs compare to the cost of AC personnel.

Reserve and Guard units are largely composed of "traditional" reservists—members of the SELRES who drill one weekend per month and attend one longer 2-week training per year.<sup>22</sup> When traditional reservists are in their drilling status (i.e., not activated), they receive cash compensation (i.e., drill pay) for the time they spend training, certain allowances for food, travel, and housing, etc. Their compensation package costs DoD and the Federal Government significantly less than active duty service members and other civilian support personnel who are employed full time. When drilling RCSMs are activated, they receive essentially the same compensation as AC service members and cost DoD and the Federal Government essentially the same amount. These costs are shown in Table 6 using Army data.<sup>23</sup> The analysis uses two cost concepts:

- **Cost to DoD:** Includes cash compensation (i.e., basic pay, allowances, special and incentive pays, etc.), benefits and other direct costs (i.e., retirement accrual payments and thrift savings plan, travel, healthcare, separation and severance pay, etc.), and longer run costs to DoD (i.e., installation support, personnel administration, training and education, etc.)
- **Cost to the Federal Government:** Includes all costs to DoD plus costs to the VA (e.g., VA disability and pension, VA healthcare, etc.), costs to the Department of the Treasury, Department of Education, Office of Personnel Management, and the Department of Labor.

Appendix B contains greater detail.

<sup>&</sup>lt;sup>22</sup> IDA Document D-21567.

<sup>&</sup>lt;sup>23</sup> Personnel costs come from the IDA Manpower Cost Model. Costs are constructed by extending guidance presented in DoDI 7041.04, "Estimating and Comparing the Full Costs of Civilian and Active Duty Military Manpower and Contract Support," to the RCs. For a detailed methodology, see Shaun K. McGee, Stanley A. Horowitz, and John J. Kane, 2017, "Analysis of Alternative Mixes of Full-Time Support in the Reserve Components," IDA Document D-8575.

	Cost to DoD		Cost to Federal Government		
	Cost	% of AC Cost	Cost	% of AC Cost	
Drilling Reserve	\$23,480	16%	\$51,825	27%	
Drilling National Guard	\$21,849	15%	\$50,065	26%	
Active Reserve	\$139,105	93%	\$179,225	94%	
Active National Guard	\$128,682	86%	\$168,802	89%	
Active Component	\$149,600		\$189,720		

#### Table 6. Estimated Average Reserve Personnel Costs, FY 2022

*Source*: IDA Manpower Cost Model (IDA Document D-8575). The costs shown in this table are average costs for Army personnel.

The data indicate that a drilling (i.e., non-active) RCSM costs DoD roughly 15 percent of the cost of an AC service member. On the other hand, active RCSMs cost DoD around 90 percent of the cost an AC service member.

Notably, policies that expand health and dental benefits for RCSMs will alter the ratio of cost among these different types of personnel. For instance, drilling RCSMs will become more expensive, thus increasing their cost as a percentage share of the active-duty cost. We will revisit this topic in Chapter 6.
# 3. **Population Analysis**

The objective of this population analysis is to document the size and demographic composition of the eligible RCSM population (including eligible dependents). We also identified what share of the eligible population is currently enrolling in different TRICARE health and dental benefits and what share relies on OHI or chooses to go uninsured. These measures will be used in the following chapters in analyses of the cost, feasibility, and benefit of TRICARE expansion for RCSMs.

# A. Size of SELRES Population Eligible for TRICARE Benefits

As of FY 2022, SELRES had roughly 769,000 RCSMs. Collectively, these individuals had nearly 1 million dependents. If all members of the SELRES (and their eligible dependents) utilized the TRICARE program, this population would represent roughly 1.75 million covered lives. Nearly 60 percent of the covered lives would be dependents.

Table 7 shows these data for each of the seven unique Reserve components. The Army National Guard accounts for nearly 40 percent of the eligible beneficiary population. The Army Reserve is the second largest Reserve component by eligible beneficiaries (23 percent of the total population), followed by the Air National Guard (16 percent). Collectively the Army and Air Force Reserve components constitute nearly 90 percent of the total population.

	-			
	RCSMs	Dependents	Covered Lives	Share of Lives
Army National Guard	327,358	361,864	689,222	39%
Army Reserve	175,733	226,109	401,842	23%
Navy Reserve	54,936	85,655	140,591	8%
Marine Corps Reserve	32,629	21,927	54,556	3%
Air National Guard	104,528	166,998	271,526	16%
Air Force Reserve	67,679	107,725	175,404	10%
Coast Guard Reserve	6,131	10,990	17,121	1%
Total	768,994	981,268	1,750,262	

Table 7. SELRES Population Eligible for TRICARE Benefits

*Source*: DMDC. Population counts are for October 2022. These numbers include the FEHB-eligible population, which is currently ineligible for TRS.

A primary purpose of this population analysis is to create the building blocks needed for a cost estimate for providing health and dental benefits to all RCSMs under different policy scenarios. From a cost perspective, examining the data by Service and component is less important than the demographic factors that most directly relate to healthcare costs like age, income, and family status (i.e., number of eligible dependents). We selected rank group (proxy for age and income) and family status as the primary categories for the cost model. Family status is a key variable, as it determines the type of plan the RCSM will buy (single or family plan) and the premium rate they will pay.

Table 8 shows the total SELRES population by the selected variables. Junior enlisted are the second largest group and the group most likely to be single; over 75 percent do not have dependents, and the average number of dependents for those who do is less than 2.0. For senior enlisted, the largest cohort, only about 30 percent of members are single, and the average number of dependents climbs to 2.5. The junior and senior officer cohorts are smaller but more likely to be married and have more children.

	Total RCSMs	RCSMs without Dependents	RCSMs with Dependents	Dependents	Avg Dependents						
Junior Enlisted	300,144	232,792	67,352	127,753	1.90						
Senior Enlisted	332,701	99,686	233,015	583,990	2.51						
Warrant Officer	13,028	1,972	11,056	28,992	2.62						
Junior Officer	60,168	24,944	35,224	83,459	2.37						
Senior Officer	62,953	7,559	55,394	157,074	2.84						
Total	768,994	366,953	402,041	981,268	2.44						

Table 8. Total SELRES Population by Rank Group and Family Status, 2022

*Source*: DMDC. Population counts are for October 2022. The average dependent count is for RCSMs with dependents (i.e., the average number they would enroll in their plan).

## **B.** The SELRES Population by Healthcare Enrollment Status

At any given time, some share of the RCSM population will be on active duty orders (i.e., activated) and therefore eligible for the active duty TRICARE benefit. Another group of RCSMs will be in transition (i.e., transitioning to or from active duty) and eligible for transitionary benefits. The remaining share of the population will be non-active (e.g., drilling but not on active duty orders); these RCSMs are ineligible for the active duty TRICARE benefit, but they may opt into the premium-based TRS program, other health insurance, or to go uninsured. Figure 1 shows the breakout of RCSMs' and dependents' enrollment status.



Figure 1. TRICARE Enrollment, FY 2022

From the figure we can see that nearly 60 percent of the RCSM population is currently enrolled in a TRICARE benefit. More specifically, roughly 28 percent of the RCSM population was active (eligible for active duty TRICARE). Another 7 percent were in transition (also eligible for active duty TRICARE),<sup>24</sup> and 23 percent were non-active and enrolled in TRS. The other 42 percent of RCSMs are not enrolled in a TRICARE benefit. For those not enrolled in TRICARE, we estimated how many were uninsured versus enrolled in FEHB or OHI. Appendix D contains details on the data sources and methodologies used to determine the TRICARE enrolled population, the OHI population, and the uninsured. Detailed population counts broken out by rank group and family status are also included. Unfortunately, we were unable to break out the OHI population by more specific coverage types (e.g., employer-sponsored plan, spouse's employer-sponsored plan, parents' plan, ACA plan, Medicaid, etc.).

## 1. TRS Take-up Rates

Under the status quo, TRICARE enrollment for RCSMs who qualify for the active or transition benefits is automatic: enrollment for the TRS benefit is not. To opt in or "takeup" the benefit, the RCSM must select a plan option (single or family) and pay the

<sup>&</sup>lt;sup>24</sup> We estimated the number of RCSMs in transition based on their TRICARE eligibility. Many are enrolled in the TAMP/Early Alert benefit, but others still show Prime or some other form of eligibility, even though they are classified as inactive (IGR).

premium. We can construct take-up rates by dividing the number of takers (those who enroll) over the eligible population. The eligible population is the total RCSM population, less those enrolled in the active and transition benefit, and those with FEHB eligibility.<sup>25</sup> Figure 2 shows the TRS take-up rates by rank group and family status (i.e., plan type).



Figure 2. TRS Take Rates by Rank Group and Plan Type, FY 2022

The overall take-up rate is roughly 20 percent for single RCSMs and 50 percent for RCSMs with dependents (or 28 percent overall across these groups). However, we noted

<sup>&</sup>lt;sup>25</sup> If the FEHB population is included in the take-up rate denominator, take-up rates fall to 18 percent for single plans and 40 percent for family plans.

significant variation across the rank groups. For instance, roughly one third of junior enlisted RCSM families opt in, whereas 60 percent of junior officer families opt in.

# C. The SELRES Population by Dental Enrollment Status

As with medical, dental benefit eligibility changes with the RCSM's activation status. At any given time, some share of the RCSM population will be on active duty orders (i.e., activated) and therefore eligible for the ADDP. The RCSMs in transition are also eligible for this benefit. The remaining non-active share of the RCSM population (e.g., drilling but not on active duty orders) is ineligible for the active duty dental benefit but may opt into the premium-based TDP, other health insurance, or go uninsured. Dependents of RCSMs are never eligible for the ADDP, but they may pay premiums to enroll in the TDP. Premiums are reduced when their sponsor is on active duty. Figure 3 shows the breakout of the eligible population into additional coverage categories (e.g., other dental insurance, uninsured, or FEHB dental). While it is likely that the medically uninsured also lack dental insurance, we cannot assume those with access to other health insurance also have access to dental insurance (or that they chose to enroll).<sup>26</sup>



Figure 3. Dental Enrollment, FY 2022

Figure 3 shows that just over 30 percent of RCSMs were enrolled in a TRICARE dental benefit. This is a lower enrollment rate relative to medical; the difference is driven by the non-active population, which must opt into the premium-based TDP. Only about 7

<sup>&</sup>lt;sup>26</sup> In the civilian setting, fewer employers offer dental benefits relative to health insurance and employee take-up rates are lower than medical take-up rates.

percent of the RCSM population is enrolled in TDP (about one third of the RCSMs who enroll in TRS).

#### 1. Dental Take-up Rates

As with TRS, enrollment in the TDP for non-active RCSMs and their dependents is not automatic. To take up the benefit, the RCSM must select a plan option (RCSM plan, single dependent plan, or multiple dependent plan) and pay the premium. We can construct take-up rates by dividing the number of takers (those who enroll) by the eligible population. We noted that FEHB eligibility does not preclude RCSMs from being eligible for TDP. Figure 4 shows the TRS take-up rates by rank group and plan type. (Recall there are three enrollment options for dental: member only, single dependent, or multiple dependents.)



#### Figure 4. Dental Take-up Rates for Non-active RCSMs and Dependents, FY 2022

The overall take-up rates for the TDP benefit are much lower than the TRS take-up rates—roughly 10 percent for single RCSMs, versus the 20 percent observed with TRS.

Likewise, dependent family plans are taken up at just under 20 percent (versus nearly 50 percent for TRS).

One difference between the medical benefit and the dental benefit is that dependents must pay a premium to participate in TDP, even when their sponsor is active. However, the premium rate is lower than the premium rate charged to dependents of non-active RCSMs. The premium rate charged to dependents of active RCSMs is the same premium rate charged to dependents of AC service members. Because this population faces different prices, we must examine their take-up rates separately. Figure 5 shows take-up rates for dependents of active RCSMs. We can see the take-up rates are higher for active dependents relative to the inactive dependent population. This difference in behavior is likely explained by the price differential and also the potential loss of access to the RCSM's employer sponsored dental plan upon their activation.



Dependent Plan: Single



Figure 5. Active RCSM Dependent Take-up Rates, FY 2022

# 4. TRICARE Medical and Dental Policy Reform Scenarios for RCSMs

Recent years have seen numerous calls for RC health and dental benefit reform. In this analysis, we consider three different medical policy reform scenarios, which we call "Premium-Free TRS," "RCSM TRICARE Prime/Prime Remote," and "Premium Support." For dental, we consider a "Premium-free TDP" scenario and an "Active Duty Parity" scenario. Some of these policies have multiple subscenarios. We outline each below.

# A. Premium-Free TRS

Premium-free TRS is probably the most commonly called for reform to RCSM health benefits. Under a premium-free TRS scenario, DoD would waive premiums for all RCSMs currently eligible for the TRS benefit.<sup>27</sup> Reform proposals for premium-free TRS sometimes vary in the treatment of dependents. Some reform proposals would waive premiums for the RCSM only, requiring dependents to continue to pay for coverage. Under other proposals, premium-free coverage is to be provided for both the member and dependents. Section 707 of the 2023 NDAA asks for consideration of both scenarios.<sup>28</sup> We therefore consider two different premium-free TRS scenarios:

- **Premium-free TRS for RCSMs only**: Under this scenario, the single RCSM plan premium is set equal to zero, and the family RCSM plan is reduced by the single RCSM premium amount.
- **Premium-free TRS for RCSMs and their dependents:** Under this scenario, both the single- and family-plan premium are zero.

Under these two scenarios, we assume no changes to the cost sharing (i.e., copays and coinsurance rates) under the current TRS program. Therefore, beneficiary OOP costs are expected to remain the same. Changes to cost sharing are not generally called for in premium-free TRS scenarios, and they could fundamentally alter program costs by changing utilization behavior and DoD's cost structure. The TRICARE-for-all scenario will allow for reductions in beneficiary cost shares.

 $<sup>^{27}</sup>$  We include the FEHB eligible population as they will be eligible to join TRS by 2030.

<sup>&</sup>lt;sup>28</sup> See The James M. Inhofe National Defense Authorization Act for FY 2023, Subsection C, Section 707, 117<sup>th</sup> Cong., 2d session, Pub. L. 117-263, December 2022, https://docs.house.gov/billsthisweek/20221205/BILLS-117hres -SUS.pdf.

In addition to the two main premium-free TRS scenarios above, we also consider a special premium-free TRS scenario specific to the National Guard. This scenario is based on a new benefit available in the State of Maryland. The Maryland scenario is discussed in Box 2.

# Box 2. State-Subsidized TRICARE Reserve Select for the National Guard

In 2023, Maryland created the "Healthcare for Hero's TRICARE premium Reimbursement Program". The program allows RCSMs in the Maryland National Guard to seek reimbursement of up to \$60 per month–enough to cover the member's enrollment in TRS and the TDP. To the beneficiary, the scenario is essentially the same as premium-free TRS because their premium cost is covered (though they do have to pay the premium and seek reimbursement). This policy is less costly to DoD than the premium-free TRS scenario because it collects premium revenue—albeit paid by a different party.

The program began officially in July 2023. To examine whether it had an impact in TRS take-up in Maryland, we compared Maryland enrollment data to enrollment data for the rest of the United States. Because enrollment shows monthly variation (often growing during open enrollment season), we calculate the month-specific growth rates. All FY 2024 monthly observations are postreform, whereas all FY 2023 observations are prereform. The formula is shown in Figure 6 using October as an example:

 $Growth Rate_{Oct} = (Enrollment_{OctFY24} - enrollment_{OctFY23})/Enrollment_{OctFY23}$ 



Figure 6. Monthly Enrollment Percentage Growth, FY 2023 to FY 2024

The data indicate that Maryland has seen larger increases in TRS participation compared to all other States as a group; its monthly percent growth rate in TRS enrollment was approximately twice that of the rest of the country when comparing the first 6 months of FY 2024 to FY 2023.

To consider what this scenario might look like on a wider scale, we estimated what it would cost DoD if all States adopted this policy (we call this policy scenario "State-subsidized premium-free TRS for the National Guard". In this scenario, we assume members of the National Guard can enroll in TRS and TDP premium-free. Members of the Federal Reserve components are not eligible for the benefit and must pay the premium.

# **B. RCSM TRICARE Prime/Prime Remote**

While many reform proposals have focused on the TRS program and on removing premiums, some have called for a greater benefit expansion-a premium-free benefit with zero cost sharing. These reform proposals have sometimes been referred to as "zero cost TRICARE." Such a reform would be most consistent with providing RCSMs with the active-duty TRICARE Prime (or TRICARE Prime Remote) benefit at all times. We therefore introduce TRICARE Prime/Prime Remote coverage for RCSMs and dependents as an alternative policy option, referred to as "RCSM TRICARE Prime/Prime Remote". This option essentially provides active-duty parity, as RCSMs receive the same health benefit as do active-duty service members, regardless of their activation status. Under such a scenario, the TRS program would no longer exist. Instead, all RCSMs and dependents would have TRICARE Prime/or TRICARE Prime Remote. This policy is expected to be costlier than a premium-free TRS because the loss of cost sharing would drive higher benefit take-up and healthcare utilization. This policy would have the benefit of ending healthcare transitions for RCSMs using TRICARE. Once enrolled in TRICARE, the RCSM and their dependents could remain on the same benefit, regardless of activation status.

# C. Premium Support

The Premium-free TRS and RCSM TRICARE Prime/Prime Remote policy options focus on expanding DoD-provided healthcare to RCSMs and their dependents. An alternative method for enhancing RCSM healthcare benefits would be to subsidize RCSMs to take up non-DoD healthcare options. For instance, DoD could provide a cash allowance that RCSMs could apply toward their employer's sponsored health plan.

Relative to the status quo, such a policy has two offsetting cost effects. First, there would be an increase in cost to DoD because take-up would be very near 100 percent, as everyone utilizing civilian insurance would want to collect the subsidy. Second, some beneficiaries would leave DoD healthcare (where DoD pays the full cost) and return to civilian healthcare (where DoD pays only partial costs). To illustrate this situation, Table 9 shows the TRS premium, the national average for employer-sponsored health plan premiums, and the estimated average cost of providing RCSM coverage under TRS or TRICARE Prime/Prime Remote. We also report the average full cost of a civilian sponsored plan.

	Single Plans	Family Plans
Employee's Premium		
TRS Premium	\$583	\$2,840
National Average for Employer-sponsored Plan	\$1,327	\$6,106
Full Cost of Benefit to DoD		
TRS Cost	\$2,596	\$12,207
Active RCSM TRICARE Cost (Prime/Prime Remote)	\$4,517	\$11,737

#### Table 9. Premiums versus Full Cost of Care, FY 2022

*Note*: The TRICARE estimates were derived for this study; the methodology is covered in the following chapter. The civilian national averages are from the Kaiser Family Foundation 2022 Employers' Health Benefits Survey.

From Table 9, we can see that providing premium-free TRS would cost DoD about twice what it would cost to provide a subsidy set equal to the employee's share of an employer-sponsored health plan (assuming the national average). Providing the active-duty benefit would be even more expensive.

For our premium support scenario, we assume DoD offers all RCSMs the option to enroll in TRS or to accept a subsidy equal to the national average employee's premium share. We present two scenarios:

- **Premium Support for RCSM only**: Under this scenario, a single RCSM can opt into the premium-based TRS plan or receive \$1,327 to apply toward the civilian health benefit; an RCSM with dependents can opt into a TRS family plan or receive the \$1,327 to apply toward a civilian plan.
- **Premium Support for RCSMs and Dependents**: Under this scenario, the RCSM can opt into the TRS plan (single or family) or receive a subsidy (\$1,327 for single RCSMs and \$6,106 for RCSMs with dependents).

Providing a subsidy has several noteworthy benefits. First, a subsidy would be valued by RCSMs at its actual value. Conversely, RCSMs would tend to undervalue DoDprovided benefits, valuing them at the cost of their alternative options. Second, providing a subsidy increases the RCSM's choice set and allows them to pick the option that best fits their needs. Many RCSMs have expressed concerns about access under TRS and not being able to see their current providers. We note, however, that the subsidy option would allow RCSMs to maintain their current coverage. A potential disadvantage is that RCSMs would likely face higher OOP costs under civilian plans. As discussed in Chapter 3, TRS has lower copays and significantly lower deductibles and OOP maximums than do civilian plans.

# **D.** Premium-free TDP

For dental care, reforms have called for RCSMs to have access to a premium-free TDP. Section 707 of the NDAA calls for examination of a premium-free dental benefit for RCSMs only and for a premium-free dental benefit for members and their dependents. However, active-duty family members are currently required to pay a premium for TDP coverage. Therefore, we think a more feasible scenario would be an "active-duty parity" scenario whereby the member pays zero premium and their dependents pay the lower active-duty premium. The two scenarios are therefore:

- Premium-free TDP for RCSMs only
- Premium-free TDP for RCSMs; active-duty parity for dependents

# 5. Cost Analysis: Cost Elements and Model

To estimate the cost of different TRICARE benefit-expansion scenarios, we develop two TRICARE benefit cost models: a medical model, and a dental model. Each model requires three major inputs:

- **Population Data:** The cost models require data on the population eligible for benefits, stratified by enrollment category (i.e., TRICARE for active RCSMs vs. TRS); plan option (i.e., single versus family plan); and rank group. The data are structured at the plan level (i.e., how many plans will be purchased, rather than how many individuals are covered, for accurate calculation of premium revenues). These data were presented in Chapter 3 and in Appendix C.
- **Costs Elements:** The cost model requires data on the average cost of providing a benefit, stratified by the same set of variables as the population data. This stratification allows adjusting for cost differences (and premium revenue) between enrollment categories, plan options, and demographics. These data are presented in Section A of this chapter.
- Behavioral Parameters (take-up rates): The cost model uses benefit take-up rates to capture how costs change under the different benefit-expansion scenarios. To these ends, we use a range of illustrative assumptions and develop a best estimate based on the health economics literature and current enrollment behavior.

This chapter begins with a discussion of the medical and dental cost elements. We then provide a more detailed overview of the model including our approach to modeling take-up rates and key cost assumptions. We conclude with a presentation of medical and dental costs under the status quo.

# A. Cost Elements

## 1. Medical Average Cost Elements

The medical cost model is structured to align with the three enrollment categories (TRS, TRICARE for active RCSMs, TRICARE for transition/other), health plan options (RCSM only or family), and rank group (our proxy for age, family size, and income). Table 10 reports the cost elements used in the analysis. Appendix D contains the methodology used to produce these estimates. These costs represent the average full cost to DoD when

providing healthcare to the different TRICARE user groups.<sup>29</sup> Premiums paid by TRS users have not been netted from the total costs (Table 11 contains costs net of premiums).

	TR	8	Active R	CSMS	Transition/Other Benefit	
Rank Group	RCSM Only	Family	RCSM Only	Family	RCSM Only	Family
JE	\$2,172	\$9,245	\$2,844	\$7,824	\$1,666	\$5,712
SE	\$2,533	\$11,877	\$4,900	\$11,480	\$2,154	\$7,500
WO	\$3,096	\$14,239	\$5,965	\$15,056	\$3,012	\$10,987
JO	\$3,126	\$13,194	\$4,272	\$12,486	\$2,485	\$9,691
SO	\$3,180	\$15,229	\$6,606	\$16,437	\$3,092	\$11,715
Weighted Avg	\$2,596	\$12,207	\$4,517	\$11,737	\$2,043	\$7,849

Table 10. Average Cost by Enrollment, Rank Group, and Family Status, FY 2022

*Source*: Estimates are derived from administrative Military Health System (MHS) data. Appendix E contains method details.JE=Junior Enlisted; SE=Senior Enlisted; WO=Warrant Officer; JO=Junior Officer; SO=Senior Officer.

The cost of providing coverage for RCSMs and RCSM families increases with rank group because healthcare costs rise with age (and thus rank) and because the number of dependents rises for families. Also, higher-paid RCSMs (e.g., officers versus enlisted or senior versus junior) and their families might spend more on healthcare due to an income effect. The cost of coverage also varies by enrollment type. Multiple factors drive the cost differences, and some work in opposite directions. These factors include: (1) TRS has more cost sharing, which can reduce demand relative to those enrolled in TRICARE Prime; (2) TRS users use more purchased care, which is cheaper than direct care; and (3) the presence of other health insurance (i.e., dependents of active RCSMs, RCSMs, and dependents in transition have higher rates of OHI, which can reduce their TRICARE costs). The presence of OHI appears to be the main driver for the lower average costs observed for the transition group, who are in the process of switching on or off of other health coverage. The higher cost of active RCSMs appears to be driven by higher direct care consumption, including readiness services.

The cost model must also factor in TRS premiums under the status quo and TRS premiums under the alternative policy scenarios. Accordingly, we constructed the average cost of care for TRS net of premiums. The FY 2022 annual premium rates for TRS were \$560 for a single RCSM, and \$2,760 for an RCSM family. Table 11 reports the average TRS costs

<sup>&</sup>lt;sup>29</sup> Purchased-care costs have an overhead factor of 4.2 percent applied. This overhead factor was developed from MHS administrative data on contract award fees and management fees.

net of premiums under the status quo, premium-free TRS for members only, and premiumfree TRS for members and their dependents.

	0				,		
	Status Quo		Premium-f Member	ree TRS Only	Premium-free TRS Member and Dependents		
Rank Group	RCSM Only	Family	RCSM Only	Family*	RCSM Only	Family	
JE	\$1,612	\$6,485	\$2,172	\$7,045	\$2,172	\$9,245	
SE	\$1,972	\$9,118	\$2,533	\$9,678	\$2,533	\$11,877	
WO	\$2,536	\$11,479	\$3,096	\$12,039	\$3,096	\$14,239	
JO	\$2,566	\$10,434	\$3,126	\$10,995	\$3,126	\$13,194	
SO	\$2,619	\$12,469	\$3,180	\$13,029	\$3,180	\$15,229	
Weighted Avg	\$2,036	\$9,447	\$2,596	\$10,008	\$2,596	\$12,207	

Table 11. Average TRS Healthcare Costs net of Premium Revenue, FY 2022

\* The family cost is reduced by the RCSM-only premium amount (\$560) to cover the member's premium.

#### 2. Dental Average Cost Elements

The dental cost model is structured to align with the dental plan enrollment categories and plan options. Dental enrollment options differ in structure from medical in two key ways. First, the RCSM's enrollment is kept separate from their dependents. Second, if dependents enroll, they must select between an individual dependent plan (covers one dependent) or a family dependent plan (covers two or more dependents, but not the RCSM). Premiums for dependents vary based on their sponsor's activation status. We therefore split the population into two main enrollment categories: (1) Active RCSMs and Dependents; and (2) Non-active RCSMs and Dependents. Each category has three plan options: RCSM only, Single Dependent, and Dependent Family. Table 12 reports DoD's average total costs of dental care (i.e., premiums have not yet been netted out).

	Activated RCS	SMs and De	pendents	Non-active RCSMs and Dependents			
	ΔΠΟΡ	TDP Dependent Plans		ТПР	TDP Dependent Plans		
Rank Group	RCSM Only*	Single	Family	RCSM Only	Single	Family	
JE	\$719	\$315	\$877	\$403	\$361	\$1,003	
SE	\$562	\$302	\$939	\$308	\$347	\$1,080	
WO	\$598	\$331	\$1,049	\$330	\$376	\$1,193	
JO	\$573	\$309	\$957	\$315	\$355	\$1,097	
SO	\$536	\$331	\$1,081	\$293	\$376	\$1,230	
Weighted Avg	\$589	\$310	\$960	\$325	\$355	\$1,101	

Table 12. Average Costs of Dental Care by Rank Group, FT 202	Table 1	12. Average	Costs of	<sup>f</sup> Dental	Care by	Rank	Group,	FY 2	2022
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Source: Estimates are derived from administrative MHS data.

\* We were able to compute only the overall average for the ADDP due to limited direct-care data. To obtain a distribution, we assumed costs followed the same distribution as TDP RCSM costs.

The cost model must also factor in TDP premiums under the status quo, and the alternative policy scenarios. So, we constructed the average cost of care for TDP net of premiums. The FY 2022 annual premium rates for TDP were \$140 for a single RCSM, \$349 for a single RCSM dependent, and \$909 for a family dependent plan (i.e., more than one dependent). Table 13 reports the average TDP costs net of premiums under the status quo, the premium-free scenario, and the active-duty parity scenario, where the RCSM pays zero premiums but dependents pay the same subsidized rate active-duty dependents pay. The negative values under the status quo indicate the department takes in premium revenue in excess of the average expenditure on certain plans for given rank groups.

	Status Quo			Premium Free			Active-duty Parity		
	RCSM	Single	Family	RCSM	Single	Family	RCSM	Single	Family
JE	\$263	-\$34	-\$32	\$403	\$315	\$877	\$403	\$175	\$514
SE	\$169	-\$48	\$30	\$308	\$302	\$939	\$308	\$162	\$576
JO	\$175	-\$40	\$48	\$315	\$309	\$957	\$315	\$169	\$594
SO	\$153	-\$19	\$172	\$293	\$331	\$1,081	\$293	\$191	\$718
WO	\$190	-\$19	\$141	\$330	\$331	\$1,049	\$330	\$191	\$687
Weighted Avg	\$185	-\$39	\$51	\$325	\$310	\$960	\$325	\$170	\$597

Table 13. Average Dental Costs Net of Premium Revenue, FY 2022

*Source*: Estimates are derived from administrative MHS data. Premium rates are from https://tricare.mil/Costs/DentalCosts/TDP/Premiums.

# **B.** Cost Model Overview

Each cost model follows the same simple methodology: (1) we determine the size of the eligible population for each enrollment category and plan option, (2) we estimate the number of plans taken, and (3) we multiply the number of plans by the average cost of providing the plans to obtain the total cost. The analysis is performed at the rank group level to demographically adjust for differences in costs and take-up behavior. Each model can be partitioned into a set of costs that are variable under the different policy scenarios, and a set of costs that are assumed to be relatively constant. The variable costs are the costs of the premium-based enrollment programs (TRS and TDP) for the non-active beneficiary population. These costs are driven by take-up behavior, which is influenced by premium rates (e.g., if the premium is waived or subsidized, more beneficiaries will sign up). The remaining costs cover benefits for RCSMs and eligible dependents in an active or transition status. These costs should not be affected by a change in the premium-based programs for inactive RCSMs; they would change only with policies that affected the number of active RCSMs. We include these costs in order to develop an estimate of total health and dental benefit spending for all RCSMs under the status quo. We can then calculate the cost impact of different policy scenarios relative to the status-quo baseline.

#### 1. RCSM Medical and Dental Costs Under the Status Quo

The costs models use the cost element data presented in the previous section and the population data from Chapter 3 to establish baseline cost estimates for RCSM health and dental benefits under the status quo. The baseline cost represents how much DoD is currently spending on benefits (factoring in premium revenue).

Table 14 presents the baseline spending on medical and dental benefits for RCSMs and their dependents. Under the status quo, we estimate that DoD spent nearly \$3.3 billion in FY 2022 on health and dental benefits for RCSMs and their dependents (net of premium revenue).<sup>30</sup> The table shows that spending on medical care (\$3 billion) dwarfs spending on dental care (\$200 million) and accounts for over 90 percent of costs.

<sup>&</sup>lt;sup>30</sup> This is spending on RCSMs covered by a TRICARE benefit. We do not include spending on programs like the Reserve Health Readiness Program.

	Variab TRS	le Cost: /TDP		Fixed Cost: Active/Transition Benefits	
	Full Cost	Premium Revenue	DoD Cost	DoD Cost	Total Cost to DoD
Medical	\$1,371	\$310	\$1,061	\$2,013	\$3,074
Dental	\$102	\$56	\$45	\$156	\$201
Total	\$1,473	\$366	\$1,106	\$2,169	\$3,275

#### Table 14. RCSM Medical and Dental Costs (in \$Millions), FY 2022

Total costs are derived from cost elements presented earlier in this chapter.

#### 2. Assumptions Required by Cost Model

In order to estimate how medical and dental costs will change from the status quo, the cost models require two sets of assumptions. The first set of assumptions is about benefit take-up under the different reform scenarios (e.g., how many new users will opt into TRS). The second set of assumptions is about our cost elements and program overhead.

#### a. Benefit Take-up Assumptions

The following discussion covers how we estimated the number of RCSMs that would switch from being uninsured or using a civilian health plan to using TRICARE as their primary health plan.

#### 1) Premium-free TRS

In Chapter 3, we presented data on TRS and TDP take-up rates under the status quo. Understanding how take-up behavior will change under the proposed policy scenarios is critical, given it will be the primary driver of how much (or how little) costs increase. For example, if premiums were removed but behavior did not change (e.g., no additional users enrolled), the only increase in DoD's cost would be lost premium revenue. Conversely, if the removal of premiums induced all eligible users to take up the benefit, the cost increase would be substantial—the cost of adding over 700,000 new covered lives to medical and dental programs. These cases represent bookends—the minimum and maximum amounts the policy reform could potentially cost DoD. In reality we expect the behavioral response to fall somewhere between these extreme cases.

To derive a best estimate, we first assumed all uninsured RCSMs would take up the benefit when the premium is waived. To estimate the behavior of RCSMs covered with civilian insurance, we turned to the health economics literature on health insurance plan elasticities. Economists use elasticities to measure how demand behavior changes with factors such as price or income. Health insurance plan elasticities measure changes in health plan take-up (behavior of switching between plan options) as plan prices change. The literature on health plan elasticities has produced a fairly wide range of estimates but tend to center between -.1 to -1 (see Appendix F for a literature review). We selected an elasticity from the literature based on the studies of the TRICARE population. Specifically, we used an elasticity of -.6, which implies that a 10 percent reduction in the price of a TRS plan will increase plan take-up by 6 percent. Using this elasticity value, we calculated elasticity-based take-up rates associated with the price changes created by the different reform scenarios. Appendix F reports the take-up rates derived using an elasticity of -.6, and the methodology.

While we believe a parameter value of -.6 is consistent with observed behavior and with the economics literature, it is subject to limitations. First, we do not observe the true differential between TRS and each RCSM's outside option (i.e., their other healthcare options); we assume that RCSMs are facing the cost of the average employer-sponsored plan. Second, the price changes implied by the policy scenarios are fairly large, while the price changes observed in the economics literature are generally much smaller. Finally, we note that the psychology of offering a "premium-free" benefit could induce greater take-up than what we predict solely based on price changes. To help illustrate the range of outcomes, we consider various scenarios ranging from conservative to full take-up:

- Status Quo Behavior Plus the Uninsured: In this scenario, we assume the only new users to the TRS program are the previously uninsured RCSMs. All RCSMs opting to enroll in OHI remain in their civilian plans, despite the change in the TRS premium (and the new, larger price differential between TRS and their civilian plan). This is a very conservative assumption.
- **Double the Status Quo:** In this scenario, cohort-specific take-up rates double (e.g., the single junior enlisted plan take-up rate of 13 percent doubles to 26 percent). If doubling implies a take-up rate of over 100 percent, the take-up rate is set to 100 percent. This assumption allows for a fairly significant increase in take-up while also factoring in current cohort-specific take-up behavior.
- **100 Percent Take-up:** In this scenario, all eligible users enroll. This scenario is meant to illustrate the potential maximum the benefit expansion could cost.

## 2) RCSM TRICARE Prime/Prime Remote

In the TRICARE-for-all scenario, the benefit on offer is TRICARE Prime (or Prime Remote). This benefit is premium-free to the RCSM and their dependents and largely free of cost sharing (unless the beneficiary opts to see out-of-network providers through the point-of-service option). The RCSM and eligible dependents could enroll in the benefit and remain in the benefit regardless of activation status. This benefit is therefore a more generous offer than premium-free TRS, and it would provide continuity of care (i.e., no

need to switch plans and providers). We therefore expect take-up to be high. We consider take-up rates of 85 percent and 100 percent as well as our elasticity-based best estimate take-up rate option (using an elasticity of -.6).

We note that the TRICARE take-up behavior of active-duty dependents is near 100 percent; very few dependents opt to use OHI (i.e., a health plan available through a spouse's employer). We estimate roughly 3 percent of active-duty dependents have OHI, though this percentage could be an underestimate if they don't file any claims with TRICARE.

#### 3) Premium Support

In the premium support scenario, we allow all RCSMs to either enroll in TRS at current premium rates or to collect the subsidy to purchase insurance through their employer. As with the premium-free TRS option, there were two scenarios: RCSM-only subsidy, and RCSM and dependent subsidy.

The take-up rate behavior scenarios under premium support parallel the scenarios we used for premium-free TRS, but with a critical difference. For the premium-support analysis, we focus on OHI take-up behavior, not TRS take-up behavior. We are attempting to consider how many RCSMs might leave TRS as the TRS premium is held constant, but a subsidy was provided to take employer-sponsored insurance.

We start the analysis with the same bookend cases. The first, status quo behavior, assumes that everyone enrolled in TRS stays in TRS, and everyone else takes the subsidy. For the 100 percent take-up scenario, we assume 100 percent take-up of the subsidy (rather than TRS). In reality, we expect behavior to fall somewhere in between these extreme scenarios.

To derive a best estimate for premium support, we calculate the average expected OHI price reduction and use it along with the same price elasticity (-.6) to estimate how many current non-OHI users (TRS enrollees or uninsured) will take up OHI.

#### b. TRICARE as a Second Payer

Under the status quo, RCSMs must opt in to the TRS program by completing an enrollment process and paying the monthly premium. If the premium is waived, there is little to impede enrolling (i.e., filling out enrollment paperwork). The DoD may even move to automatic enrollment, which would remove all enrollment friction. With barriers to enrollment greatly reduced or eliminated, it is likely that many RCSMs who elect to maintain civilian health coverage would also enroll in TRICARE, enabling the TRICARE program to serve as a second payer on top of RCSMs' primary insurance. According to

DoD policy, TRICARE will serve as a second payer for individuals with other health insurance.<sup>31</sup>

The amount that TRICARE will pay as a second payer is determined through the coordination-of-benefit process. Generally speaking, if a beneficiary follows the rules of their primary insurance for getting care and filling claims but their insurance doesn't cover the full amount (i.e., they have a 20 percent coinsurance rate), then they may file a second claim with TRICARE to help cover the difference. Having TRICARE as a second payer could be valuable for individuals electing to use a civilian plan as the primary insurer, as civilian catastrophic caps are generally high (the maximum individual cap is \$8,700, while the family cap is \$17,400). So, individuals who incur high healthcare costs will be required to pay thousands of dollars out of pocket in coinsurance before their plan covers 100 percent of the costs. If the beneficiary is using TRICARE as a second payer, they can file claims to have TRICARE cover some or all of their OOP costs. We believe it is likely that RCSMs opting to maintain OHI will pursue using TRICARE as a second payer.

To estimate the cost associated with this phenomenon, we examined what it currently costs the TRICARE program to cover individuals with OHI. Our analysis found individuals using TRICARE as a second payer cost 30 percent of the average user cost. We therefore assume RCSMs who enroll themselves and their families in OHI but who use TRICARE as a second payer will cost 30 percent of their average cohort cost.

It is more difficult to determine what share of those who elect to enroll in OHI will actually use TRICARE as a second payer. Current observed OHI rates are fairly low among populations who aren't required to pay premiums, but the true rates could be higher if individuals are not filing TRICARE claims. For this analysis we assume 50 percent of the OHI population will elect to use TRICARE as a second payer. This percentage will likely grow over time as beneficiaries become more knowledgeable about this option and the claim-filing process.

#### c. Cost Assumptions

#### 1) Program Overhead Assumption

Operating the TRICARE network (e.g., enrolling providers, managing the program, etc.) incurs overhead costs. We capture these costs with a 4.2 percent overhead rate loaded onto the cost of all healthcare delivered in the TRICARE network. The rate is derived based

<sup>&</sup>lt;sup>31</sup> For several OHI programs, TRICARE will not function as a second payer. These programs include: Medicaid, TRICARE supplements, State Victims of Crime Compensation programs, other Federal Government programs identified by the Director, Defense Health Agency (i.e., Indian Health Service). Active-duty RCSMs also face greater restrictions on using OHI. See https://www.tricare.mil/Plans/OHI for more detail.

on the TRICARE contractor fee plus administrative fees net of premium revenue.<sup>32</sup> By adapting the current overhead rate, we are assuming overhead costs will grow proportionally with an expansion in healthcare costs, driven by a growing beneficiary population.

#### 2) Cost Element Assumptions

The TRS analysis implicitly assumes that the cost of covering the non-enrolled TRSeligible population can be represented by the average cost of covering current users, conditioned on their rank group and family status (i.e., a single junior enlisted member with no dependents who is currently not using TRS can be approximated by the average cost of single junior enlisted TRS enrollees). Conditioning on rank ensures that cost elements are adjusted for age and expected number of dependents. However, we cannot rule out the possibility that some selection is occurring that would make non-enrolled users more (or less) expensive, on average. For instance, if the non-enrolled single junior enlisted population were systematically healthier than the current TRS enrolled single junior enlisted population, our average might overestimate the true cost. Such an overestimate could happen if the uninsured choosing to forgo insurance were the youngest and healthiest or if those choosing to enroll in TRS were doing so because they expected to use a large amount of healthcare and wanted to take advantage of the plan's relatively low-cost shares. Alternatively, if individuals expecting to use high amounts of healthcare were systematically opting for employer-sponsored plans, then the non-enrolled population could cost more than the cohort averages constructed from the current TRS user population.

While we acknowledge that some of this selection behavior is occurring at the individual level, we do not have reason to suspect that there are systematic effects in one direction at the population level (i.e., that our averages for the current user groups either systematically over- or underestimate the true cost of covering the non-enrolled population).

We invoke the same cost assumptions for the TRICARE-for-All analysis and the Dental Analysis—that the cost of covering non-enrolled eligible populations can be represented by the average cost of covering current users, conditioned on their rank group and family status.

<sup>&</sup>lt;sup>32</sup> The 4.2 percent was derived from the FY 2023 Annual TRICARE Report to Congress.

In this section, we present cost estimates for the policy scenarios described in Chapter 4.B. We begin by presenting our aggregate cost estimates. This is followed by a discussion of the cost savings to RCSMs and how the cost of a RC service member will change relative to an AC service member.

# A. Aggregate Cost

This section contains the cost estimation results in aggregate (e.g., by how many billions of dollars medical and dental costs will increase under each policy option). These costs are borne by DoD—more specifically, by the Defense Health Program (DHP)). For each reform scenario, we report how DoD's cost would change from the status quo under several take-up-rate scenarios.

# 1. Premium-free TRS

For the estimated cost of providing premium-free TRS, we present the range of takeup rates described in Chapter 5, which included: status quo take-up rates, status quo plus uninsured, double the status quo, 100 percent take-up, and our elasticity-based best estimate. Best estimates are summarized below for the three premium-free TRS scenarios; Table 15 lists all results.

- **Premium-free TRS (RCSM Only):** Our best estimate suggests costs would increase by roughly 30 percent, or \$935 million dollars annually. The increase in covered lives would be just under 283,000, including dependents.
- **Premium-free TRS (RCSMs and Dependents):** Our best estimate suggests costs would increase by roughly 51 percent, or \$1.6 billion dollars annually. The increase in covered lives would be just under 332,000.
- **Premium-free TRS through State Subsidy (National Guard Only):** Our best estimate suggests costs would increase by roughly 14 percent, or \$437 million dollars annually. The increase in covered lives would be just over 158,000.

While our best estimates are informed by the health economics literature, it is difficult to forecast behavior when the price change is larger than those typically observed and specifically when a benefit is advertised as "premium-free." We also know that real or perceived quality differences which will likely influence take-up behavior. In addition, it is possible that our best estimates will describe behavior well in the short run but that over time, more and more RCSMs will eventually opt into TRS as price differentials between premium-free TRS and civilian options increase.<sup>33</sup> To illustrate these concerns, the 100 percent take-up rate shows what the costs would be under the maximum take-up; this information is shown in Table 15.

	-	Fotal Cost		C	Covered Lives			
	Total	Cost Change	Pct Change	Total	Lives Change	Pct Change		
Status Quo	\$3,074			1,019,651				
Premium-Free TRS RCS								
SQ Take-up	\$3,290	\$216	7%	1,019,651	0	0%		
SQ Plus Uninsured Take-up	\$3,510	\$436	14%	1,116,800	97,149	10%		
SQ Take-up Doubles	\$4,364	\$1,290	42%	1,416,928	397,277	39%		
100 Percent Take-up	\$5,120	\$2,046	67%	1,750,262	730,611	72%		
Best Estimate	\$4,009	\$935	30%	1,302,578	282,927	28%		
Premium-free TRS RCSM	I and Depe	ndents:						
SQ Take-up	\$3,729	\$655	21%	1,019,651	0	0%		
SQ Plus Uninsured Take-up	\$3,966	\$892	29%	1,116,800	97,149	10%		
SQ Take-up Doubles	\$4,881	\$1,807	59%	1,416,928	397,277	39%		
100 Percent Take-up	\$5,683	\$2,609	85%	1,750,262	730,611	72%		
Best Estimate	\$4,649	\$1,575	51%	1,351,473	331,822	33%		
State-subsidized TRS (G	uard Memb	ers Only)						
SQ Take-up	\$3,148	\$74	2%	1,019,651	0	0%		
SQ Plus Uninsured Take-Up	\$3,253	\$179	6%	1,074,055	54,404	5%		
SQ Take-up Doubles	\$3,703	\$629	20%	1,242,126	222,475	18%		
100 Percent Take-up	\$4,059	\$985	32%	1,428,793	409,142	29%		
Best Estimate	\$3,511	\$437	14%	1,178,090	158,439	13%		

 Table 15. Estimated Aggregate Medical Costs for Premium-free TRS Scenarios (in \$Millions), FY 2022

*Note*: The total costs include the cost of TRS beneficiaries and the cost of active/transitioning RCSM beneficiaries. The cost change (and change in covered lives) is driven by changing TRS take-up behavior and loss of premium revenue. For State-subsidized TRS, there is no loss of premium revenue (premiums are paid by the State). Best estimate was calculated assuming elasticity of -.6.

<sup>&</sup>lt;sup>33</sup> TRICARE premiums have historically grown at slower rates than civilian plans. Over the last two decades, the price differential led military retirees to take up TRICARE (as opposed to employersponsored plans) at ever higher rates. Today, less than 10 percent of military retirees under 65 choose civilian health insurance options over TRICARE. https://www.health.mil/Reference-Center/Reports/2023/09/07/Annual-Evaluation-of-TRICARE.

# 2. RCSM TRICARE Prime/Prime Remote

For the TRICARE-for-All scenario, we report the higher take-up rate scenarios as discussed in Chapter 5. Our best estimate suggests that costs will increase by roughly \$2.6 billion dollars. These costs will cover over 500,000 new beneficiaries. This option is more costly than premium-free TRS due to the higher average costs and the expanse of the benefit package, which are expected to lead to much higher take-up rates, shown in Table 16.

		Total Cos	t	Covered Lives			
	Total	Cost Change	Pct Change	Total	Lives Change	Pct Change	
Status Quo	\$3,074			1,019,651			
85 Percent Take-up	\$5,976	\$2,902	94%	1,695,219	675,568	66%	
100 Percent Take-up	\$6,038	\$2,964	96%	1,750,262	730,611	72%	
Best Estimate (Percent Take-up)	\$5,626	\$2,552	83%	1,549,976	530,325	52%	

 Table 16. Estimated Aggregate Medical Costs for RCSM TRICARE Prime/Prime Remote (in \$Millions), FY 2022

# 3. Premium Support

Under the following scenarios, the RCSM can select the status quo TRS benefit or a subsidy to cover OHI. We present the range of take-up rates described in Chapter 5, which included: status quo OHI take-up, 100 percent subsidy take-up, and our elasticity-based best estimate. Best estimates are summarized below for the three premium-free TRS scenarios; Table 17 shows all results.

- **Premium Support (RCSM Only):** Our best estimate suggests costs would increase by roughly 20 percent, or \$627 million dollars annually. Lives covered by TRICARE would decrease by nearly 60,000.
- **Premium Support (RCSMs and Dependents):** Our best estimate suggests costs would increase by roughly 70 percent, or \$2.1 billion dollars annually. Lives covered by TRICARE would decrease by nearly 170,000.

		Total Cost		TRICARE Covered Lives			
	Total	Cost Change	Pct Change	Total	Lives Change	Pct Change	
Status Quo	\$3,074			1,019,651			
Premium Support RCS	M Only:						
SQ OHI Take-up	\$3,797	\$723	24%	1,019,651	0	0%	
100 Percent OHI Take-up	\$2,965	-\$109	-4%	618,328	-401,323	-39%	
Best Estimate	\$3,701	\$627	20%	963,022	-56,629	-6%	
Premium Support RCS	M and Dep	endents:					
SQ OHI Take-up	\$5,314	\$2,240	73%	1,019,651	0	0%	
100 Percent OHI Take-up	\$5,163	\$2,089	68%	618,328	-401,323	-39%	
Best Estimate	\$5,250	\$2,176	71%	852,765	-166,886	-16%	

Table 17. Estimated Annual Aggregate Medical Costs for Premium Support Scenarios (in<br/>\$Millions), FY 2022

*Note*: 100 percent Take-up is 100 percent take-up of the subsidy (i.e., everyone leaves TRS). Best estimate assumes an elasticity of -.6.

These findings suggest providing premium support would be less costly than the premium-free TRS (RCSM Only). However, premium support becomes relatively more expensive if a subsidy for dependents is also provided. Further consideration of premium support options may be desirable if low TRS take-up rates are driven by a strong preference for civilian health care coverage. They may also be desirable if shifting beneficiaries to civilian coverage could lessen beneficiary access issues.

## 4. Dental

Table 18 shows the results of providing a premium-free TRICARE dental program to inactive RCSMs. We also consider providing a reduced premium to the dependents of inactive RCSMs, that would be equal to the TRICARE dental program premium paid by active-duty service member dependents (and active RCSM dependents). We present the same range of take-up rates as before.<sup>34</sup>

<sup>&</sup>lt;sup>34</sup> As discussed in Chapter 3, we did not observe a dental uninsured rate. Here we use the medical uninsured rate as a proxy for the dental uninsured rate, recognizing this is likely an underestimate, as dental insured rates tend to be higher than medical.

	Total Cost			Covered Lives*				
	Total	Cost Change	Pct Change	Total	Lives Change	Pct Change		
Status Quo	\$201			561,630				
Premium-free TRS RCSM Only:								
SQ Take-up	\$214	\$13	7%	588,299	26,669	5%		
SQ Plus Uninsured Take-up*	\$231	\$30	15%	647,642	86,012	15%		
SQ Take-up Doubles	\$268	\$67	33%	879,356	317,726	57%		
100 Percent Take-up	\$425	\$224	111%	1,750,262	1,188,632	212%		
Best Estimate	\$284	\$83	41%	837,586	275,956	49%		
Premium-free TRS RCSM and Dependents:								
SQ Take-up	\$226	\$25	12%	588,299	26,669	5%		
SQ Plus Uninsured Take-up*	\$274	\$73	36%	647,642	86,012	15%		
SQ Take-up Doubles	\$341	\$140	70%	879,356	317,726	57%		
100 Percent Take-up	\$580	\$379	189%	1,750,262	1,188,632	212%		
Best Estimate	\$337	\$136	68%	860,586	298,956	53%		

Table 18. Estimated Aggregate Dental Costs by Scenario (in \$Millions), FY 2022

\* The uninsured population is the population without medical insurance. We did not observe the uninsured dental population. The medically uninsured population is likely an underestimate of the population without dental insurance.

Under the scenarios, we describe our best estimates below:

- **Premium-Free TRICARE Dental Program (RCSM Only):** Our best estimate suggests costs would increase by roughly 41 percent, or \$83 million annually. Approximately 276,000 new lives would be covered.
- Premium-Free TRICARE Dental Program for RCSMs and Active-duty Parity for Dependents: Our best estimate suggests costs would increase by roughly 68 percent, or by \$136 million annually. Approximately 299,000 new lives would be covered

We note the uncertainty in our best estimates is greater for dental. The literature on dental insurance take-up behavior, data on civilian coverage costs, and data on RCSM dental coverage are all more limited than the data available on for medical insurance. For instance, the Periodic Health Assessment (PHA) provides excellent data on how many RCSMs report having other health insurance, but no similar data exist for dental insurance.

## 5. Combining Medical and Dental Benefits

Table 19 shows the estimated combined total cost of providing medical and dental benefits. This analysis sums our cost estimates from the previous sections. For simplicity,

we present only our best estimates and the 100 percent take rate. We also focus on three cases:

- **RCSM-only Benefits:** Premium-free TRS and premium-free TDP to RCSMs-only (i.e., no subsidy for dependents)
- **RCSM and Dependent Benefits:** Premium-free TRS (RCSM and Dependents) and active-component parity for TDP (i.e., TDP is free for RCSM, and dependents pay the same rate as do active-component dependents).
- **RCSM TRICARE Prime/Prime Remote:** RCSMs and dependents get the active-duty TRICARE benefit and the active-duty parity TDP benefit.

Table 19. Estimate Total Annual Cost Increase (in \$Millions), FY 2022						
	Take-up Assumption	Medical	Dental	Total		
RCSM-only Benefit Expansion	Best Estimate	\$935	\$83	\$1,019		
	100 Percent	\$2,046	\$224	\$2,270		
RCSM and Dependent Benefit Expansion	Best Estimate	\$1,575	\$136	\$1,711		
	100 Percent	\$2,609	\$379	\$2,988		
RCSM TRICARE Prime/Prime Remote	Best Estimate	\$2,552	\$136	\$2,687		
	100 Percent	\$2,964	\$379	\$3,343		

*Note*: These numbers are taken from Table 15, Table 16, and Table 18.

# **B.** Cost to Individual

This section presents how total medical costs would change for individual RCSMs and RCSM families under the proposed scenarios. Figures include the premium costs as well as average OOP costs (i.e., deductibles, coinsurance, and copayments, etc.). By determining the change in total medical costs (or savings to the RCSM) we can better understand the perceived value of this benefit to the member and their families.

#### 1. Medical

The analysis below considers the average savings each policy scenario would generate for individual RCSMs and RCSM families. Table 20 shows the average estimated total cost of participating in an employer-sponsored health plan (premiums and OOP) versus TRS under the status quo, the two premium-free TRS options, and RCSM TRICARE Prime/Prime Remote. OOP costs for the TRS population are based on current OOP costs of TRS users. OOP costs for the civilian plan are derived from Merative<sup>™</sup> MarketScan®Commercial Database.<sup>35</sup>

5							
		Single			Family		
<b>RCSM Total Cost</b>	Premium	OOP	Total	Premium	OOP	Total	
Status Quo:							
Employer-sponsored Plan	\$1,327	\$1,336	\$2,663	\$6,106	\$3,513	\$9,619	
TRS Cost (Status Quo)	\$560	\$244	\$804	\$2,760	\$874	\$3,634	
Reform Scenarios:							
TRS Cost (Premium-free RCSM Only)	\$0	\$244	\$244	\$2,199	\$874	\$3,074	
TRS Cost (Premium-free RCSM and Family)	\$0	\$244	\$244	\$0	\$874	\$874	
RCSM TRICARE Prime/Prime Remote	\$0	\$1	\$1	\$0	\$295	\$295	

Table 20. Average Medical Premium and OOP Costs, FY 2022

*Source*: Civilian cost data are from KFF (premiums), Merative<sup>™</sup> MarketScan®Commercial Database (OOP). TRS premium costs are from TRICARE.mil. The OOP costs are derived from MHS administrative data.

Table 20 shows that the average RCSM family would spend nearly \$10,000 on healthcare annually in an employer-sponsored plan. Under TRS, the average family would spend just over \$3,600. Figure 7 uses these costs to illustrate how much an RCSM family would save when switching from the average civilian plan to TRS and then the additional savings they would realize under different policy scenarios. Interestingly, the largest savings to the RCSM accrue when they first switch to TRS under the status quo. The additional savings that would be gained by waiving TRS premiums or providing the TRICARE Prime benefit are lower. For example, an RCSM with a family can save an estimated \$5,985 dollars per year by switching from the average employer-sponsored plan to TRS. However, once the RCSM is enrolled in TRS, the additional savings from the TRS premium-free scenario would be only \$560 per year under the member-only option.

<sup>&</sup>lt;sup>35</sup> Merative provides quarterly cost data broken out by age group, gender, and MHO vs. PPO. Our civilian OOP costs are derived from the 2022 Merative data and are based on the age and family size demographics of the RCSM population. OOP costs were initially derived for each rank group and family structure. We then constructed the weighted averages shown in Table 12. The analysis assumes 40 percent HMO and 60 percent PPO enrollment. The civilian premium numbers are the same numbers presented in Chapter 2. The premium data source is the KFF Health Benefit Survey for 2022.



Figure 7. Estimated Medical Cost Savings to RCSMs, FY 2022

## 2. Dental

The analysis below considers the average savings each policy scenario would generate for individual RCSMs and RCSM families who rely on civilian dental benefits or the status quo TDP program. While there are three dental plan options (RCSM only, single dependent, and multiple dependents), we focus on the single plan and family plan cases to allow for comparability with civilian data.<sup>36</sup> We note the amount of research and data available on dental plans (particularly OOP costs) are more limited than medical data.

Table 21 shows the average estimated total cost of participating in an employersponsored dental plan (premiums and OOP) versus TDP under the status quo and the two dental scenarios. OOP costs for the TDP population are based on current OOP costs of TDP users.<sup>37</sup> OOP costs for the civilian plan in Table 21 are derived from a Health Policy Institute (HPI) research brief on dental spending among individuals with dental benefits.<sup>38</sup>

Table 21. Average Dental Premium and OOP Costs, FY 2022							
RCSM Total Cost	Premium	Single OOP	Total	Premium	Family OOP	Total	
Status Quo							
Employer-sponsored Plan	\$528	\$117	\$645	\$1,583	\$399	\$1,982	
TDP Cost (Status Quo)	\$140	\$125	\$265	\$1,048	\$610	\$1,658	
Scenarios							
TDP Cost (Premium-free RCSM Only)	\$0	\$125	\$125	\$908	\$610	\$1,518	
TDP Cost (Premium-free RCSM and Family)	\$0	\$125	\$125	\$362	\$610	\$972	

*Source*: The civilian premiums are FEHB plan rates presented previously in Chapter 2, Table 3. The civilian OOP costs are derived from HPI. TDP data are calculated from MHS administrative data.

Table 21 shows that the average RCSM family would spend nearly \$2,000 on dental care annually in an employer-sponsored plan. Under TDP, the average family would spend over \$1,600. Figure 8 uses these costs to illustrate the savings an RCSM family would save by switching from the average civilian plan to TDP, and then the additional savings they would realize under the different policy scenarios. Because TDP premiums are heavily subsidized for members but less so for families, the savings from switching to TDP under the status quo are roughly the same for an individual RCSM or for a family. The marginal savings of the proposed reform are small for RCSMs (the annual premium of \$140). However, if dependents were allowed to pay the active duty family premium rate of \$362 rather than the current rate of \$1,048, savings would be just under \$1,000.

<sup>&</sup>lt;sup>36</sup> Family TDP OOP costs are constructed by including the average estimated OOP cost for an RCSM (\$125) and the average cost for an RCSM dependent (\$202), times the average number of dependents.

<sup>&</sup>lt;sup>37</sup> OOP costs are calculated as the allowed amount minus the TRICARE paid amount.

<sup>&</sup>lt;sup>38</sup> "An Analysis of Dental Spending Among Adults with Private Dental Benefits," https://www.ada.org/-/media/project/ada-organization/ada/ada-org/files/resources/research/hpi/hpibrief\_0516\_1.pdf. These data were reported in 2015 dollars. We inflated values to 2022 dollars using the DHP deflator.

#### **RCSM Single Plan**



#### **RCSM Family Plan**



Figure 8. Estimated Dental Cost Savings to RCSMs, FY 2022

#### 3. Medical and Dental Savings

We combined the total estimated medical and dental savings that will likely accrue to RCSMs who switch to TRICARE (TRS and TDP) under each reform scenario. These estimated savings are simply the sum of the savings presented in the previous two sections.
As noted before, the savings are much greater for RCSMs with dependents. The numbers presented here are overall weighted averages for all RCSMs. However, we note that within each category, the savings also rise by rank group due to the observed rise in OOP spending by rank group, shown in Figure 9.



#### **RCSM Single Plan**

#### **RCSM Family Plan**



#### Figure 9. Estimated Medical and Dental Cost Savings to RCSMs, FY 2022

We will use these savings estimates in the benefit analysis we present in Chapter 7.

## C. Cost of Active vs. Reserve Component

Table 22 details how the aggregate cost increase in spending on RCSM health and dental benefits would affect the average cost for RCSMs and the cost for RCSMs relative to active-component personnel. We use the cost to the DoD concept.

Non-active Percent Reservist Cost Percent of AC Increase Cost Cost Change **Status Quo** Actual \$21,849 15% **Premium-free TRS** 9% **Best Estimate** \$23,835 \$1,986 16% and TDP (RCSM Only) 100 Percent Take-up \$26,274 \$4,425 20% 17% **Premium-free TRS** \$25,185 \$3,336 17% **Best Estimate** 15% (RCSM and Dependents), Active-100 Percent Take-up \$27,674 \$5,825 27% 18% duty Parity for TDP **RCSM TRICARE Best Estimate** \$27,088 \$5,239 24% 19% Prime/Prime Remote; Active-duty Parity for 100 Percent Take-up \$28,366 \$6,517 30% 19% TDP

Table 22. Average Cost for Non-active Reservist under Expanded Benefit Scenarios

*Note*: The cost increase is constructed by dividing the total cost increase from Table 19 by the number of nonactive RCSMs (e.g., the TRS-eligible population, 512,935). For the percent of AC cost, we calculate the cost of a non-active reservist relative to an active duty service member (using the data from Table 6; annual AC cost to DoD is \$149,000).

## 7. Benefit Analysis

Potential benefits are often mentioned when discussing RCSM health and dental benefit expansions, but they are rarely quantified. This analysis attempts to quantify the commonly discussed benefits (e.g., improved medical readiness, improved recruiting, improved retention, etc.) using a framework that estimates the potential marginal gains (i.e., how many addition RCSMs might be made medically ready, recruited, retained, etc.). Our quantitative analysis focuses on three categories:

- Improved Medical Readiness
- Potential Savings in the Reserve Health Readiness Program
- Improved Recruitment and Retention

To help decision-makers assess whether the marginal improvements in readiness, recruiting, etc. are cost effective, we also calculate the marginal cost of achieving the marginal gains through benefit expansion. When possible, we compare the marginal cost of benefit expansion to alternative policy options. For instance, in the case of recruiting, we also look at increasing bonuses, number of recruiters, or advertising spending—all well-recognized and studied policy instruments.

In addition to discussing quantitative assessments, we also discuss several additional benefits qualitatively.

#### A. RCSM Medical Readiness

All service members are required to meet individual medical readiness (IMR) requirements and to report medical issues that could affect their ability to deploy. The factors that determine a service member's IMR status are outlined in DoD Instruction (DoDI) 6025.19, "Individual Medical Readiness." This publication defines six elements that all Service components use to track the IMR of service members: the PHA; deployment-limiting medical conditions (DLMC) status; dental readiness; immunization status; medical readiness laboratory studies; and individual medical equipment. Table 23 outlines each element in greater detail and provides the DoD reference documents.

To determine whether expanding health and dental benefits could improve medical readiness, we need to understand the current rates of medical readiness and general trends (e.g., do RCs have problems with medical or dental readiness?). We also need to understand if providing DoD health and dental benefits could address current shortfalls. If medical readiness rates are high, the marginal benefit of expansions will be low. On the

other hand, if medical readiness rates are low, and health and dental benefit expansion can target the six IMR elements, then the marginal benefit increases.

IMR Element	Requirement/Description/DoD Reference			
Periodic Health Assessment (PHA)	<ul> <li>Requirement: Service members must complete a PHA annually; the PHA is considered overdue if not completed within 90 days after the due date.</li> <li>Description: PHAs are medical screening exams used to assess the overall health and readiness status of a service member. PHAs are conducted annually and consist of several components, including a self-reported health assessment, a one-on-one interview with a provider, a mental health assessment with a trained health care provider, and a review of the individual's medical history/records. A PHA will not be considered complete until the individual completes the screening process and the provider submits the completed form (DD Form 3024) to the Defense Medical Surveillance System (DMSS).</li> <li>DoD References: DoDI 6200.06, DoDI 6025.19, and DD Form 3024</li> </ul>			
Deployment- Limiting Medical Conditions (DLMCs)	<ul> <li>Requirement: Service members must be free of any DLMCs.</li> <li>Description: DLMCs include any physical or psychological conditions that might interfere with the service member's ability to perform duties when deployed. DLMCs are defined in DoDI 6490.07 as well as in Military Department—specific policies.</li> <li>DoD References: DoDI 6200.06, DoDI 6025.19</li> </ul>			
Dental Assessment	<ul> <li>Requirement: Service members must have a dental readiness classification (DRC) of 1 or 2.</li> <li>Description: The DRC categories are <ul> <li>DRC 1: exam current; no dental treatment or reevaluation required</li> <li>DRC 2: exam current; requires non-urgent dental treatment or reevaluation for a condition unlikely to result in emergencies within 12 months</li> <li>DRC 3: exam current; requires urgent or emergent dental treatment</li> <li>DRC 4: exam is not current; classification undetermined</li> </ul> </li> <li>DoD Reference: DoDI 6025.19 and DD Form 2813</li> </ul>			
Immunization Status	<b>Requirement:</b> Service member is current for all required vaccines. DoD Reference: DoDI 6025.19			
Medical Lab Tests	<b>Requirement:</b> Service members must have a current HIV test and a deoxyribonucleic acid (DNA) sample on file. <b>DoD Reference:</b> DoDI 6025.19			
Medical Equipment Check	DoD Reference:DoDI 6025.19Requirement:The core requirement is one pair of gas mask inserts for all deployable assets needing visual correction.Service and occupation- specific requirements may also exist.DoD Reference:DoDI 6025.19			

Table 23. Six IMR Elements

Source: This table is an updated version of Table 19 from IDA Document D-21567.

*Note*: HIV = Human Immunodeficiency Virus.

The discussion of current medical readiness rates is complicated by a recent change in the methodology for determining readiness. Specifically, we note that the method for determining IMR, and the IMR instruction, were updated in 2022 in a non-trivial way that makes time series analysis of IMR data problematic. At present, under the new definition, IMR rates appear to be at historical highs. Furthermore, RCSM IMR rates appear on par with—or even higher than—the IMR rates observed for AC service members. However, a closer look at the data reveals some potential risks. We therefore describe the old IMR categories, metrics, and targets versus the new categories, metrics, and targets and present a method for making comparisons.

#### 1. IMR Methodology Change

Under the old formula, individuals were grouped into four possible IMR categories: fully medically ready (FMR), partially medically ready (PMR), not medically ready (NMR), or medical readiness indeterminate (MRI).

Table 24 provides the specifics of how each category was defined. Using these categories, each component reported their total force medical readiness rate (TFMR) as well as the rate of individuals that were NMR and MRI. Table 24 includes the formulas for each metric. The old target for the TFMR rate was 85 percent.

Under the new system, the MRI category was dropped. All individuals falling into this category (e.g., those with overdue PHAs and dental exams) were moved into the partially medically ready category. Using the new categories, the Services now report the following three metrics:

- Total Force Medically Ready (TFMR) = (FMR+PMR)/Total Service Members
- Partially Medically Ready (PMR) = PMR/Total Service Members
- Not Medically Ready = NRM/Total Service Members

The target for the TFMR rate was raised to 90 percent. New targets for the PMR rate were introduced (15 percent or lower for AC and 25 or percent or lower for RC).

The new system introduces greater risk into DoD's assessment of medical readiness. Prior to the change, the PMR group included only individuals who were known to be both medically and dentally ready but who lacked an immunization, medical lab, and/or medical equipment check (things that can be quickly remedied). The category therefore contained only individuals who truly were partially ready. Those whose status was unknown/indeterminate were not counted as partially ready but rather were counted as indeterminate and were not included in the TFMR numerator.

Under the new method, individuals with an indeterminate status are included in the partially ready category, even though their status is actually unknown. They are therefore also included in the TFMR numerator. Their inclusion introduces risk because it assumes

that individuals of an indeterminate status are ready (and just need to complete an administrative exam process to be fully ready). However, it is possible that the exam will result in the service member's being deemed non-medically ready. According to subject matter experts (SMEs), 20 percent of the old MRI category were generally found to be NMR, and there is a risk this percentage could change under the new regime.

	Old Methodology	New Methodology
	• Fully Medically Ready (FMR): The service member passed all requirements for the six IMR elements listed in Table 23 (e.g., complete PHA, no DLMCs, DRC of 1 or 2, and current on immunizations, medical labs, and medical equipment).	• Fully Medically Ready (FMR): The service member passed all requirements for the six IMR elements listed in Table 23 (e.g., complete PHA, no DLMCs, DRC of 1 or 2, and current on immunizations, medical labs, and medical equipment).
Categories	• <b>Partially Medically Ready (PMR):</b> Service members are considered PMR if they meet the first three requirements outlined in Table 23 (i.e., complete PHA, no DLMCs, and DRC of 1 or 2) but do not meet one of the remaining requirements (e.g., lack an immunization, medical test, or required medical equipment).	• <b>Partially Medically Ready (PMR):</b> Service members are considered PMR if they meet the first three requirements outlined in Table 23 (i.e., complete PHA, no DLMCs, and DRC of 1 or 2) but do not meet one of the remaining requirements (e.g., lack an immunization, medical test, or required medical equipment) or if their medical and/or dental status is
	<ul> <li>Not Medically Ready (NMR): Service members with DLMCs and/or requiring dental treatment (DRC 3)</li> <li>Medical Readiness Indeterminate (MRI): Service members with an overdue PHA and/or overdue dental exam (DRC 4)</li> </ul>	<ul> <li>indeterminate.</li> <li>Not Medically Ready (NMR): Service members with DLMCs and/or requiring dental treatment (DRC 3)</li> <li>Medical Readiness Indeterminate (MRI): No longer used</li> </ul>
	<ul> <li>Total Force Medically Ready (TFMR)</li> <li>= FMR+PMR/Total Service Members</li> </ul>	<ul> <li>Total Force Medically Ready (TFMR)</li> <li>= FMR+PMR/Total Service Members</li> </ul>
Metrics	Not Medically Ready (NMR)     = NMR/Total Service Members	<ul> <li>Not Medically Ready (NMR)</li> <li>= NMR/Total Service Members</li> </ul>
	Medically Indeterminate (MRI)     =MRI/Total Service Members	Partially Medically Ready (PMR)     = PMR/Total Service Members
Targets	• TFMR = 85 or higher	<ul> <li>TFMR = 90 or higher</li> <li>PMR =15 or less for AC; PMR = 25 or less for RC</li> </ul>

## Table 24. Comparing IMR Determination Methods

The PMR targets of 15 percent or lower for the AC (and 25 percent for the RC) were meant to help mitigate this risk. However, current data show MRI rates have grown rapidly since the metric change and that the Air Force is the only service currently meeting these targets.

Figure 10 shows AC and RC MRI rates from 2015 through 2023. The vertical line illustrates when the break in IMR reporting occurred. At that point we must impute the MRI rate using data on the number of individuals with overdue PHAs and/or who are classified as dental class 4<sup>39</sup>; the data indicate that RC MRI rates have since risen.



Figure 10. Quarterly MRI Rates of the Active and Reserve Components (All Services)

Because MRI is now in the TFMR numerator, TFMR rates are at historic highs illustrated in Figure 11 by plotting the TFMR rate for all RCs with the new and imputed old TFMR definition. The solid line represents the official TFMR rate over time, with the vertical bar indicating where the definition changed. The dashed line shows where TFMR

<sup>&</sup>lt;sup>39</sup> If we simply sum the number of individuals who have overdue PHAs and the number of individuals who are dental class 4, we will overestimate the size of the MRI population because some individuals fall into both categories. We adjust for the overlap in this population using historic rates of overlap between the two populations.

rates would be under the old definition. There is a clear difference for both ACs and RCs, but the difference is much larger for the RCs.



Figure 11. IMR Rates Calculated under Current and Previous Methods

Under the new definition, Reserve TFMR exceeded 90 percent in 2023, but under the old definition it has fallen below 75 percent. This is a potentially concerning finding, driven by the large number of RCSMs who are overdue on PHAs. Discussion with SMEs from the Services and Defense Health Agency (DHA) indicated the rise in overdue PHAs stems from ongoing problems with the RHRP, which is a significant provider of PHA services. In 2021, the RHRP contract was awarded to a new vendor, QTC Medical Services, who began operating the program in spring of 2023. Transition challenges, including staffing challenges due to postCOVID shortages in civilian providers, resulted in the RHRP's customers' not being able to obtain services in a timely manner. While there has been some improvement in MRI rates, they still remain significantly higher than the historical preCOVID average.

#### 2. Can Health and Dental Benefit Expansions Improve Medical Readiness?

Table 25 show IMR rates for the last quarter of 2023, our most recent observation. For variables with policy targets, we indicate in blue color that a Service component is meeting its target (red indicates missing the target).

		Total				
Service	Component	Strength	FMR	PMR	NMR	TFMR
Army	Active	363,747	61%	29%	11%	89%
	Guard	247,854	36%	55%	10%	90%
	Reserve	144,136	20%	69%	11%	89%
	Total	755,737	45%	45%	11%	89%
Navy	Active	271,215	68%	26%	6%	94%
	Reserve	44,023	62%	30%	8%	92%
	Total	315,238	67%	26%	7%	93%
Marine Corps	Active	113,622	73%	20%	7%	93%
	Reserve	30,434	40%	50%	10%	90%
	Total	144,056	66%	27%	7%	93%
Air Force	Active	267,648	77%	13%	10%	90%
	Guard	90,987	76%	17%	7%	93%
	Reserve	49,151	81%	12%	7%	93%
	Total	407,786	78%	14%	9%	91%
Coast Guard	Active	39,971	46%	49%	5%	95%
	Reserve	6,124	49%	47%	5%	95%
	Total	46,274	46%	49%	5%	95%
Total Force		1,668,912	59%	32%	9%	91%
Total Active		1,056,203	68%	24%	9%	91%
Total Guard + Res		612,709	44%	47%	9%	91%

Table 25. IMR Rates for Active and Reserve Components, CY 2023 Q4

*Source*: All Quarterly IMR data were provided by DHA. Data in table are for Q4 of CY 2023. The TFMR target is 90 percent. The PMR target is component-specific: 15 percent or less for AC, and 25 percent or less for RC.

In the following section, we examine the potential for health and dental benefit expansions to (1) reduce the number of RCSMs that are not medically ready, and (2) move more RCSMs from partially ready to fully ready.

## **3.** Can Health and Dental Benefit Expansions Reduce the Not Medically Ready Population?

By the current standard, RCSM medical readiness is at a historic high of 91 percent (the same as the AC on average), with an NMR rate of 9 percent. Here we consider the marginal benefit and cost of further reducing the NMR rate. The NMR rate will never be zero due to readiness frictions (people get injured, develop illnesses, become pregnant, etc.). Many of these DLMCs are temporary and will resolve with time alone or time and medical (or dental) treatment. We therefore consider two possible improvement targets: an NMR target of 5 percent, and NRM target of active-duty parity (e.g., if the Army AC NMR rate is 7 percent, Army RCs will target 7 percent).

As of Q4 of 2023, there were roughly 60,000 NMR RCSMs, with an overall NMR rate of 9 percent. Reducing the NRM rate to 5 percent would require shifting just over 26,000 RCSMs from NMR to TFMR status. Likewise, targeting active-duty parity would require shifting 1,900 RCSMs. Table 26 shows these calculations.

	NMR Count	NMR Rate	Change Required (NMR = 5%)	Change Required (Active-duty Parity)		
Army Guard	24,637	10%	12,244	0		
Army Reserve	15,919	11%	8,712	221		
Navy Reserve	3,472	8%	1,271	654		
Marine Corps Reserve	3,051	10%	1,529	994		
Air Guard	5,947	7%	1,398	0		
Air Force Reserve	3,390	7%	932	0		
Coast Guard Reserve	283	5%	0	7		
Total	56,699	9%	26,087	1,876		

## Table 26. Required Changes in RCSM NMR Rates to Meet Targets

Source: DHA provided all quarterly IMR data. Data in table are for Q4 of CY 2023.

If providing a health and dental benefit to all RCSMs guaranteed an NMR of 5 percent or lower, we could compare the marginal gain of 26,000 newly ready RCSMs to the expected marginal cost of the different benefit-expansion scenarios and calculate the cost per newly ready RCSM. Table 27 shows these numbers. Because the population of NMR RCSMs is small and the benefit expansion would apply to all RCSMs, the cost per newly ready member is high—over \$30,000 for the most limited expansion scenario and optimistic readiness improvement assumption (that the NMR rate can be reduced to 5%). If RCSMs can only achieve NMR parity with active duty, the marginal cost jumps to nearly \$500,000.

Scenario	Take-up Assumption	Expected Cost Increase (in \$Millions)	Cost per Newly Ready RCSM (NMR = 5%)	Cost per Newly Ready RCSM (Active-duty Parity)
RCSM-only	Best	1,019	\$39,044	\$542,929
Benefit Expansion	100 Percent	2,270	\$87,001	\$1,209,808
RCSM-and-	Best	1,711	\$65,586	\$912,013
Dependent Benefit Expansion	100 Percent	2,988	\$114,539	\$1,592,741
RCSM	Best	2,687	\$103,019	\$1,432,548
TRICARE Prime/Prime Remote	100 Percent	3,343	\$128,149	\$1,782,000

Table 27. Expected Cost Per Newly Ready RCSM

*Note*: The cost per newly ready RCSM is the expected cost increase divided by 26,087 (NMR = 5%) or 1,876 (NRM = active-duty parity).

These estimates suggest the marginal cost of expanding health and dental benefits would likely exceed the marginal benefit. To further consider whether benefit expansions can improve NMR rates, we use individual-level data from the PHA to examine whether having health insurance affects medical readiness.

#### 4. PHA Analysis: Does Health Insurance Status Impact Readiness

IDA received an extract of 2022 individual-level PHA data covering AC and RC service members from the DHA. Individual-level data allow us to investigate IMR status by demographic characteristics and insurance status. It also allows us to take a more detailed look at what type of DLMCs the NMR population has and whether service members are seeking treatment. Appendix G provides detail on our PHA sample. We also compare TFMR rates produced using the PHA data to the aggregate quarterly IMR data. Generally, TFMR rates from the different data sources are very close. We note that in the case of the Army Reserve, the PHA-based TFMR is 7 percentage points higher than the TFMR rate from the aggregate data.

Using data from the PHA, we constructed NMR rates for the full sample of RCSMs and by insurance status (whether RCSMs had or didn't have insurance). The results are shown in Table 28 and indicate little difference in readiness by insurance status. The results showed a 94 percent TFMR for the subsample of RCSMs with insurance versus a 93 percent for those without. Based on these data, we conclude that insurance status does not appear to have a meaningful impact on medical readiness.

	Full Sample	With Insurance	Without Insurance
Guard	92%	92%	90%
Reserve	97%	97%	98%
Overall	94%	94%	93%

Table 28. PHA-Based TFMR rates by Insurance Status, 2022

*Note*: The sample is all Guard and Reserve members who answered the insurance status question. A t-test indicates the means are statically different.

Next, we focused specifically on the sample of RCSMs who report having DLMCs, including some who are classified as ready, and some classified as not ready. Some 26 different DLMC categories are listed on the PHA, with prevalence rates ranging from .1 percent (congestive heart failure) to 20 percent (chronic muscle, joint, or lower back pain).

Table 29 reports the prevalence rate and treatment rate (e.g., is the individual currently under treatment or follow-up) for each condition, by insurance status. The sample is all RCSMs who answered the question. The prevalence rate is slightly higher for the insured sample, suggesting a potential selection effect—those who know they need medical care are more likely to buy insurance. The treatment rate is also higher, on average, for those with insurance. For instance, the overall treatment rate is 33 percent for those with insurance, and 20 percent for those without—suggesting that ensuring RCSMs have access to medical care increases the likelihood they will seek medical treatment.

Table 30 reports the same data as Table 29, but we restrict the sample to only RCSMs who are currently categorized as NMR. For the restricted sample, treatment rates are higher on average for both RCSMs with and without insurance. The pattern of insured RCSMs receiving treatment at higher rates also holds (45 percent versus 30 percent).

Overall, RCSMs who report having health insurance do not appear to have higher medical readiness rates than do RCSMs who report being uninsured. However, RCSMs with DLMCs are more likely to report seeking medical treatment if they have insurance.

Sample	Has Insurance		No In	surance	Treatment
Condition	Prev Rate %	Treatment Rate%	Prev Rate %	Treatment Rate%	Rate Ratio (Insurance/ No Insurance)
Asthma	2	52	1	36	1.2
Blood Problems	0	53	0	32	1.3
Cancer	1	39	0	28	1.2
Chest Pain/Angina	3	22	2	13	1.6
Congestive Heart Failure	<1	56	<1	38	1.3
High Cholesterol	4	64	1	51	1.2
Diabetes	1	74	0	60	1.1
Dizziness, Fainting, Consciousness Loss	3	25	3	14	1.6
Chronic Headache or Migraine	8	34	6	22	1.4
Hearing Loss Affecting Duty	3	17	3	10	1.6
Cardiac Dysrhythmia or Arrhythmia	1	28	1	17	1.6
Hypertension	6	63	3	41	1.4
Immune System Dysfunction	<1	75	<1	57	1.3
Kidney Dysfunction	1	30	1	23	1.2
Liver Disease	0	55	0	39	1.5
Pulmonary Dysfunction	1	32	1	24	1.2
Chronic Muscle, Joint, or Lower Back Pain	21	35	15	22	1.4
Neurological Problems	1	62	0	43	1.2
Tinnitus or Hearing Problems	17	11	11	8	1.4
Dermatologic Condition	3	39	2	27	1.3
Gastrointestinal Problems	5	45	3	30	1.3
Tuberculosis	<1	7	<1	9	1.1
Traumatic Brain Injury	2	24	1	18	1.1
Tooth or Gum Disease	3	33	4	17	1.7
Vision Loss Affecting Duty	6	25	5	14	1.5
Wheezing or Shortness of Breath	3	27	3	17	1.5
Overall	4	33	3	20	1.4

#### Table 29. DLMC Prevalence and Treatment Rates for All RCSMs by Insurance Status, 2022

*Note*: The DLMC question reads: "Since your last PHA, have you experienced any of the following health conditions, and if so what is your status? 1 = No, 2 = Yes, but did not get medical care; 3 = Yes, got medical care, but NO LONGER under treatment/follow-up; and 4 = Yes, and NOW under treatment/follow-up." We calculate the prevalence rate as the rate of people who selected 2, 3, or 4. The treatment rate is calculated as the rate of individuals who selected 4 (currently under treatment/follow-up).

Sample	Has	Has Insurance		Insurance	Troatmont	
Condition	Prev Rate %	Treatment Rate%	Prev Rate %	Treatment Rate%	Rate Ratio (Insurance/ No Insurance)	
Asthma	4	60	3	48	1.2	
Blood Problems	1	71	1	35	2.0	
Cancer	2	60	1	30	2.0	
Chest Pain/Angina	6	36	5	19	1.9	
Congestive Heart Failure	<1	69	<1	38	1.8	
High Cholesterol	6	66	3	63	1.0	
Diabetes	2	81	1	67	1.2	
Dizziness, Fainting, Consciousness Loss	8	39	6	22	1.8	
Chronic Headache or Migraine	18	46	12	31	1.5	
Hearing Loss Affecting Duty	7	25	5	18	1.4	
Cardiac Dysrhythmia or Arrhythmia	4	44	3	24	1.8	
Hypertension	10	63	6	46	1.4	
Immune System Dysfunction	1	86	1	74	1.2	
Kidney Dysfunction	2	37	1	31	1.2	
Liver Disease	1	65	<1	44	1.5	
Pulmonary Dysfunction	3	47	2	37	1.3	
Chronic Muscle, Joint, or Lower Back Pain	36	56	23	36	1.5	
Neurological Problems	2	76	1	52	1.5	
Tinnitus or Hearing Problems	25	19	16	14	1.4	
Dermatologic Condition	5	48	3	37	1.3	
Gastrointestinal Problems	11	54	7	36	1.5	
Tuberculosis	<1	7	<1	33	0.2	
Traumatic Brain Injury	4	39	3	29	1.4	
Tooth or Gum Disease	6	38	7	18	2.1	
Vision Loss Affecting Duty	10	33	8	21	1.6	
Wheezing or Shortness of Breath	8	39	6	27	1.4	
Overall	7	45	5	30	1.5	

#### Table 30. DLMC Prevalence and Treatment Rates for NMR RCSMs by Insurance Status

*Note*: The DLMC Question reads "Since your last PHA, have you experienced any of the following health conditions, and if so what is your status? 1 = No, 2 = Yes, but did not get medical care; 3 = Yes, got medical care, but NO LONGER under treatment/follow-up; and 4 =Yes, and NOW under treatment/follow-up." We calculate the prevalence rate as the rate of people who selected 2, 3, or 4. The treatment rate is calculated as the rate of individuals who selected 4 (currently under treatment/follow-up).

# 5. Can Health and Dental Benefit Expansions Address Partial Medical Readiness?

The number of RCSMs who are considered only partially medically ready has grown considerably in recent years. Table 31 reported an overall RC PMR rate of 47 percent—nearly twice the PMR target of 25 percent. In fact, there are currently more RCSMs counted as partially medically ready than fully medically ready. To consider the marginal benefit of improving partial medical readiness, we first calculate how many partially medically ready RCSMs would need to become fully medically ready to hit the RC target rate of 25 percent and the AC target rate of 15 percent.

	PMR	Rate	Change Required (PMR = 25%)	Change Required (PMR = 15%)
Army Guard	135,116	55%	73,153	97,938
Army Reserve	99,274	69%	63,240	77,654
Navy Reserve	13,182	30%	2,176	6,579
Marine Corps Reserve	15,076	50%	7,468	10,511
Air Guard	15,684	17%	0	2,036
Air Force Reserve	5,917	12%	0	0
Coast Guard Reserve	2,859	47%	1,328	1,940
Total	287,108	47%	147,364	196,657

#### Table 31. Required Changes in RCSM PMR Rates to Meet PMR Targets

Source: All Quarterly IMR data were provided by DHA. Data in table are for Q4 of CY2023.

The calculations indicate roughly 150,000 RCSMs need to change from PMR to FMR status in order to hit the RC target of 25 percent. Nearly 200,000 would need to change to hit the AC target of 15 percent. These gains are significantly higher than the gains required to improve NMR rates, meaning that benefit expansion could have a higher potential benefit in the case of PMR. Table 32 shows the marginal cost of reducing PMR rates to the targets discussed above. These costs are significantly lower than the marginal costs associated with improving NMR rates. However, this statistic will only be true if TRICARE health and dental benefits can be used to address the factors that keep RCSMs in a partially ready status.

Scenario	Take-up Assumption	Expected Cost Increase (in \$Millions)	Cost per Fully Ready RCSM (PMR = 25%)	Cost per Fully Ready RCSM (PMR = 15%)
RCSM-only	Best	\$1,019	\$6,912	\$5,179
Benefit Expansion	100 Percent	\$2,270	\$15,401	\$11,541
RCSM-and-	Best	\$1,711	\$11,610	\$8,700
Dependent Benefit Expansion	100 Percent	\$2,988	\$20,276	\$15,194
RCSM	Best	\$2,687	\$18,237	\$13,666
TRICARE Prime/Prime Remote	100 Percent	\$3,343	\$22,686	\$16,999

 Table 32. Expected Cost of Reducing Partially Medically Ready Population per RCSM

*Note*: The cost per fully ready RCSM is the expected cost increase divided by 147,364 (PMR = 25%) or 196,657 (PMR = 15 %).

Individuals who are classified as partially medically ready need one or more of the five following things to move into the fully medically ready category: (1) PHA exams, (2) dental exams, (3) immunizations, (4) medical labs, or (5) medical equipment check. Below we indicate whether TRICARE health and dental benefits could address these items.

- PHA Exam (DoD Form 3024): According to DoD policy, the medical record review portion of the PHA must be completed by "health care personnel trained on the PHA Record Review Process."<sup>40</sup> Under the status quo, it is our understanding that PHA record review is executed only by DoD providers and the RHRP. It is IDA's understanding that TRICARE network providers do not conduct PHAs. If so, expanding healthcare benefits will not address this need.
- **Dental Exam:** TDP network providers and other civilian dentists may complete the dental exams (DD Form 2813) for RCSMs. Expanding dental benefits could address this need.
- Immunizations: TRS network providers and other civilian providers may provide RCSMs with required immunizations (and immunization records). Expanding health benefits could address this need.
- **Medical Labs:** TRS network providers and other civilian providers may provide RCSMs with certain required medical labs. Expanding health benefits could address this need.

<sup>&</sup>lt;sup>40</sup> DHA Procedural Instruction 6200.06, https://www.health.mil/Reference-Center/DHA-Publications/2017/05/09/DHA-PI-6200-06; and DoDI 6200.06, https://www.esd.whs.mil/Portals/54/Documents/DD/issuances/dodi/620006p.pdf.

• **Medical Equipment:** The issuance of medical equipment is a DoD-specific function based on Service-specific policy. Expanding health and/or dental benefits will not address this need.

Table 33 reports how many RCSMs need each item. The top panel of the table indicates the total number of RCSMs who need each item. The middle panel indicates the number of RCSMs who need each item in order for the component to hit its target PMR rate of 25 percent. Likewise, the bottom panel indicates the number of RCSMs who need each item to hit the AC PMR target of 15 percent.

The data indicate medical immunizations are the item required by the greatest number of RCSMs. Specifically, over 250,000 RCSMs required immunizations. If just over 120,000 of these RCSMs received their required immunizations, the RC would meet its PRM target of 25 percent or less for this category.

Count of F	RCSMs that	Need Each S	ervice		
	РНА	Dental Exam	Immunization	Medical Lab	Medical Equipment
ARNG	14,569	14,279	124,560	36,491	23,164
USAR	35,603	34,903	91,950	39,746	19,294
USNR	4,257	4,176	11,336	4,361	2,072
USMCR	4,627	4,594	12,200	4,457	10,276
ANG	4,711	5,084	10,801	2,471	69,309
USAFR	2,246	2,190	4,198	1,154	36,770
USCGR	350	1,016	1,268	888	1,084
Total	66,363	66,242	256,313	89,568	161,969
	Count of R	CSMs that N	eed Each Service	to Reach .25 PF	RM Target
		Dental			
	PHA	Exam	Immunization	Medical Lab	Medical Equipment
ARNG	-	-	62,597	-	-
USAR	-	-	55,916	3,712	-
USNR	-	-	330	-	-
USMCR	-	-	4,592	-	2,668
ANG	-	-	-	-	46,562
USAFR	-	-	-	-	24,482
USCGR	-	-	-	-	-
Total	-	-	123,434	3,712	73,712
	Counts of F	RCSMs that N	leed Each Service	to Reach .15 P	MR Target
	PHA	Dental Exam	Immunization	Medical Lab	Medical Equipment
ARNG	-	-	87,382	-	-
USAR	13,983	13,283	70,330	18,126	_
USNR	-	-	4,733	-	-
USMCR	62	29	7,635	-	5,711
ANG	-	-	-	-	55,661
USAFR	-	-	-	-	29,397
USCGR	-	97	349	-	165
Total	14,045	13,409	170,428	18,126	90,935

Table 33. Count of IMR Services Required by RCSMs, FY 2023 Q4

If expanding the TRS to all RCSMs could guarantee higher completion rates of immunizations and other applicable IMR services, the marginal cost of addressing these IMR shortfalls through this channel could be calculated by dividing the expected increase in cost over the expected gain in fully ready RCSMs. If, for example, 123,434 RCSMs

completed their immunizations and moved into the FMR category, the expected marginal costs of these gains would be between \$8,000 to \$27,000 dollars per newly FMR RCSM, shown in Table 34. These marginal costs are lower than the marginal costs associated with using health and dental benefits to improve NMR rates, but they are not necessarily cost effective. For example, the RHRP provides immunizations for an average unit cost of \$55.<sup>41</sup> We discuss the RHRP in more detail in Chapter 8.B.

Table 54. Expected Cost per Newly FMR RCSM (Initialization Example)					
Scenario	Take-up Assumption	Expected Cost Increase (in \$Millions)	Cost per Newly FMR RCSM		
RCSM-only Benefit	Best	\$1,019	\$8,252		
Expansion	100 Percent	\$2,270	\$18,387		
RCSM-and-	Best	\$1,711	\$13,861		
Dependent Benefit Expansion	100 Percent	\$2,988	\$24,207		
RCSM TRICARE	Best	\$2,687	\$21,772		
Prime/Prime Remote	100 Percent	\$3,343	\$27,084		

Table 34. Expected Cost per Newly FMR RCSM (Immunization Example)

*Note*: We divide the total expected cost increase by 123,434 to obtain the marginal cost per newly FMR RCSM.

#### 6. Other Measures of Medical Readiness and Deployability

The previous analysis relied on the IMR metric to assess RCSM medical readiness, medical readiness trends, and to consider the potential impact of benefit expansion on medical readiness. We chose to focus the analysis on IMR because it is the primary determinant of medical readiness and it is reported for all Services and components using a standardized process. In addition, the PHA allowed us to examine IMR metrics by insurance status. However, we note that being classified as IMR is not a sure guarantee that a RCSM will be deemed medically fit for deployment to a specific COCOM.

There are instances where an RCSM, deemed medical ready based on IMR, will be found to be non-medically ready when mobilized. This could occur under various circumstances. For example, the RCSM could report a new injury, diagnosis, or medication requirement that affects their deployability. This could become a more likely occurrence under the new IMR methodology which counts the medically indeterminant population (those with overdue medical/dental exams) among the partially ready. In addition, there could also be Service-specific or COCOM-specific medical readiness requirements that are

<sup>&</sup>lt;sup>41</sup> Calculated from RHRP quantity and cost data taken from briefing titled "Reserve Health Readiness Program (RHRP) Background and Contract Update."

more stringent than the minimum medical standards established across DoD in DoDI 6490.07 that preclude certain RCSMs from deploying on a mission with certain operating environments.

Ideally, we would like to examine the rates at which RCSMs deemed medically ready (by IMR) are disqualified from deploying due to medical reasons when mobilized— "medical deployment fallout rates." We would further like to know if these rates vary by insurance status. However, we were unable to obtain comprehensive data on deployment fallout rates for medical reasons. In addition, our data on RCSM insurance status came from the PHA only provided RCSM IMR status variables. We were therefore unable to estimate the prevalence of medically-based deployment fallouts or whether or not medical/dental benefit expansion could impact this issue.

## B. Potential Savings in the Reserve Health Readiness Program

The RHRP provides IMR medical and dental services as well as other deployment health-related services though a large multiyear support contract; it was created to provide these services to Reserve and active-duty service members in remote locations with little access to MTFs. DHA's Deployment Health Branch currently manages the RHRP, which has grown in size and scope over the last decade. Today it supports the six DoD RCs as well as several other user groups, including active-duty enrolled in TRICARE Prime Remote, the USCG, and DoD civilians who are redeploying.

The RHRP's funding comes primarily from Service components, with only a small part of the program funded directly through the Defense Health Program to support mental health assessments, post-deployment health reassessments, and separation history and physical examinations. Numerous medical and dental services are provided to users of the RHRP; its program office provided IDA with a list of over 700 different services that can be aggregated into four different categories, which are summarized in Table 35.<sup>42</sup>

<sup>&</sup>lt;sup>42</sup> IDA Document D-21567.

Category	Subcategory			
IMR Services: Services required to	• PHAs			
determine an RCSM's IMR status.	Immunizations			
conditions affecting IMR are not	Laboratory Services			
considered IMR services.	Dental Assessment			
<b>Deployment Services:</b> Additional pre- and post-deployment-related services	<ul> <li>Mental Health Exam (MHA); DD Form 2978</li> </ul>			
See DoDI 6490.03 (Deployment Health) and DoDI 6490.12 DoD (Mental Health Assessments) for more details.	<ul> <li>Pre-deployment health assessment (Pre-DHA); DD Form 2795</li> </ul>			
	<ul> <li>Post-deployment health reassessment (PDHRA); DD Form 2900</li> </ul>			
	Audio services			
	Vision services			
Other Medical/Dental Services: Other	BH Specialist			
medical/dental services include Behavioral Health (BH) screenings	Dental treatment services			
dental treatments (e.g., extractions,	Miscellaneous medical services			
fillings, crowns, etc.), and other miscellaneous medical services (e.g., breast exams, chest x-rays, EKGs, etc.)	Physical exam			
	Record review- Maintenance/Miscellaneous			
Invoices for Service Cancellations	Admin Fees-Cancel			
and No-Shows	Admin Fees-No Show			

## Table 35. RHRP Services by Category

Source: IDA Document D-21567.

Table 36 provides RHRP summary costs and service counts for FY 2022 along the broad categories described above. Approximately 51 percent of the total costs associated with the RHRP are attributed to IMR services associated with the screening and documentation requirements in DoDI 6025.19. Overall, just over \$150 million was spent on services for RCSMs in FY 2022.

Services	Total Cost (in \$Millions)	Percent of RHRP Total	Average Cost Per Service
IMR:			
PHA	30	20%	\$76
Immunizations	8	5%	\$55
Lab	11	7%	\$29
Dental Assessments	30	19%	\$62
Deployment Services:			
MHA	3	2%	\$25
Audio	13	8%	\$25
Vision	6	4%	\$33
Other Medical/Dental Service:			
Dental Treatments	22	14%	\$412
Misc. Medical Services	<1	<1%	\$19
Physical Examination	1	1%	\$253
Record Review / Maintenance	1	1%	\$5
Overhead:		0%	
Travel/Shipping Costs	20	13%	-
No Show/Cancellation Fees	5	4%	-
Total	152		

Table 36. RHRP Costs, FY 2022

*Source*: MHS Administrative data provided by the RHRP's program office. We exclude the services provided to non-RCSM participants (i.e., AC service members, DoD civilians) and those that are DHP funded.

Section 707 of the FY 2023 NDAA specifically called for an assessment of whether the proposed expansions to RCSM health and dental benefits could lead to cost savings in the RHRP. This is a logical question given RHRP provides medical and dental services that could potentially be covered by insurance and performed by TRICARE network providers. To consider this question, we examined the cost and quantity of the different services provided by RHRP to RCSMs and assessed whether they could be provided through TRICARE network medical and dental providers. We also interviewed SMEs from the RHRP's program office on this topic.

As previously mentioned, many of the services provided through RHRP are militaryspecific screenings used to ensure service members do not have medical conditions that would preclude them from mobilization. Under the status quo, it is our understanding that such exams must be conducted by DoD providers or RHRP contractors who have been trained on these screening processes. However, SMEs have suggested that TRICARE network providers, could deliver many of the IMR-related services required in DoDI 6025.19. In this scenario under expanded TRS and TDP coverage, these healthcare providers could deliver many of the same services thereby reducing demand for the RHRP's services (and greatly reducing it in scope). Below we highlight some of the potential saving opportunities as well as potential barriers.

Dental may provide the greatest savings potential. If RCSMs received uniform dental coverage, the RHRP spending for dental assessments and treatment services of approximately \$52 million (or one third of the program total) could, in theory, be greatly reduced. However, there is some nuance here that must be recognized. Under TDP, services classified as treatments require cost sharing (generally 30 to 50 percent depending on the service). If the average treatment cost is similar to that shown for the RHRP (\$412), the member would need to pay over \$100 for care. This could lead some to postpone or forgo accessing dental care through TDP. Under the RHRP, treatment is free to RCSMs, so many may prefer this option if it remained available. Exams and routine cleanings for RCSMs would be covered, so they could receive these services free of charge. However, they would need to find a provider, obtain the exam, have the civilian dentist fill out the documentation, and make sure the paperwork gets back to the unit. These steps are all feasible but can present challenges. RHRP has streamlined the process to reduce administrative burden.

For medical coverage, TRICARE network providers could provide PHA and MHA examinations, immunizations, medical labs, and perhaps certain audio and vision screenings. The RHRP's spending on these items of roughly \$70 million annually could then be greatly reduced. However, we note that asking civilian network providers to assume responsibility for the type of proper screening and documentation necessary to consistently comply with DoD reporting requirements would be extremely challenging. Civilian TRICARE providers may have little experience completing the types of military specific forms required to record service member readiness. Part of this risk could be mitigated by making IMR documentation training a required element of becoming a participating TRICARE network provider. Additionally, improved reporting tools could be developed that contain complete (direct and purchased care) visibility of service member medical histories to be used in unit screening activities. Asking civilian providers to assume all services currently provided through the RHRP may be unrealistic at the moment, but if TRS and the TDP were to be broadly expanded to the ready reserve, re-visiting this subject would be appropriate given how many of those same services would become part of their new DoD benefit package.

Lastly, we note that while there does appear to be potential for some savings in the RHRP, the cost-effectiveness of the RHRP versus expanded TRICARE benefits should also be considered. The RHRP is a cost-effective program because it is tactically focused on readiness, providing the IMR and other deployment-specific services an RCSM needs to deploy (but nothing else). Health and dental benefits, on the other hand, are comprehensive in nature and cover not only the member but also dependents, resulting in significant cost differences.

In FY 2022, the RHRP spent roughly \$150 million on RCSM services. Conversely, the TRICARE program spent over \$1.5 billion on health and dental benefits for RCSMs enrolled in TRS and TDP.<sup>43</sup> Under the proposed expansion scenarios, an increase in spending of between \$1 billion to over \$3 billion is expected, depending on the scenario.

### C. Recruitment and Retention

Expanding health and dental benefits available to RCSMs represents a potentially sizable increase in compensation for RCSMs. We therefore expect a benefit expansion to have a positive impact on recruitment and retention. To examine the potential magnitude of this impact, we leverage the extensive literature examining how military enlistment and retention respond to changes in measures of military compensation, cash incentives such as enlistment and reenlistment bonuses, benefits such as retirement and education, and recruiting resources (number of recruiters and advertising spending).<sup>44</sup> We focus specifically on the literature that has developed quantitative estimates (or elasticities), which describe how increasing a given factor—say, military pay increases—affects recruitment or retention.<sup>45</sup> We use this literature to develop estimates of how the proposed benefit expansions could affect recruitment and retention, and the marginal cost of these gains relative to other tools (i.e., spending more on advertising or using cash bonuses).

Box 3 describes how we use elasticities to make these calculations, and our selected elasticity values.<sup>46</sup> For simplicity, we focus the analysis on the Army National Guard, the largest of the seven Reserve components. We caution that the following analysis is meant only to provide the reader with a sense of the plausible order of magnitude we might expect to see under different policy scenarios.

<sup>&</sup>lt;sup>43</sup> This figure includes RCSMs and dependents enrolled in the premium-based programs. It does not include spending on activated or transitioning RCSMs.

<sup>&</sup>lt;sup>44</sup> We relied on several excellent literature surveys in our research: Asch (2019), "Navigating Current and Emerging Army Recruiting Challenges;" Warner (2012), "The Effect of the Civilian Economy on Recruiting and Retention;" and Goldberg (2001). However, much of the literature focused on the AC. One recent paper, Ovris et al., Al (2022) focused on the Army Reserve. We therefore select many of our elasticity parameters from this work.

<sup>&</sup>lt;sup>45</sup> A CBO Analysis, "Recruiting, Retention, and Future Levels of Military Personnel," also provides a fairly comprehensive range of literature elasticity estimates and how to use them to estimate the impact of different policies on outcomes (i.e., increase in enlistments) and their marginal costs.

<sup>&</sup>lt;sup>46</sup> This methodology is adopted from a 2006 CBO Analysis, "Recruiting, Retention, and Future Levels of Military Personnel."

## Box 3. Using Elasticities to Estimate Changes in Recruitment and Retention and the Marginal Costs of the Change

To calculate the impact of changing an element of compensation (i.e., pay, cash bonuses, benefits, and recruiting resources) on our outcome variables of interest (enlistments or retention), we multiply the elasticity for that compensation element by its percentage change and the base value of our outcome variable of interest. For example, if we believe the cash bonus elasticity for enlistment is .04 and we want to consider a policy that would increase bonuses by 10 percent across the board. If we have an enlistment baseline of 40,000 enlistments, then the expected increase would be  $.04^*.1^*40,000 = 160$  new enlistments.

Using this example, the marginal cost of the enlistment increase could be calculated by dividing the change in cost by the change in enlistments. If the ARNG had spent roughly \$140 million on enlistment bonuses, then a 10 percent enlistment increase would have cost \$14 million and the marginal cost would equal (\$14M/160) = \$87,500 per new enlistment. Table 37 shows the elasticities we have selected to use for each our compensation elements.

	Elasticity	Source		
Enlistment Elasticities:				
Pay Elasticity	0.49	Orvis et al., Al (2022)*		
Bonus Elasticity	0.04			
Advertising Elasticity	0.03			
Recruiter Elasticity	0.42			
Retention Elasticities:				
Pay Elasticity	1	Goldberg (2001)*		
<ul> <li>We selected parameter values from Orvis et al., AI (2022) because it was one of the only studies specifically focused on a reserve component (these values are also consistent with the larger literature based on the AC). Goldberg (2001) provided a survey of retention elasticities. We selected a pay elasticity of 1, which falls in the middle of the range of studies that use military compensation as the pay measure.</li> </ul>				

#### Table 37. Elasticities for the Recruiting and Retention Analysis

One challenge we faced in this analysis was the absence of direct elasticity estimates of how changes in TRICARE benefits (a form of non-cash compensation) affect recruitment and retention.<sup>47</sup> Therefore, we treat expanded health and dental benefits as a form of compensation (for which we do have elasticities).

To estimate the cash value of these benefits, we use the calculated expected average savings they offer to RCSMs enrolled in civilian benefit plans or the current TRS and TDP programs. These estimates were presented in Chapter 6.B. Savings calculations are performed at various levels: the plan type (single versus family), rank group, and enrollment status. For ease of presentation, we present weighted average savings estimates by plan type only for each policy scenario. Table 38 contains the results. The first column shows the estimated average annual savings (or the increase in compensation). These values are a weighted average of estimated savings available to those switching from civilian insurance and the savings available to those already enrolled in TRS. The second column reports the estimated percentage increase in compensation if the RCSMS fully values savings on medical and dental care.<sup>48</sup> For single RCSMs, the estimated savings represent a 14 to 15 percent increase in compensation, on average. For RCSMs with families, the savings represent a 24 to 44 percent increase in compensation, depending on the scenario. The next three columns of the table consider that RCSMs may not value \$1 in potential healthcare savings as much as they would value \$1 in cash compensation. We believe this to be the case for several reasons. First, for RCSMs to value the savings they receive when switching from an employer's plan to TRS as much as they value cash, they would need to view their civilian coverage and TRS coverage as perfect substitutes (i.e., no quality difference). If they perceive the TRS benefit to be lower in quality in certain aspects (such as provider network access), the value of savings is reduced. Given that many RCSMs choose to remain on employer-sponsored plans, this perception is likely a factor. In addition, young, healthy individuals who use little healthcare may place little value on the benefit. Data show that over 15 percent of junior enlisted service members choose to go uninsured even when a health benefit is available for just under \$50 per month. Lastly, the expected savings offer no value if RCSMs do not use the benefit. Taking these factors into consideration, we estimated the expected savings each policy reform could generate for RCSMs, and the corresponding percent increase in compensation if the member values these benefits at only 75 percent, 50 percent, or 25 percent of the expected savings.

<sup>&</sup>lt;sup>47</sup> While the literature acknowledges the importance of health benefits for recruiting and retaining employees, we were unable to find any direct elasticity estimates.

<sup>&</sup>lt;sup>48</sup> The base compensation level used in the analysis is the DoD cash compensation (basic pay, continuation pay, allowances, and special/incentive pays) and benefits (retirement, healthcare, tax exemptions, and allowances for cost of living adjustments, travel, and clothing).

		Percent Change in Compensation When Benefit Valuation Is:			
	Compensation Increase (Estimated Savings)	100%	75%	50%	25%
Single RCSMs					
Premium-free (RCSM Only)	\$2,538	14%	10%	7%	3%
RCSM TRICARE Prime/Prime Remote	\$2,756	15%	11%	8%	4%
RCSMs with Families					
Premium-free TRS (RCSM Only)	\$4,431	24%	18%	12%	6%
Premium-free TRS (RCSM and Dependents)	\$7,322	40%	30%	20%	10%
RCSM TRICARE Prime/Prime Remote	\$7,901	44%	33%	22%	11%

Table 38. Expected Increase in Compensation at Different Valuations

*Note*: The average base compensation value is \$18,148; this is cash compensation plus benefits for nonactive Army National Guard in FY 2022.

Lastly, before presenting our estimates on the magnitude of potential gains in recruiting and retention, we consider current accession and retention numbers for the ARNG. This consideration helps to understand if the ARNG currently has a recruiting or retention challenge, the magnitude of shortfalls, and whether the potential gains in recruiting/retention align with the shortfalls. Table 39 presents budget data on ARNG accession and reenlistments, including goals, actuals, and differences. Over the last several years, the ARNG has missed its recruiting goals by 2 to 6 percent (the miss was greatest in 2022). In 2023, the ARNG was short by just of over 1,500 accessions, or 5 percent. The ARNG has also fallen short on reenlistment targets for three of the last four years. In 2023, the shortfall was roughly 1,000 reenlistments, or 3 percent.

		-	· · J				
		FY2020	FY2021	FY2022	FY2023	FY2024	FY2025
	Goal	47,726	47,726	40,068	30,880	34,140	38,794
Accessions	Actual	46,818	46,492	37,772	29,310		
	Difference	-908	-1,234	-2,296	-1,570		
	Goal	37,551	37,551	32,225	37,497	39,589	33,557
Reenlistments	Actual	36,673	34,658	32,621	36,402		
	Difference	-878	-2,893	396	-1,095		

Table 39. Army National Guard Accession and Reenlistment Goals and Actuals,FY 2022 through 2025

Source:

https://www.asafm.army.mil/Portals/72/Documents/BudgetMaterial/2025/Base%20Budget/Military%20Per sonnel/National%20Guard%20Personnel%20Army-Volume%201.pdf

Note: These data are taken from Army National Guard military personnel budget data.

#### 1. Recruiting Analysis

To estimate the potential increase in ARNG enlistments in response to the compensation increase created by the proposed benefit expansions, we assume a pay elasticity of .49 and a baseline accession target of 34,140.<sup>49</sup> Table 40 shows the estimated increase in enlistments for each expansion policy if the health benefits are valued at 100 percent or 25 percent. The marginal cost is equal to our best estimate of total cost increase for the ARNG, divided by the number of new enlistments.<sup>50</sup>

<sup>&</sup>lt;sup>49</sup> The FY 2024 Accession target is 30,140. https://www.asafm.army.mil/Portals/72/Documents/BudgetMaterial/2024/Base%20Budget/Military%2 0Personnel/NGPA Vol 1 FY 2024 PB(Revised).pdf.

<sup>&</sup>lt;sup>50</sup> We allocate the total cost increase across services based on estimated covered lives. The ARNG-specific total cost estimates are \$307 million for the premium-free TRS RCSM-only option, \$531 million for the premium-free TRS for RCSMs and dependents, and \$1.1 billion for RCSM TRICARE Prime/Prime Remote.

	Benefit Valuation	Increase in Enlistments	Increase in Cost	Marginal Cost
Premium-free TRS	100 percent	3,627	¢207M	\$110K
(Member Only)	25 percent	907	\$397 W	\$483K
Premium-free TRS	100 percent	4,430		\$151K
(Member and Dependents)	25 percent	1,108	\$667M	\$602K
RCSM TRICARE Prime/Prime Remote	100 percent	4,756	¢1 049M	\$220K
	25 percent	1,189	φ1,040IVI	\$882K

Table 40. Estimated Impact of Medical and Dental Expansions on ARNG Recruiting

*Note*: For each policy, we used the ARNG share of our best estimate for the total cost increase. The ARNG share is calculated by allocating the total costs across the different Reserve components by their estimated covered lives.

The analysis suggests the ARNG would see gains in recruiting under the benefitexpansion scenarios. If benefits are fully valued, the potential gains appear sizable—more than twice the current accession shortfalls. However, the size of the gains will be relatively small if RCSMs value health benefits significantly less than cash. The marginal cost of the new recruits is also high because the scenarios require providing the benefit to all RCSMs who opt in, not just the new recruits.

To consider the cost-effectiveness of expanding health benefits as a tool for improving recruitment, we compare these results to with results for increasing spending on other common tools—bonuses, advertising, and recruiters. Specifically, we consider the impact of increasing spending by 25 percent. Table 41 shows our estimates.

	231 610611						
	Current Spending	Increase in Enlistments	Cost Increase	Marginal Cost			
Enlistment Bonuses	\$140M	341	\$35M	\$103K			
Advertising	\$91M	256	\$23M	\$89K			
Recruiters	\$470M	3,825	\$118M	\$33K			

 Table 41. Estimated Impact of Increasing Bonuses, Advertising, or Recruiters by

 25 Percent

*Note*: The current spending level for enlistment bonuses and advertising are actual values from FY 2024 ARNG budget materials. Using data from DMDC on the number of recruiters (2,858) and the IDA Manpower Cost Tool, we estimated current spending on recruiters, assuming they are full-time support personnel and costing them accordingly. The estimated average full cost of recruiters is \$165K.

The analysis indicates increasing bonus spending, advertising spending, and recruiter spending by 25 percent would be significantly less costly than expanding health benefits. For instance, the expected cost increase of providing premium-free TRS (RCSM-only option) is \$397 million, while increasing bonuses spending by 25 percent would cost \$35

million. Furthermore, the marginal cost estimates indicate bonuses are more cost-effective policy tools. Increasing the number of recruiters appears to be the most cost-effective option. Based on current assumptions, increasing recruiters by less than 25 percent would be sufficient to cover current recruiting shortages.

#### 2. Retention

To estimate the potential increase in ARNG reenlistment in response to the compensation increase created by the proposed benefit expansions, we assume a reenlistment pay elasticity of 1, and a baseline reenlistment target of 32,000, shown in Table 42.<sup>51</sup>

	Benefit Valuation	Increase in Reenlistment	Increase in Cost	Marginal Cost
Premium-free (Member	100 percent	7,245		\$56K
Only)	25 percent	1,811	\$397	\$219K
Premium-free (Member and Dependents)	100 percent	10,071	¢667	\$66K
	25 percent	2,518	\$00 <i>1</i>	\$256K
RCSM TRICARE Prime/Prime Remote	100 percent	10,885	¢4.040	\$96K
	25 percent	2,721	<b>\$1,048</b>	\$385K

Table 42. Estimated Impact of Health and Dental Benefit Expansion on ARNG Retention

*Note*: For each policy, we use the ARNG share of our best estimate for the total cost increase. The ARNG share is calculated by allocating the total costs across the different Reserve components by their estimated covered lives.

The analysis suggests the ARNG would see gains in retention under the benefitexpansion scenarios. Based on the predicted gains, health and dental benefit expansion appears to affect retention more than recruitment, which makes sense given the benefits will provide more value to older RCSMs with a higher number of dependents. While the size of the gains will be relatively small if RCSMs value health benefits significantly less than cash, they are still fairly sizable. The marginal cost of the new reenlistments is lower than the marginal costs of new accessions given the more sizable estimated impact. We note the estimated impact in reenlistments is significantly higher than recent shortfalls, suggesting the benefit is likely more generous than required to meet retention goals. However, if retention becomes a more significant challenge in the future, benefit expansion could be a possible policy instrument.

<sup>&</sup>lt;sup>51</sup> The FY 2022 reenlistment goal was 32,225, while actual reenlistments were 23,621, https://www.asafm.army.mil/Portals/72/Documents/BudgetMaterial/2024/Base%20Budget/Military%2 0Personnel/NGPA\_Vol\_1\_FY\_2024\_PB(Revised).pdf.

## **D.** Other Benefits

#### 1. Reduced Healthcare Transitions

In Chapter 2, we tracked a cohort of RCSMs who joined the RC in 2002 over a 20year window. We found that the average RCSM spends roughly 20 percent of their career eligible for the active-duty TRICARE benefit and typically experiences about 3 healthcarebenefit transitions.

Providing a premium-free TRS benefit under the current system will not eliminate transitions. Service members and their dependents will still switch between the active-duty benefit (TRICARE Prime/Prime Remote) and TRS. The removal of premiums will not remove the requirement to enroll in TRS once active-duty benefits end, as TRS and TRICARE Prime are different benefits. DoD should work to ease these transitions for RCSMs regardless of whether a premium-free TRS benefit expansion occurs.

Providing RCSM TRICARE Prime/Prime Remote would eliminate transitions for all RCSMs who opt to use TRICARE, regardless of their activation status. RCSMs who elect to use civilian plans when they are in a non-active status would still face transitions.

#### 2. Medical Surveillance

Expanding TRICARE health and dental coverage for RSCMs offers another potential benefit: the additional visibility gained by having a more complete patient history available for review in support of readiness reporting. Currently, when an RCSM receives treatment for a medical or dental condition covered under their civilian employer medical/dental program, the service member could—either intentionally or unintentionally—fail to report important deployment-limiting conditions or chronic illnesses that would make them ineligible for deployment or military service. Unless the RCSM disclosed such information to the Reserve unit, they could continue to drill or participate in unit activities while suffering from medical, dental, or psychological conditions that would normally preclude military service. If all RCSMs were on the same TRS/TDP coverage, more complete patient histories could be made available for readiness reporting based on the RCSM's claims history in these programs. The MHS GENESIS system and broader adoption of health information exchanges may provide greater visibility of RCSM medical histories in the future, regardless of RCSM benefit expansion, as greater numbers of regional and nationwide exchanges come online supporting civilian health plans.

#### 3. Benefit to RCSM Civilian Employer

When an RCSM opts to use TRS rather than an employer-sponsored health plan, the employer saves a significant amount of money. In 2022, the average employer's share of a

family plan was \$16,357 (while the employee's share was \$6,106).<sup>52</sup> If employers know an RCSM will use the TRS benefit, hiring RCSMs becomes more attractive. All else equal, an RCSM employee will cost employers \$16,000 less than an employee who will take up the health plan they offer. Employers would therefore have a financial incentive to target members of the Reserve or National Guard in hiring decisions relative to other employees due to this savings in company health insurance costs. The incentive would be especially high for lower-earning positions, where benefit costs represent a larger share of the worker's total compensation. This financial benefit could help offset some of the disadvantages associated with hiring an RCSM (e.g., needing to plan for deployments and time the RCSM must spend away for training). It is possible that the RCSM may also further benefit from DoD health and dental benefits in salary negotiation. For instance, the RCSM could make the case that they will cost their employer \$16,000 less in health benefits and argue for a portion of the savings in compensation.

<sup>&</sup>lt;sup>52</sup> https://files.kff.org/attachment/Report-Employer-Health-Benefits-2022-Annual-Survey.pdf.

The analysis so far has assumed that the TRICARE network has the capacity to absorb new users. This is a critical assumption that must be validated to ensure that new users would have adequate access to care, and current users would not find their access worsened. In this chapter, we begin by reviewing studies and survey data on access to care in the TRICARE network. We then develop our empirical TRICARE Network Assessment Model that examines network capacity for select specialties, across the county. We conclude with several scenarios that test network accessibility when the number of TRICARE beneficiaries is increased based on the estimated increase in covered lives shown in Chapter 6.

## A. Review of Literature and Survey Data on Access to Care

A recent report by the House Armed Services Committee (HASC) called the "Quality of Life Panel Report" notes that timely access to care has been a long-standing challenge for TRICARE beneficiaries. The HASC report highlights a series of reports by the DoD Inspector General (DODIG) and the Government Accountability Office (GAO), released between 2018 and 2024, with findings such as:

- Certain MTFs routinely fail to meet access-to-care standards for both routine and urgent appointments.<sup>53</sup> This has been at least partially attributed to provider shortages.<sup>54</sup>
- Access challenges are most acute for specialty care—particularly for mental health care.<sup>55</sup>

<sup>&</sup>lt;sup>53</sup> Access to Care at Selected Military Treatment Facilities DODIG-2018-111, Department of Defense of Inspector General, May 1. 2018, https://www.dodig.mil/reports.html/Article/1514562/access-to-care-atselected-military-treatment-facilities-dodig-2018-111/.

 <sup>&</sup>lt;sup>54</sup> Alyssa M. Hundrup, "Defense Health Care: DOD Should Monitor Urgent Referrals to Civilian Behavioral Health Providers to Ensure Timely Care," Government Accountability Office, February 6. 2024.

<sup>&</sup>lt;sup>55</sup> Defense Health Care: DOD Should Monitor Urgent Referrals to Civilian Behavioral Health Providers to Ensure Timely Care, GAO-24-106267; "Evaluation of Access to Mental Health Care in the Department of Defense (DODIG-2020-112)," Department of Defense of Inspector General, August 10. 2020, https://www.dodig.mil/reports.html/Article/2309785/evaluation-of-access-to-mental-health-carein-the-department-of-defense-dodig-2/; and Kimberly A. Hepner, Carol P. Roth, Nabeel Qureshi, Jessica L. Sousa, "Improving Behavioral Health Care in the Military Health System: Challenges,

• Factors believed to be contributing to access challenges include nationwide shortages in medical providers, increased demand for mental health care, and low and delayed TRICARE reimbursement rates.<sup>56</sup>

To provide a better understanding of TRICARE beneficiary access to care challenges, we examined access-to-care survey data reported in the annual "Evaluation of TRICARE Program." The Joint Outpatient Experience Survey (JOES) and the Joint Outpatient Experience Survey-CAHPS (JOES-C) focus on beneficiaries' experience accessing outpatient care. We use the JOES-C, as it examines access for both MTFs and the TRICARE network.<sup>57</sup> Figure 12 provides JOES-C results for MTFs and the TRICARE network for "Getting Care When Needed." Getting Care When Needed is assessed in each survey as an agreement to the following statement: "In general, I am able to see my provider when needed." The five-point scale for this question ranges from "strongly disagree" to "strongly agree." The results provided above are for those beneficiaries report better access experience in the TRICARE network than they do in MTFs. Both trends show a decrease over time, though the network decrease is fairly small—a reduction of roughly 3 percentage points (from 88 percent to 85 percent).



Source: Evaluation of the TRICARE Program for FY 2023 and FY 2024.

Figure 12. JOES-C Getting Care When Needed, FY 2019–23

Promising Strategies, and Research Directions," Santa Monica, CA: RAND Corporation, 2023, https://www.rand.org/pubs/perspectives/PEA2038-1.html.

<sup>&</sup>lt;sup>56</sup> "Evaluation of Access to Mental Health Care in the Department of Defense."

<sup>&</sup>lt;sup>57</sup> The JOES-C is based on the Agency for Healthcare Research and Quality (AHRQ) CAHPS Clinician & Group Survey (CAHPS-CG). It can therefore be compared to the overall CHAPS civilian benchmark.
Figure 13 shows results for the JOES-C access-to-care composite, which is calculated based on multiple questions, including whether the patient was able to be seen for routine and urgent appointments and if the patient received an answer to a question within an appropriate time. The TRICARE network received better scores than the MTFs, but both showed a downward trend.



Figure 13. JOES-C Access-to-Care Composite, FY 2019–23

Overall, the JOES-C access-to-care data indicate access to care has declined over the last 5 years. Increasing the size of the beneficiary population, and thus demand for care, to a system with declining beneficiary access satisfaction could exacerbate access issues for existing users. Unfortunately, DoD's current ability to evaluate access to care is aggregate in nature; it is not specific to location and specialty. This aspect of the data makes it difficult to determine where problems are most acute. To address this challenge, in Section B we develop a model to study access at a more granular level.

Before turning to our model for evaluating access, we review a recent RAND study that examined access to healthcare specifically for the RCSM population. The RAND study found healthcare and access to healthcare in general to be key stressors for many Guard members. Senior leaders reported that few doctors accept TRICARE, and access is most limited for specialty care and mental health, particularly in remote areas. Leaders also acknowledged that extending coverage to everyone regardless of status would not solve RCSM access issues because of the limited availability of TRICARE providers. This issue will remain unless DoD pays providers higher rates.

#### **B. TRICARE Network Assessment Model**

The objective behind the TRICARE Network Assessment Model was to develop an empirical methodology using available data on TRICARE network supply and demand factors to evaluate access across geographies. Specifically, we wanted the ability to determine what degree of access (low, medium, or high) beneficiaries had in a particular market. With this capability, additional assessments on the likely impact of adding more RCSM beneficiaries to the TRICARE could then be performed. For instance, we could estimate what percentage of new users would be entering "low" access markets, where they might struggle to obtain care. We could also determine whether adding new beneficiaries might reduce access ratings of current users—from high to moderate or moderate to low, etc. We focused the initial model on family medicine, a key primary care specialty. Results for pediatrics are also included.

#### 1. Data and Methodology

The TRICARE Network Assessment Model uses a simple supply and demand framework for evaluating access. Because healthcare is both local and specialty-specific, all variables are constructed at the specialty (i) and ZIP Code (j) level. We adopted a gravity model framework that allows patients to travel outside of their home ZIP Code for care. For purposes of this analysis, all 50 States and the District of Columbia were included in the analysis; U.S. territories (e.g., Puerto Rico, U.S. Virgin Islands, Guam) were not included.

#### a. Supply Variables

Our primary variable for providers is the estimated number of TRICARE provider full-time equivalents (FTEs). This variable is constructed using administrative MHS TRICARE encounter data. For each specialty (i) and ZIP Code (j), we estimated the number of TRICARE FTEs by dividing total TRICARE encounters by a specialty-specific volume parameter ( $\hat{\delta}_i$ ), approximating one provider FTE ( $FTE_{ij} = \sum_{ij} ENC_{ij} / \hat{\delta}_i$ ). The specialty-specific FTE parameter is calibrated from the Medical Group Management Association (MGMA) Cost and Revenue dataset.<sup>58</sup>

We preferred the TRICARE provider FTE metric over simple counts of TRICARE providers because provider counts lack information about the volume of services these providers deliver (i.e., do they all treat TRICARE patients? If so, how many?). The IDA team heard many anecdotes about beneficiaries' not being able to see providers who

<sup>&</sup>lt;sup>58</sup> MGMA provides data on the number of encounters per physician FTE or per provider FTE (includes physician assistants and nurse practitioners) by specialty. We used 2,500 encounters as our provider FTE parameter. This is the median value of encounters per FTE (2,490), rounded to the nearest hundred.

supposedly were in the TRICARE network. Our methodology attempted to account for this issue. Table 43 illustrates the methodology by reporting the total TRICARE encounters for FY 2022 and our estimate of FTEs by MHS market. These data are specific to general practice and family practice providers; the data include physicians and advanced practitioners (i.e., nurse practitioners and physician assistants). We found that including advanced practitioners was important in rural markets that rely heavily on this type of provider.

Market	TRICARE Encounters	FTE Volume Parameter	Total FTEs
Alaska	48,812	2,500	19.5
Augusta	61,760	2,500	24.7
California Desert	1,243	2,500	0.5
Central Louisiana	16,565	2,500	6.6
Central North Carolina	270,254	2,500	108.1
Central Texas	185,548	2,500	74.2
Charleston	31,832	2,500	12.7
Coastal Mississippi	66,642	2,500	26.7
Coastal North Carolina	160,854	2,500	64.3
Colorado	224,602	2,500	89.8
DHAR- Indo Pacific	58,130	2,500	23.3
El Paso	73,046	2,500	29.2
Florida Panhandle	263,548	2,500	105.4
Jacksonville	293,162	2,500	117.3
Kansas	24,751	2,500	9.9
Las Vegas	81,239	2,500	32.5
Low Country	94,931	2,500	38
National Capital Region	483,560	2,500	193.4
Ozarks	21,225	2,500	8.5
Puget Sound	181,670	2,500	72.7
SSO	89,048	2,500	35.6
Sacramento	65,616	2,500	26.2
San Antonio	280,365	2,500	112.1
San Diego	303,160	2,500	121.3
Southwest Georgia	77,104	2,500	30.8
Southwestern Kentucky	104,504	2,500	41.8
Tidewater	554,085	2,500	221.6
West Point	27,000	2,500	10.8
White Space	9,971,588	2,500	3,988.6

Table 43. Supply Variables by Market, Family Medicine, 2022

*Note*: SSO = Small and standalone; White Space refers to other areas within the United States that are not made of up markets. These results are aggregated from ZIP Code-level data.

#### b. Demand Variables

Our primary variable for beneficiary demand is the estimated TRICARE beneficiary population that will seek care in the purchased-care network. To construct this variable, we

began with the total TRICARE beneficiary population  $(TB_{ij})$ .<sup>59</sup> However, in markets where direct-care infrastructure is present, we adjusted the population to account for care delivered in the MTFs. Our adjusted TRICARE beneficiary population  $(ATB_{ij})$  was constructed by multiplying the total TRICARE beneficiary population by a parameter  $(\gamma_{ij})$ representing the share of beneficiaries estimated to use the TRICARE network for specialty *i* in ZIP code *j*. The parameter  $(\gamma_{ij})$  is calibrated from beneficiary direct- and purchasedcare utilization data.

Table 44 presents TRICARE beneficiary counts and the adjusted beneficiary count based upon the purchased-care adjustment parameter, by MHS market.

<sup>&</sup>lt;sup>59</sup> The total beneficiary population includes active-duty service members, active-duty family members, all enrolled RCSMs and RCSM dependents and retirees, plus any other enrolled users. The population does not include the Reserve population that is eligible but not currently enrolled.

		•	
Market	TRICARE Beneficiaries	Purchased Care Adjustment Parameter	Adjusted TRICARE Beneficiaries
Alaska	72,058	0.431	31,074
Augusta	66,281	0.478	31,694
California Desert	10,075	0.193	1,940
Central Louisiana	23,452	0.363	8,516
Central North Carolina	197,165	0.525	103,557
Central Texas	181,470	0.532	96,547
Charleston	30,032	0.650	19,513
Coastal Mississippi	45,906	0.543	24,939
Coastal North Carolina	133,044	0.445	59,187
Colorado	168,897	0.593	100,197
DHAR- Indo Pacific	142,283	0.382	54,410
El Paso	114,724	0.334	38,335
Florida Panhandle	119,481	0.659	78,772
Jacksonville	145,449	0.732	106,489
Kansas	42,442	0.379	16,099
Las Vegas	83,390	0.638	53,163
Low Country	89,021	0.465	41,427
National Capital Region	446,155	0.501	223,365
Ozarks	32,915	0.365	12,005
Puget Sound	211,086	0.490	103,371
SSO	81,814	0.505	41,294
Sacramento	70,111	0.623	43,679
San Antonio	250,357	0.538	134,670
San Diego	361,506	0.549	198,544
Southwest Georgia	74,491	0.471	35,103
Southwestern Kentucky	104,671	0.463	48,427
Tidewater	436,329	0.540	235,812
West Point	32,648	0.606	19,795
White Space	5,192,203	0.840	4,363,536

Table 44.Demand Variables by Market, 2022

*Note*: SSO = Small and standalone; White Space refers to other areas within the United States that are not made of up markets. These results are aggregated from ZIP Code-level data.

#### c. Estimating Network Access from Supply and Demand

To evaluate access, we must bring our supply and demand variables together. One way to do this is to construct physician-to-population ratios (or population-to-physician ratios). These ratios have long been used as a tool for measuring and planning healthcare resources.<sup>60</sup> However, if we simply construct ratios of providers to the beneficiary population in a given market, we would fail to account for the fact that people travel beyond their home ZIP Code (or even county) to access care. To address this issue, we employed a gravity model.

Gravity models are a predictive tool employed in public health for studying access to healthcare.<sup>61</sup> They allow the researcher to evaluate the likelihood of interactions between patients and healthcare providers in distinct geographical regions, using key variables such as population size and spatial separation to estimate the potential extent of connectivity in healthcare delivery.

When assessing the availability of physicians in a given area, the gravity model considers the local population as the demand for healthcare services, and the number of physicians (or providers) as the supply. Through an analysis of these factors in conjunction with the geographical distance between locations, the model estimates the anticipated patterns of patient-physician interactions.

This methodology is useful for pinpointing regions where healthcare resources, particularly physicians, may be inadequate relative to the healthcare demands of the population. It offers a quantitative framework for healthcare planning and resource allocation by integrating both the demand for services and the spatial distribution of healthcare providers. Moreover, it offers several distinct advantages to the physician-to-population-ratio approach. First, it disregards arbitrary borders altogether, providing a more comprehensive understanding of regional healthcare dynamics. Second, the gravity framework allows the researcher to consider metropolitan versus rural ZIP Code characteristics and adjust the demand elasticity of a given population accordingly. For instance, our model is calibrated to allow residents of rural ZIP Codes to travel further distances for care than those residing in metropolitan areas.

The TRICARE Network Assessment Model measures access  $(A_i)$  in ZIP Code *i* with the following specification:

$$A_i = \sum_j \frac{S_j}{D_i f(d_{ij})}$$

<sup>&</sup>lt;sup>60</sup> B. Starfield, "Is primary care essential?," *Lancet* 344,8930 (1994): 1129–33, https://doi.org/10.1016/s0140-6736(94)90634-3.

<sup>&</sup>lt;sup>61</sup> The gravity model employer here is adapted from J. Bauer, and D. Groneberg, "Measuring Spatial Accessibility of Health Care Providers – Introduction of a Variable Distance Decay Function within the Floating Catchment Area (FCA) Method," *PLOS ONE* 11, no. 7 (2016): e0159148, https://doi.org/10.1371/journal.pone.0159148.

Here the numerator  $S_j$  represents the supply of providers in area *j*, measured in FTEs, and the denominator represents the demand for these providers from all accessible areas. Demand,  $D_j$ , is given by the following equation:

$$D_j = \sum_i \frac{P_i}{f(d_{ij})}$$

Demand  $(D_i)$  is a function of the number TRICARE beneficiaries  $(P_i)$  and a "distance impendent" function  $f(d_{ij})$ . The purpose of the function is to gradually reduce beneficiary demand based on their distance from the provider, conditional on the type of area the beneficiary resides in. This function implies that beneficiaries in locations with "access" to providers in area *j* contribute some weight toward the demand for providers in that area, based on their distance. The distance impedance function,  $f(d_{ij})$ , that defines the "accessible" distance is given by:

$$f_{Area}(d_{ij}) = \begin{cases} 1 \text{ when } d_{ij} \leq dis_u \\ g_\mu(d_{ij}) \text{ when } d_{ij} \in (dis_u, dis_{max}] \\ \infty \text{ when } d_{ij} > dis_{max} \end{cases}$$

In the equation above,  $d_{ij}$  represents the straight-line distance between the centroids of areas *i* and *j*, in miles. Below we describe the function in general terms. The specific parameter values and functions used in the model are calibrated by specialty and discussed in the specialty-specific sections.

For beneficiary-provider pairs in areas *i* and *j*, respectively, the distance impedance function is set to 1 when their distance is within the distance,  $dis_u$ . For family medicine,  $dis_u = 5$  miles. This means that a beneficiary located within 5 miles of a provider's location counts as one complete beneficiary toward the demand of providers in that location. This modeling approach captures beneficiary behavior where demand remains unaffected by distance when the provider is sufficiently close to the beneficiary.

When the beneficiary's distance falls between the distance  $dis_u$  and the maximum "accessible" distance,  $dis_{max}$  from a provider, the distance impedance function is determined by some function of distance and a tuning parameter,  $g_{\mu}(d_{ij})$ , where  $\mu$  is the tuning parameter. For instance, in our family medicine model, let us suppose a rural beneficiary is 6 miles away from a provider area. In this case, the distance impedance would be  $e^{0.15 \cdot (6-5)} \approx 1.16$ . Consequently, this rural beneficiary would contribute approximately  $\frac{1}{1.16} \approx 0.86$  beneficiaries toward the demand of providers in that area. This effectively represents how individuals are less inclined to seek care from a provider as their distance from that provider increases.

If the provider is outside of  $dis_{max}$ , the impedance function is equal to infinity.

With this model in mind, a categorical tiered system was employed for primary care services across different geographies. The analysis focused on the distances between healthcare providers and beneficiaries, accounting for metropolitan, micropolitan, small town, and rural areas. Using a distance matrix, we applied an exponential function to adjust distances. The tuning parameter in the exponential function governs the rate of demand decrease as the distance between providers and beneficiaries increases. In metropolitan areas, distances up to 5 miles maintain a demand factor of 1, indicating no change in demand. Beyond 5 miles, the demand factor decreases exponentially, with adjustments up to 15 miles. Similar adjustments are applied for micropolitan and small-town areas (these geographies were combined in the analysis), each with distinct distance thresholds. In rural areas, the demand factor decreases exponentially for distances beyond 5 miles, with a higher threshold of 40 miles.

#### d. Family Medicine

For family medicine, three tuning parameters (0.25, 0.20, and 0.15) were employed, based on geography A higher value leads to a faster decrease in demand as distance increases, while a lower value results in a slower decrease. The selection of this value was based on a review of the literature and on sensitivity analyses. Table 45 associates the geographies with the minimum and maximum demand distances that were a basis for the demand estimation for primary-care services.

Geography	Minimum Distance (miles)	Maximum Distance (miles)	Tuning Parameter
Metropolitan	5	15	0.25
Micropolitan and/or small town	5	35	0.20
Rural	5	40	0.15

Table 45. Minimum and Maximum Distances Where Exponential Decay Function is Applied

Using these parameters, we computed accessibility scores for all ZIP Codes in the United States. These scores are quantified in units of FTEs per beneficiary. We used MGMA panel-size data to categorize these scores into five bins, as detailed in Table 46, which presents a breakdown of accessibility scores, categorizing them into five ranges: Very Low, Low, Moderate, High, and Very High. Each range corresponds to a specific score range, indicating the level of accessibility to essential services such as healthcare. Additionally, the table provides corresponding panel ranges, which refer to the number of patients a family medicine provider can support within each accessibility score range. For instance, a panel size exceeding 3,300 patients falls under the very low accessibility score range, indicating severe limitations in access to services, while a panel size below

800 patients falls within the very high accessibility score range, suggesting excellent access to services.<sup>62</sup>

Accessibility	Score Range	Panel Range
Very Low	0–3.03	> 3,300
Low	3.03-4.55	2,200-3,300
Moderate	4.55-7.69	1,300–2,200
High	7.69–12.5	800–1,300
Very High	12.5 +	< 800

Table 46. Accessibility Bins Based on MGMA Family Medicine Panel Data

In general, we believe our accessibility categories provide a fairly accurate representation of the relative ease or difficulty beneficiaries may face accessing care in a given area. When the ratio of providers to beneficiaries is fairly high, patients will likely have an easier time accessing care, and more capacity exists in the market. Conversely, when the ratio of provider FTEs to beneficiaries is low, we would expect patients to have a harder time accessing care. A low or very low accessibility ranking does not mean patients will not be able to access care, but it does suggest they will face greater difficulty. The difficulty could take many forms, including:

- Providers turn TRICARE beneficiaries away because they do not accept TRICARE
- Providers turn TRICARE beneficiaries away because they are no longer accepting new patients (this could be any new patients or specifically patients with TRICARE)
- Patient can access care but they face long wait times
- Patient wants to see a pediatrician but must rely on family medicine instead
- TRICARE beneficiary must drive long distances to access care

Notably, the access challenges described above are not unique to TRICARE beneficiaries;. they apply to many who live in rural/remote areas where the supply of providers—particularly specialists—is limited.

<sup>&</sup>lt;sup>62</sup> The panel size-based bins are anchored to the distribution of panel sizes observed in the MGMA data for family practice providers (per FTE provider). The median of roughly 1,800 patients per provider panel falls in our *moderate* category. The *low* access category is anchored to approximately the 75<sup>th</sup> percentile, and the *very low* category is over the 90<sup>th</sup> percentile. Similarly, the *very high* bin falls below the 10<sup>th</sup> percentile, and the *high* bin is anchored to the 25<sup>th</sup> percentile.

#### 2. Results

#### a. Family Medicine

Figure 14 presents all U.S. ZIP Codes (excluding Alaska and Hawaii), with colors assigned based on their accessibility scores. ZIP Codes lacking beneficiaries are depicted in grey, while those classified as ranging from very low access to very high access are depicted along a color spectrum from white to dark brown.



Figure 14. Overall Family Medicine Accessibility for TRICARE Beneficiaries

To demonstrate the applicability of this methodological approach (i.e., varying the geographic unit of analysis), Appendix F presents family medicine results for a select set of states including Virginia, Texas, North Carolina, Kentucky, and Minnesota.

Table 47 presents a quantitative breakdown of accessibility levels across the United States, inclusive of Alaska and Hawaii, but excluding territories. Accessibility is categorized into five tiers: very low, low, moderate, high, and very high. Overall accessibility across the United States stands at 8.7 percent for very low, 9.6 percent for low, 27.5 percent for moderate, 34.6 percent for high, and 19.6 percent for very high accessibility levels. Prime service areas (PSAs) revealed similar trends, with slightly better access overall. Conversely, non-Prime service areas demonstrated slightly lower access. Overall, results suggest roughly 18 percent of beneficiaries live in markets where access is low (or very low). For those in PSAs, this figure falls to 17 percent. For those outside of PSAs, this figure increases to 22 percent.

			Accessibilit	y, %	
Area	Very Low	Low	Moderate	High	Very High
Overall	8.7	9.6	27.5	34.6	19.6
Prime Service Areas	7.7	9.2	27.9	36.5	18.7
Non-Prime Service Areas	11.4	10.9	26.5	29.0	22.3

 Table 47. Weighted Percentages of TRICARE Beneficiaries' Accessibility to Family

 Medicine Providers

Table 48 presents access scores by markets. We rank the markets by the share of beneficiaries in low- or very-low-access areas, from lowest to highest, so that the markets at the top of the table have the least access issues, while the markets at the bottom have the greatest. Based on these results, Tidewater, the National Capital Region (NCR), and the Florida Panhandle are the markets where beneficiaries are least likely to experience trouble accessing the TRICARE network, while Alaska and the Ozarks are markets where access is more challenging. We compared the results of this ranking to a market-based ranking based on JOES survey data found in the Annual TRICARE Report to Congress. The comparison is not "apples to apples" because the JOES data include direct care, while our analysis focused on the TRICARE network. Overall, our rankings are similar, with some notable exceptions. For instance, our TRICARE network-based ranking rates Tidewater and Coastal North Carolina much higher than the JOES access score rankings, and Sacramento much lower. The JOES-based rankings are shown in Appendix F. Future work should continue efforts to validate our model results against alternative survey and administrative data.

	Accessibility, %					
Market	Very Low	Low	Moderate	High	Very High	
Tidewater	2.7	2.3	24.3	53.6	17.1	
National Capital Region	1.7	4.1	27.7	59.9	6.5	
Florida Panhandle	3.6	3.6	12.1	54.5	26.2	
Coastal Mississippi	3.1	5.5	6.3	48	37	
San Antonio	1.6	7.5	42.2	37.1	11.6	
Coastal North Carolina	0.2	10.9	10.1	41.5	37.4	
Charleston	8.5	3.7	57.3	30.6	0	
Kansas	7.1	5.1	68.9	19	0	
Central Louisiana	10.9	3.8	9.6	75.8	0	
Central North Carolina	7.8	7.8	12.7	39.3	32.5	
Colorado	5.9	10.8	30.8	21.5	31	
SSO	9.5	7.6	25.5	36	21.4	
Jacksonville	8.4	9.3	15.9	28.3	38.1	
White Space	8.6	9.2	26.7	33.8	21.7	
El Paso	4.5	16.2	40.7	33.1	5.5	
Puget Sound	6.9	14.6	43.3	28.3	6.9	
Augusta	17.5	4.2	32.4	36.6	9.3	
San Diego	10.7	18.8	42.6	27.9	0	
Southwestern Kentucky	29.1	1.1	5.4	45.1	19.3	
Southwest Georgia	29.5	4.2	14.4	24.4	27.5	
Las Vegas	14.8	19.1	38.2	27.9	0	
Central Texas	29.2	6.2	39.2	14.5	11	
West Point	4.6	31.6	53.7	8.5	1.6	
Sacramento	4.9	34.8	39.3	21	0	
Low Country	9.9	33	5.8	20.9	30.3	
Alaska	26.5	20	17.9	33.3	2.3	
California Desert	48.6	0	51.4	0	0	
DHAR- Indo Pacific	22	27.2	50.8	0	0	
Ozarks	11.6	47.6	11.6	19	10.2	

 Table 48. Weighted Percentages of TRICARE Beneficiaries' Accessibility to Primary

 Care Providers, by Market

*Note*: SSO = Small and standalone; White Space refers to other areas within the United States that are not made of up markets. These results are aggregated from ZIP Code-level data.

#### **b.** Pediatrics

Family medicine is often referred to as the "backbone" of primary care. Family medicine providers can serve the primary care needs of the entire patient population,

including children, Prime-age adults, and the elderly. However, certain specialists, including pediatricians (treating children aged 0–17 years), also provide primary care services. In an urban setting where healthcare is plentiful, it is common to rely on these specialties (e.g., children typically see pediatricians). However, in rural/remote settings, it is much more common to rely on a family medicine provider for these services.

Still, access to pediatricians is something that military families value, so we looked at these providers and the subpopulations they serve. For ease of presentation, we report only overall access scores.

Our pediatric analysis restricts the TRICARE beneficiary population to individuals aged 17 and younger.

Table 49 shows overall access to care for the pediatric population (i.e., we included family medicine, general medicine, and other primary care advanced practitioners in our provider sample), while Table 50 shows access specifically to pediatricians.

Table 49. Weighted Percentages of Pediatric TRICARE Beneficiaries'	Accessibility to
Family Medicine and Pediatric Providers	

	Accessibility, %				
Area	Very Low	Low	Moderate	High	Very High
Overall	11.9	12.4	31.6	32.8	11.4
Prime Service Areas	11.0	12.1	32.4	33.5	11.1
Non-Prime Service Areas	15.1	13.7	28.6	30.1	12.5

# Table 50. Weighted Percentages of Pediatric TRICARE Beneficiaries' Accessibility to Pediatrician Providers Only

	Accessibility, %				
Area	Very Low	Low	Moderate	High	Very High
Overall	38.0	18.5	28.8	12.0	2.8
Prime Service Areas	35.8	19.0	29.8	12.6	2.7
Non-Prime Service Areas	45.9	16.5	24.7	9.8	3.1

The pediatric population comparison clearly showed that while overall access to care appears reasonable when all providers are considered, access to pediatricians is notably limited across various regions. For instance, Table 49 indicates that in non-PSAs, only 12.5 percent of pediatric TRICARE beneficiaries have very high accessibility to family medicine and pediatric providers, whereas Table 50 reveals that a mere 3.1 percent have very high accessibility to pediatricians. Similarly, in PSAs, while 11.1 percent have very high accessibility to family medicine and pediatric providers.

Overall, our results suggest that pediatric patients have access to care but that in many areas, access—specifically to pediatricians—is low. While both family medicine and pediatricians are generally equipped to take care of children, pediatricians are often recommended for children born prematurely, children with physical disabilities, children with developmental issues, and children with more complex healthcare needs.<sup>63</sup>

#### 3. Increase in Reserve Population Scenarios

As the TRICARE population grows, demand for healthcare from TRICARE network providers will also grow. Understanding how increasing TRICARE beneficiary numbers affect access to providers is essential for policy-makers and stakeholders to address emerging challenges and ensure access for all individuals and communities.

To assess the impact of increasing the beneficiary population, we explored three scenarios based on beneficiary population increases derived from the different predicted benefit-expansion and uptake scenarios:

- **Premium-free TRS RCSM-only, Best Estimate:** Under this scenario, we predict an increase in TRICARE-covered lives of 282,927, representing a 2.9 percent increase in the beneficiary population.
- **Premium-free TRS RCSM and Dependent, Best Estimate:** Under this scenario, we predict an increase in TRICARE-covered lives of 331,822, representing a 3.5 percent increase in the beneficiary population.
- **100 Percent Take-up of TRS/RCSM TRICARE Prime/Prime Remote:** Under this scenario, we predict an increase in TRICARE-covered lives of 730,611, representing a 7.6 percent increase in the beneficiary population.

The results are shown in Table 51, Table 52, and Table 53.

Table 51. Percent of Population with 202,927 RCSM increase					
	Accessibility, %				
	Very Low	Low	Moderate	High	Very High
Overall – Before	8.67	9.64	27.53	34.6	19.57
Overall – After	9.48	10.06	29.51	33.61	17.34
Non-RCSM	9.42	10.01	29.33	33.69	17.55
RCSM	9.78	10.38	30.56	33.1	16.18
Prime Service Areas	8.4	9.46	30.03	35.18	16.92
Non-Prime Service Areas	12.58	11.79	28.02	29.06	18.56

Table 51. Percent of Population with 282,927 RCSM Increase

<sup>&</sup>lt;sup>63</sup> https://www.healthpartners.com/blog/pediatrician-vs-family-doctor/.

	Accessibility, %				
	Very Low	Low	Moderate	High	Very High
Overall – Before	8.67	9.64	27.53	34.6	19.57
Overall – After	9.58	10.19	29.8	33.47	16.96
Non-RCSM	9.52	10.12	29.62	33.53	17.22
RCSM	9.92	10.58	30.78	33.14	15.57
Prime Service Areas	8.45	9.57	30.38	34.97	16.63
Non-Prime Service Areas	12.83	11.95	28.15	29.15	17.93

Table 52. Percent of Reserve Population with 331,822 RCSM Increase

	Accessibility, %				
	Very Low	Low	Moderate	High	Very High
Overall – Before	8.67	9.64	27.53	34.6	19.57
Overall – After	10.73	11.62	31.54	31.77	14.34
Non-RCSM	10.51	11.3	31.23	32.18	14.78
RCSM	11.6	12.86	32.77	30.14	12.63
Prime Service Areas	9.35	10.92	32.08	33.39	14.27
Non-Prime Service Areas	14.56	27.24	30.04	13.56	14.59

Table 53. Percent of Reserve Population with 730,611 RCSM Increase

Overall, the results indicate access falls as more beneficiaries are added to the network. When we consider the 100 percent take-up scenario, the number of beneficiaries residing in low- or very-low-access areas increases from 18 to 22 percent—an increase of 3.8 percentage points (or 20 percent). Likewise, the number of beneficiaries residing in high- or very-high-access markets falls from 54.1 to 46.1 percent—a decrease of 8.0 percentage points (or 14 percent). We note that PSAs fair better than non-PSAs as the population increases. This is due to there being more population growth in non-PSAs and these areas' having lower access to begin with. For example, in non-PSAs, the number of beneficiaries residing in low-/very-low-access areas increases from 18 to 22 percent (a 55 percent increase). For PSAs, the increase is only 9 percent. This rise in beneficiaries residing in low-/very-low-access areas is much less dramatic under the more limited population growth scenario. The overall increase is 6 percent, whereas the non-PSA increase is 33 percent.

The DoD OIG, GAO, and others all found that beneficiary access varies by location and is generally better for family practice than for some specialty areas. Our analysis found that benefit expansion would likely be absorbed with little reduction in access in welldeveloped areas and for family practice, but would result in further stress to access in more remote and less-well-developed areas and in some specialty areas. Past research has found that the TRICARE contracting approach of having low provider reimbursement rates (lower than commercial and Medicare rates) limits choice and access to beneficiaries. Shifting more beneficiaries from commercial insurance to TRICARE may add additional stress to a system that is already under stress and not consistent with civilian practices for buying healthcare.

#### 4. Discussion of Results

Overall, the results suggest that most TRICARE beneficiaries experience moderate to high access for primary care (based on our family medicine results and pediatric results). Regional disparities are apparent, with certain areas like Washington D.C. boasting extreme levels of access, while more remote regions such as Alaska face pronounced challenges. These variations persist across MHS markets, highlighting the intricate relationship between geographic location and healthcare accessibility within the TRICARE network. We believe this analysis helps highlight the critical need for access reporting at the specialty/locality level.

The TRICARE Network Assessment Model developed in this study represents a novel approach to studying access to care at a more detailed level than the DoD currently reports. Specifically, we developed specialty-specific estimates by locality using ZIP Code-level data. We believe this is a promising approach but that additional work is needed to refine and validate the model. The IDA team explored access to several other specialties, including OB/GYN, general surgery, and orthopedic surgery. However, extending the model to specialty care was complicated due to the blending of inpatient and outpatient services, the need to more narrowly define which beneficiaries will demand certain services, and the limited literature on the appropriate number of providers for a given sized population. We do not include specialty care results because we believe they need further development. Below we summarize what we view as model strengths and limitations and possible extensions.

#### a. Strengths

The methodology developed in this study exhibits several noteworthy strengths. First, the model uses TRICARE encounters, enabling a comprehensive analysis of healthcare activity across all 50 States. Using these data, the analysis may be run for any identifiable provider specialty using ZIP Code-level data. Results can be reported for any market area that can be mapped to ZIP Code (e.g., counties, MHS markets, etc.). Second, the model uses a provider supply variable based on actual care provided, not the number of providers reportedly accepting TRICARE. Third, the gravity framework used by the model allows patients to travel outside of their home ZIP Code, with travel expectations calibrated based on where they live, and by specialty.

#### **b.** Limitations

The model also has limitations. First, the IDA team must calibrate the model for each specialty. Such calibration involves making determinations about how many patients a provider of a given specialty can serve, what provider-to-patient ranges should be considered low, moderate, and high, how far a beneficiary should be expected to travel, etc. We currently rely on the population heath literature and on industry data from MGMA to guide these determinations. However, outside of primary care, the data are somewhat limited. One of the primary challenges encountered when employing a gravity model to simulate access lies in determining the optimal tuning parameter to yield realistic outcomes. A tuning parameter that is excessively large tends to overestimate demand, while one that is too small may underestimate it. In our analysis, we attempted to calibrate the tuning parameters to generate results aligning with real-life benchmarks. A potential avenue for enhancing the model in the future involves empirically examining beneficiary demand elasticity and deriving tuning parameters based on those findings. This approach would offer a more data-driven method for calibrating the model, potentially leading to more accurate and reliable results. Input from DoD SMEs could also be used.

Second, we were unable to validate the model against DoD survey or administrative sources on beneficiary access. To our knowledge, data on beneficiary access specific to the TRICARE networks at the specialty and local level do not exist. IDA is currently in the process of building a database of all civilian providers across the country (based upon the Center for Medicare & Medicaid Services NPI registry) and linking it to TRICARE providers. We were unable to complete this process in time to report it in this study, but it should provide a useful tool for model validation in the future. In follow-on work, we plan to estimate the share of all providers treating TRICARE patients at the specialty/ZIP Code level, which will provide an alternative metric for assessing variation in access by locality.

Third, our model is static and either holds supply fixed or makes assumptions about how much capacity might be able to expand in markets with moderate to high levels of access. More research is needed to determine the likelihood of more providers joining the network or current providers' taking on more TRICARE patients.

Lastly, our simulations of population expansion scenarios assumed the non-enrolled TRICARE RCSM population resides in the same areas as the current TRS population. We believe this is a reasonable assumption necessitated by data issues.<sup>64</sup> However, if the non-enrolled population lives in significantly different areas, our results are less useful. Future work could address this issue with improved data.

<sup>&</sup>lt;sup>64</sup> The IDA team originally tried to conduct the analysis specifically based on where non-enrolled RCSMs live. However, we encountered data issues comparing DEERs enrollment data on the TRICARE population with DMDC data on the total SELRES population.

The objective of this study was to examine the costs, benefits, and feasibility of several TRICARE health and dental benefit-expansion scenarios for the RCSM population. Key findings are summarized below.

## A. Summary of Findings

## 1. RCSM Access to Health and Dental Benefits

RCSM enrollment options for DoD-provided health and dental benefits are tied to activation status. We estimate nearly 60 percent of the eligible RCSM population (which includes dependents) has some form of TRICARE health benefit. The different enrollment options and use rates follow:

- RCSMs on orders of more than 30 days (and eligible dependents) are eligible for the Primary premium-free TRICARE benefit. Under the status quo, roughly 28 percent of the eligible RCSM population is enrolled in TRICARE due to activation.
- RCSMs transitioning on or off of active duty also receive premium-free benefits up to 180 days pre and post activation (for activations of more than 30 days). The pre-activation benefit, TRICARE Early Alert, is available to those being activated in support of a contingency operation. The post-activation benefit, TAMP, covers RCSMs activated in support of a contingency operation or preplanned missions. We estimate roughly 7 percent of the RCSM population is enrolled in TRICARE via transition benefits.
- RCSMs who are not activated or in transition may purchase a premiumbased TRS plan for themselves and their dependents. Roughly 23 percent of the RCSM population is enrolled in TRS. RCSMs who are Federal civilians may not currently purchase TRS, but they will be eligible to do so in 2030.
- Many RCSMs who are not activated or in transition chose not to enroll in a TRICARE benefit; they rely on civilian-based OHI or go uninsured. Roughly 42 percent of the eligible RCSM population is not enrolled in a TRICARE benefit (we estimate 9 percent are enrolled in FEHB, 26 percent have OHI, and 7 percent are uninsured).

- Under the status quo, RCSMs transition between the primary TRICARE benefit and civilian health insurance (or TRS) multiple times over their careers. We estimate the RCSM will experience roughly 3 healthcare transitions. These numbers suggest the average RCSM spends around 20 percent of their career eligible for the primary TRICARE benefit. Accounting for transition benefits is difficult given they do not apply to all activations and they may not be used for the full 180 days. However, we estimate that transition benefits likely increase the time spent on the primary TRICARE benefit by 5 to 10 percent.
- Enrolling in the TRS benefit is less expensive than enrolling in the average employer-sponsored health plan: We estimate enrolling a family in the average civilian employer-sponsored health plan costs roughly twice what it costs to enroll a family in TRS. TRS OOP costs are also lower than those of the average civilian plan.
- The TRS Take-up Rate is 28 percent across the RCSM population, but with significant variation by family status and rank group. Roughly 20 percent of eligible single RCSMs take up the TRS benefit. The enrollment rate for junior single enlisted is only 13 percent, while the single senior officer enrollment rate is 41 percent. Roughly 49 percent of RCSMs with dependents enroll in TRS. The junior enlisted take-up rate is 33 percent, while the junior officer rate is 60 percent.
- More research is needed to better understand why TRS take-up rates aren't higher. TRS costs roughly half of the average civilian employersponsored health plan. However, we estimate that less than a third of the eligible population takes up the benefit (and some go uninsured), suggesting there could be barriers to program participation (i.e., information problems) and/or a strong preference for civilian health plans. A preference for civilian health plans could be due to real (or perceived) differences in care quality and/or access or a preference for care continuity. A better understanding of these possibilities should be gained before pursuing major benefit expansions.

RCSM enrollment options for dental care works in a parallel fashion to medical insurance; options are tied to activation status. One key difference is that eligible dependents must pay a premium even when their RCSM sponsor is active (parity with AC dependents). Below we summarize some key findings for dental:

• RCSMs on orders of more than 30 days are eligible for the premium-free active-duty dental plan. Their dependents must pay a premium to enroll in TDP. Roughly 35 percent of single dependents enroll, while just over 60 percent of dependent families enroll.

- RCSMs who are not activated or in transition can enroll themselves (and their dependents) in the TDP. Take-up rates for TDP for this population are low. Roughly 10 percent of RCSMs enroll. Single dependents also have a 10 percent take-up rate. Dependent families have a 17 percent take-up rate.
- The study team was unable to determine if RCSMs had access to other dental insurance. The administrative and survey data sources we used to learn about RCSM access to other health insurance did not contain data on dental insurance. It is likely that RCSMs using OHI also have access to dental plans (and that the medically uninsured probably don't have dental insurance), but we do not know this with certainty. The PHA could include a question on dental insurance to address this information gap.
- Enrolling in TDP is less expensive than enrolling in the average civilian dental plan (employer-sponsored or commercial). We estimate premiums for the average employer-sponsored family dental plan cost about 1.5 times more than TDP premiums. However, dental insurance is not always a good buy for the consumer; premiums can cost more than the value of services utilized, which is true of civilian and TRICARE plans. This pricing could partially explain the low take-up rates.

## 2. Expected Cost of Benefit Expansion

DoD currently spends roughly \$3.3 billion on health and dental benefits for RCSMs. This figure includes the cost of benefits for activated and transitioning RCSMs (and dependents) and the cost of covering those enrolled in premium-based TRS and TDP. Providing RCSMs (and dependents) with premium-free health and dental benefits is estimated to increase costs by \$1 billion to nearly \$3.3 billion, depending on the benefit-expansion scenario and benefit take-up behavior. Specifically, we estimate:

- The Premium-free TRS (member-only) option is estimated to increase costs by roughly \$935 million annually. This figure is based on our elasticity-based best estimate of take-up behavior. For single RCSMs, this corresponded to an average take-up rate of 42 percent (up from 19 percent). The average family take-up rate was 66 percent (up from 40 percent). If take-up rates were 100 percent, costs would increase by just over \$2 billion. The difference in costs illustrates the importance of accurately forecasting take-up behavior.
- The Premium-free TRS (member and dependent) option is estimated to increase costs by roughly \$1.6 billion annually. This figure is based on our elasticity-based best estimate of behavior (single take-up rate of 42 percent and family take-up rate of 71 percent). If take-up rates were 100 percent, costs would increase by roughly \$2.6 billion.

- The TRICARE-for-All option is estimated to increase costs by roughly \$2.6 billion annually. This figure is based on our elasticity-based best estimate of behavior (single take-up rate of 45 percent and family take-up rate of 73 percent). The cost would increase to \$3 billion if it was taken at 100 percent.
- Premium-support options could be cheaper than premium-free TRS or RCSM TRICARE Prime/Prime Remote. We estimate premium support for the RCSM-only option would increase costs by roughly \$630 million annually, which is less than the \$935 million we estimate it would cost to provide premium-free TRS (member-only option). We note premium-support becomes the more expensive option if a subsidy is also paid to cover dependents. Premium-support options are estimated to cost less than RCSM TRICARE Prime/Prime Remote.
- Premium-free TDP (member-only) option is estimated to increase costs by roughly \$83 million annually. If the take-up rates were 100 percent, costs would increase by \$224 million.
- Premium-free TDP (member and dependents) is estimated to increase costs by \$136 million annually. If the take-up rates were 100 percent, costs would increase by \$379 million.

## 3. Expected Benefits from Health and Dental Benefit Expansions

In discussions of RCSM health and dental benefit expansions, potential benefits are often discussed but rarely quantified. We developed a framework for quantifying potential marginal benefits (i.e., newly medically ready RCSMs) and expressing their marginal costs. Some of the key findings included:

- Expanding health and dental benefits would have limited impact on RCSM total force medical readiness (TFMR) rates. Medical readiness rates for RCSMs, measured by the TFMR rate, are at historic highs (91 percent) and essentially the same as those of the AC. The rate will never be 100 percent due to readiness frictions (people get injured, become ill or pregnant, etc.), leaving little opportunity for further improving readiness. If expanding health and dental benefits could guarantee a 95 percent TFMR rate, we would see a marginal gain of 26,000 newly ready RCSMs. However, for the most limited expansion scenario the marginal cost would be nearly \$40,000 per newly ready RCSM. Gains would be smaller (and marginal costs higher) if we assume RCSMs could achieve only active-duty parity in TFMR, which is lower than 95 percent for most components.
- RCSM health insurance status does not appear to affect individual medical readiness rates (IMR). We used data from the PHA to investigate IMR

readiness categories by health insurance status. Those with insurance had an IMR rate of 94 percent while those without had an IMR rate of 93 percent. However, we did find that those with DLMCs were more likely to report seeking medical care if they had insurance.

- Expanding health and dental benefits could potentially help to improve partial medical readiness (PMR) rates. A large number of RCSMs are currently classified as partially medically ready (as opposed to fully medically ready). This group is assumed to be free of deployment limiting conditions but they are overdue for medical or dental exams or require IMR services (immunizations, medical lab work, or medical equipment checks). The percentage of RCSMs falling into this category, 47 percent, currently exceeds DoD's policy target of no more than 25 percent. More specifically, roughly 150,000 RCSMs need to move from partially to fully ready to hit the target.
- Expanding health and dental benefits could reduce RHRP spending, but the • potential is limited. The RHRP spends a little over \$150 million annually to provide military-specific screenings and other readiness and deployment-related services to RCSMs. Many of these services can (or could) also be delivered by TRICARE network providers. In theory, providing benefits could therefore reduce the need for the RHRP, but we would expect challenges in shifting the RHRP's workload to civilians. For instance, the RHRP spent \$52 million on dental assessments and treatments in FY 2022. The exams would be covered by TDP. However, obtaining treatment through TDP would require the RCSM to incur out of pocket costs (often over \$100). Treatment in the RHRP is free. The RHRP also offers convenience and streamlines the documentation process which reduces administrative burden on the RCSM and unit. Putting more responsibility on the RCSM to find civilian providers, pay OOP costs, and ensure their civilian provider properly completes DoD screening paperwork would not go without challenges. However, if benefits are expanded, DoD should work to shift certain workload from the RHRP to network providers.
- The RHRP is a far more cost-effective channel for providing RCSMs with medical readiness and deployment services. The RHRP is cost-effective because it is tactically focused on readiness; it provides the IMR and other deployment-specific services an RCSM needs to deploy (but nothing else). Health and dental benefits, on the other hand, are comprehensive and cover not only the member but also dependents. The TRICARE program spent over \$3.2 billion on health and dental benefits for RCSMs enrolled in TRS and TDP—10 times the cost of the RHRP. Under proposed expansion scenarios, spending would grow somewhere between \$1–\$3.3 billion. Potential RHRP savings would do little to offset this growth.

- Expanding health and dental benefits increases RCSM compensation. Health and dental benefits are a form of compensation. We calculated the value of the compensation increase to RCSMs by estimating what it would save them in premium and OOP medical and dental costs. The analysis indicates that savings rise with rank group and are much larger for RCSMs with dependents. For individual RCSMs not already enrolled in DoD health benefits, the average savings would range from \$2,200 to just over \$3,000 annually. For RCSMs with families, the average savings would range from roughly \$6,000 to \$10,000 annually. We also consider that the RCSM may not value a dollar in savings in healthcare spending as much as a dollar in cash compensation.
- Expanding health and dental benefits would likely have a positive impact on recruitment, but the marginal cost of these gains is very high. The proposed benefit-expansion scenarios constitute increases in compensation, and the literature shows increasing compensation can increase enlistments. Using Army National Guard as a case study, we estimated premium-free TRS (member-only option) would increase enlistments by 3,600 if benefits were valued equally as cash, but by less than 1,000 if benefits were valued at 25 cents on the dollar. The marginal cost of these gains would be high (over \$100K per recruit in the full valuation scenario, and nearly \$500K per recruit in the 25 percent valuation scenario). The marginal costs of increasing enlistments through cash bonuses, advertising, and more recruiters are lower.
- Expanding health and dental benefits would have a larger impact on retention than recruitment, but the costs are still high. The literature shows increased compensation increases retention. Again, the magnitude of the effect will depend on how much the RCSM values healthcare savings. Using the Army National Guard case study, we estimated premium-free TRS would increase reenlistment by 7,000 if benefits were valued equally as cash, but by less than 2,000 if benefits were valued at 25 cents on the dollar. The marginal cost of these gains is still high (nearly \$60,000 per reenlistment). We also note these figures exceed current retention shortfalls.

#### 4. Feasibility of Health Benefit Expansions

If all RCSMs (and dependents) who are eligible for TRS but not currently enrolled signed up tomorrow, the increase in covered lives would be just over 730,000—a population increase of roughly 8 percent. Our feasibility analysis examines the TRICARE program's capacity to absorb the new users. Some key findings from our feasibility analysis are summarized below:

• Timely access to care has been a long-standing issue for TRICARE beneficiaries, and survey data indicate the problem has worsened in recent

**years.** A growing number of government reports highlight access challenges reported by TRICARE beneficiaries. An analysis of survey data taken from the evaluation of the TRICARE program shows negative trends in several measures of access, including "Getting care when Needed" and the access-to-care composite score.

- Our TRICARE Network Assessment Model finds roughly 18 percent of beneficiaries live in areas with low or very low access to care. These results are specific to family medicine—the main primary-care specialty. Results for specialty care show greater access to care challenges. We find access is generally slightly higher in PSAs and lower in non-PSAs.
- We estimate access falls as more beneficiaries are added to the TRICARE network. Our analysis of the family medicine specialty suggests the beneficiary population living in low-/very-low-access areas could increase from 18 to 22 percent on average if all eligible RCSMs and dependents joined the network.

## **B.** Recommendations

Expanding health and dental benefits for RCSMs is a complex decision that depends on many different factors. The goal of this analysis was to provide decision-makers with a better understanding of the likely costs, benefits, and feasibility issues for each of the proposed benefit-expansion scenarios. We do not seek to recommend which if any of the proposed scenarios should be adopted over the status quo. However, we do offer several recommendations related to the broader discussion.

The DoD should consider the marginal cost of achieving its policy objectives through broad health and dental benefit expansions against the marginal cost of more targeted policy instruments. The most commonly discussed benefits of the proposed RCSM health and dental benefit expansions include improved medical readiness and increasing recruitment/retention. While we do find expanding health and dental benefits could provide improvements in these areas, we note they come at high marginal costs. To solve specific challenges in medical readiness, recruiting, and/or retention, DoD should pursue the most targeted cost-effective solutions. For instance, our analysis shows the RHRP is a far more cost-effective channel for providing RCSMs with medical readiness services. Likewise, hiring more recruiters would be a far more cost-effective solution for targeting recruiting shortfalls. In addition, using more recruiters or cash bonus incentives for both recruiting and retention objectives provides DoD with more flexibility; recruiters and bonuses can be reduced in more favorable recruiting/retention environments when no longer needed. Benefit expansions, on the other hand, are extremely difficult to take away.

- DoD should address growing access-to-care issues before adding more beneficiaries to an already stressed program. TRICARE beneficiaries, including reservists, are increasingly reporting challenges with access to care. The challenges appear to be greater for those in non-PSAs, where RCSM populations are more likely to live. The access problems in the TRICARE program are structural in nature; they are driven by the program's low reimbursement rates and general model for contracting for care.<sup>65</sup> The trend of rising costs in the civilian healthcare market will put further pressure on TRICARE providers and likely result in even narrower networks if payment rates are not increased. Trends in civilian premium growth (7 percent on average in recent years) will also likely lead more RCSMs to take up the TRS benefit, even if premiums remain.<sup>66</sup> Without payment reform, network access to care for TRICARE beneficiaries is likely to continue its downward trend. A decision to expand healthcare benefits for RCSMs would be an ideal opportunity to explore alternative methods of contracting for military healthcare benefits. A new benefit-contracting design based on civilian insurance-benefit design methods (and, importantly, provider reimbursement rates) would likely provide the desired benefit expansion in a more affordable manner.
- If DoD expands RCSM health and dental benefits, it should consider several key factors to reduce total implementation cost. Health and dental benefits provide many services that are also contracted for in the RHRP. If benefits are expanded, DoD should attempt to shift certain services currently delivered by the RHRP to the health and dental benefit programs. This action could require policy changes (i.e., allowing TRICARE network providers to conduct PHAs) and altering incentives. For example, obtaining dental treatment through a TRICARE dental benefit would still require OOP payments, while the RHRP would provide the treatment at no cost. Without intervention, RCSMs may opt to continue using the RHRP over their new benefit for such services. In addition, DoD should consider how enrollment occurs (i.e., must RCSMs still opt in, or does enrollment become automatic?) and if TRICARE must serve as a second payer for RCSMs who opt to keep civilian coverage.
- DoD should study Maryland's newly implemented "Healthcare for Hero's TRICARE Premium Reimbursement Program." Maryland has begun a program to reimburse Guardsmen for the TRICRE medical and dental

<sup>&</sup>lt;sup>65</sup> See IDA Paper P-5309 for a discussion of how the TRICARE program contracts for civilian care.

<sup>&</sup>lt;sup>66</sup> KFF, "2022 Employer Health Benefits Survey," October 27, 2022, https://www.kff.org/mentalhealth/report/2022-employer-health-benefits-survey/; and "2023 Health Benefit Survey," October 18, 2023. https://www.kff.org/health-costs/report/2023-employer-health-benefits-survey/.

premiums. This effectively provides the premium-free TRS only option to members of the National Guard. The difference is that rather than waiving the member's premium, it is now covered by Maryland. This creates an interesting natural experiment that DoD can study to learn more about many of the issues examined in this report. These include take-up behavior, the uninsured population, access issues, and possible benefits (e.g., does medical readiness, recruiting, or retention improve for the Maryland National Guard relative to other states). Once a year or two of data become available, this natural experiment will present very valuable insights into the true costs, benefits, and feasibility of benefit expansion.

# Appendix A. FEHB-eligible Population

# Identifying the Federal Employees Health Benefit (FEHB)-eligible Population

We used data from the Defense Manpower Data Center (DMDC), Reserve Master file (RSM), and Civilian Master file (CVM) to identify FEHB-eligible RCSMs (i.e., Reserve component service members (RCSMs) who are also Federal civilians). Identifying the population required merging these datasets and flagging individuals that overlapped. Figure A-1 illustrates the overlapping FEHB-eligible population identified through this procedure with a Venn Diagram.



**RCSMs Who Are Also Federal Civilians** 

(FEHB-eligible	RCSMs)
----------------	--------

Selected Reserve (not including AGR or MILTECH)	12,629
Active/Guard Reserve (AGR)	12,384
Military Technicians (MILTECH)	57,895
Total	82,908

Figure A-1. FEHB-eligible Population, FY 2022

Once the population was identified, we constructed counts of the FEHB-eligible population by our rank group and family status variables (including dependents). The counts are reported in Table A-1.

Total FEHB-eligible RCSM Population				
	Total RCSMs	RCSMs w/out Dependents	RCSM w Dependents	Dependents
EJ	7,539	4,471	3,068	6,069
ES	5,506	1,411	4,095	10,042
OJ	55,954	12,805	43,149	104,543
OS	9,789	1,018	8,771	24,096
WO	4,120	477	3,643	9,304
Total	82,908	20,182	62,726	154,054

Table A-1. FEHB-eligible RCSMs by Rank Group and Family Status, FY 2022

## **Accounting for Activations**

When FEHB-eligible service members are activated, they become eligible for the primary TRICARE benefit. We must account for this fact when reporting how many RCSMs are currently using FEHB. To calculate the FEHB-eligible population, we apply rank-specific activation rates observed across the overall selected Reserve to the FEHB-eligible population. We assume the remaining FEHB-eligible RCSMs are not in an active status. This population is shown in Table A-2. The non-active population can be subtracted from the TRICARE Reserve Select (TRS)-eligible population to account for their current ban from the program.

FEHB-eligible RCSM Population (Non-active)				
	Total RCSMs	RCSMs w/out Dependents	RCSM w Dependents	Dependents
EJ	6,252	3,708	2,544	5,033
ES	38,224	8,747	29,476	71,416
OJ	4,087	1,047	3,040	7,454
OS	6,660	693	5,968	16,395
WO	2,587	300	2,288	5,842
Total	57,810	14,495	43,315	106,140

Table A-2. FEHB-eligible RCSMs in Non-active Status, by Rank Group and Family Status,FY 2022

## Appendix B. Personnel Costing

The Institute for Defense Analyses (IDA) maintains a manpower costing tool for comparing the average cost of different personnel types, including active component (AC) personnel, Reserve and Guard personnel, and civilian personnel. The costs are developed based on Department of Defense Instruction (DoDI) 7041.04, "Estimating and Comparing the Full Costs of Civilian and Active Duty Military Manpower and Contract Support" published by the Office of the Secretary of Defense (OSD) Cost Assessment and Program Evaluation (CAPE). IDA extended the methodology to the Reserve components following the same framework. The full methodology is provided in IDA Document D-8575, "Analysis of Alternative Mixes of Full-Time Support in the Reserve and Guard components, the model provides estimates of the full cost of active personnel and non-active drilling personnel.

Table B-1 provides a summary of the different cost categories the model can produce and a description of all the cost elements included in each. For this analysis we focus on the Cost to DoD and the Cost to the Federal Government categories (reported in Table 6). In Chapter 7, when we consider the percentage increase in compensation represented by benefit expansion, we use the Cost to the Program (cash compensation plus benefits).

		· · · · · · · · · · · · · · · · · · ·
Category	Variation	Description
Cost	to the Depa	rtment of Defense (Program)
Cash Compensation	Short run	Basic pay & salary
(Program)		Housing & subsistence allowances
		Incentive, special & other pays
Benefits & Other Direct	Short run	Cost of living & other allowances
Costs (Program)		Retirement accrual payments & thrift savings plan
		Subsistence-in-kind
		Federal Insurance Contributions Act payments
		Permanent change of station & other travel
		Current medical care & health benefits
		Other personnel benefits & costs
		Specific training (optional)
		Separation & severance pays
	Cost to the	Department of Defense
Other Department of	Long run	Installation support
Defense		Personnel administration
		Personnel benefits
		General training & education
	Cost to the	e Federal Government
Department of Veterans	Short run	Veterans Affairs disability & pension
Affairs		Veterans Affairs healthcare
		Veterans Affairs other benefits
Department of the	Short run	Concurrent receipt of retirement & disability
Treasury		Non-Medicare-eligible retiree healthcare (<65)
		Medicare-eligible retiree healthcare fund (>65)
Department of Education	Short run	Impact aid
Office of Personnel Mat.	Short run	Civilian retiree healthcare
Department of Labor	Short run	Training & employment of Veterans
	Revenue to t	he Federal Government
Department of the Treasury	Short run	Tax revenue
Co	st & Revenu	e to the State Government
State Treasury	Short run	Tax revenue (no cost)
Co	st & Revenu	e to the Local Government
Local Treasury	Short run	Tax revenue (no cost)
-		

#### Table B-1. Summary Cost Element Matrix

*Note*: Sources for each cost are provided in IDA Document D- 8575. Some factors in DoDI 7041.04 are not considered for this paper, such as the costs of unfunded liabilities for legacy retirement systems.

# **Appendix C. Population Details**

## The TRICARE-enrolled Population

The source of the TRICARE enrollment data is the Defense Enrollment Eligibility Reporting System (DEERs), available through the Military Health System (MHS) Management Analysis and Reporting Tool (MART), commonly referred to as M2. DEERs enrollment is reported monthly. For this analysis, we use enrollment data for September of fiscal year (FY) 2022.

We use the beneficiary category variable to identify our population of interest. The beneficiary categories we select for our analysis are:

- **Guard/Reserve on Active Duty (GRD):** These are active Reserve component service members (RCSMs) who qualify for the primary TRICARE benefit
- **Dependent of Guard/Reserve on Active Duty (DGR):** These are the dependents of the GRD population. They also qualify for the primary TRICARE benefit.
- Inactive Guard/Reserve (IGR): These are members of the selected Reserve who are not on active orders of more than 30 days, that would qualify them for the primary TRICARE benefit. Their enrollment is either due to eligibility for a transition benefit (i.e., Transitional Assistance Management Program (TAMP)) or enrollment in the TRICARE Reserve Select (TRS) program.
- **Dependent of Inactive Guard/Reserve (IGD):** These are the dependents of the IGR population. Their enrollment is either due to eligibility for a transition benefit (i.e., TAMP) or enrollment in the TRS program.

All beneficiaries classified as GRD/DGR are grouped as "Active RCSMs and Dependents with TRICARE (TRICARE Prime/Prime Remote Users)" (we call this the "active" population for short). The IGR/IDG beneficiaries must be further subdivided into two populations: "TRS," and those with "other" eligibility. We use the enrolled Health Care Delivery Program (HCDP) code to make this subdivision. Enrollment in TRS is identified by HCDP code 306 (TRICARE Select - Reserve Select Sponsors and Family Members). We assume the IGR/IGD populations not enrolled in TRS are largely eligible through a transition benefit.<sup>1</sup>

Table C-1 reports the enrollment counts used in the analysis for each of the three TRICARE enrollment categories: active, other, and TRS users.

Active: Active RCSMs and Dependents with TRICARE (TRICARE Prime/Prime Remote Users)				
	Total RCSMs	RCSMs w/out Dependents	RCSM w Dependents	Dependents
EJ	51,251	41,952	9,299	17,638
ES	105,425	25,277	80,148	200,870
WO	4,847	867	3,980	10,437
OJ	15,504	6,616	8,888	21,058
OS	20,120	2,781	17,339	49,165
Total	197,147	77,494	119,653	299,168
	Othe	er: Non-active RCSMs and Dep (TAMP/Early Alert/Other no	endents with TRICARE on-TRS Plans)	
	Total RCSMs	RCSMs w/out Dependents	RCSM w Dependents	Dependents
EJ	24,896	18,763	6,133	11,633
ES	24,318	10,226	14,092	35,318
WO	714	109	605	1,587
OJ	5,696	3,008	2,688	6,368
OS	3,288	398	2,890	8,195
Total	58,912	32,504	26,408	63,101
_	TRS	: Non-active RCSMs and Depen	ndents Enrolled in TRS	
	Total			
	RCSMs	RCSMs w/out Dependents	<b>RCSM w Dependents</b>	Dependents
EJ	38,918	22,417	16,501	31,299
ES	71,654	16,176	55,478	139,040
WO	2,274	223	2,051	5,377
OJ	17,394	4,969	12,425	29,439
OS	18,302	1,506	1,506 16,796 47,626	
Total	148,542	45,292	103,250	252,781

Table C-1.	RCSM	TRICARE	Enrollees.	FY 2022
	1.000			

Source: DEERs; Enrollment data for September, FY 2022.

<sup>&</sup>lt;sup>1</sup> Many of the beneficiaries we classify as "other" are identified as participating in TAMP (HCPD code = 314), but others are still listed under the TRICARE Prime and Prime Remote benefits.

The dental enrollment data are structured differently. RCSMs are enrolled separately from dependents. There are three categories of plans: RCSM plan, individual dependent plan (i.e., just a spouse or just one child), and family dependent plans (i.e., spouse and kids), shown in Table C-2.

	Active: Active/Transitioning RCSMs and Dependents with TRICARE Dental				
	Total RCSMs*	Individual Dependent Plan	Family Dependent Plan	Dependents	
EJ	76,147	469	733	2,633	
ES	129,743	9,460	35,910	123,312	
WO	5,561	509	1,834	6,291	
OJ	21,200	828	2,823	9,935	
OS	23,408	1,662	9,121	31,454	
Total	256,059	12,928	50,421	173,625	
Other: Non-active RCSMs and Dependents with TRICARE Dental					
Total RCSMs RCSMs w/out Dependents RCSM w Dependents Depend					
EJ	12,345	1,415	3,160	10,748	
ES	29,230	4,666	18,633	63,863	
WO	909	181	791	2,735	
OJ	7,366	1,193	3,842	13,582	
OS	7,607	1,055	6,130	21,703	
Total	57,457	8,510	32,556	112,631	

Table C-2. TRICARE Dental Plan Enrollees, FY 2022

Source: DEERs; Enrollment data for September FY 2022.

\* This is the number of active and transitioning RCSMs who are eligible for Active Duty Dental Program (ADDP) or TRICARE Dental Plan (TDP) Remote. We did not observe ADDP enrollment, so we assume all eligible individuals have the benefit. All other data in this table are based on actual observed TDP enrollment.

The DEERS enrollment data available in the Military Health System Management Analysis and Reporting Tool (M2) included only RCSMs with current TRICARE enrollment. To identify the total eligible population, we use data from the Defense Manpower Data Center (DMDC).

## Tab

To identify the non-enrolled eligible TRS population, we begin with the total population shown in Table 7 of Chapter 2. We then subtract those already enrolled in TRICARE. We then split the remaining group into two subgroups—those with other health

insurance (OHI) and the uninsured. To make the split we rely on the health insurance question available in the periodic health assessment (PHA).

#### **Estimating the Uninsured Population**

The health insurance question on the PHA reads: "Are you currently covered under a health insurance policy? Mark all that apply" with the options "Yes -TRICARE", "Yes – Other Health Insurance," or "No." We use this question to determine the number of uninsured RCSMs. Table C-3 shows the PHA data.

	Yes	Percent Yes
TRICARE	375,727	58%
ОНІ	245,699	38%
No (Uninsured)	53,598	8%

#### Table C-3. Response to Health Coverage Question PHA, FY 2022

Note: Sample size is 643,686. Only traditional drilling RCSMs answer this question on PHA. AGR and active RCSMs are automatically counted as having TRICARE. Non-response rate for this question was .01 percent. It is possible to report having TRICARE and OHI.

Based on these data, we assume an uninsured rate of 8 percent and apply it to our total population. To estimate the final uninsured population, we obtain the distribution of the uninsured population by rank group. The data indicate over 70 percent of the uninsured are junior enlisted. Table C-4 shows the distribution.

	Uninsured	Total	Uninsured Rate
JE	33,902	206,291	16%
SE	11,486	256,365	4%
WO	168	10,293	2%
JO	1,432	46,465	3%
SO	503	47,874	1%
Total	47,491	567,288	8%

Table C-4. The Estimated Uninsured Population by Rank Group, FY 2022

Source: PHA Data, 2022 Sample.

We apply the rank-specific uninsured rates to our total population to obtain our final estimates of the uninsured population. These numbers are show in Table C-5.
Uninsured							
	Total RCSMs	RCSMs w/out Dependents	RCSM w Dependents	Dependents			
EJ	48,524	37,635	10,889	20,654			
ES	7,062	2,116	4,946	12,395			
WO	212	32	180	471			
OJ	2,693	1,116	1,577	3,735			
OS	401	48	353	1,002			
Total	58,892	40,948	17,944	38,257			

Table C-5. The Estimated Uninsured RCSM Population, FY 2022

*Source*: These estimates are calculated using DMDC data on the total Selected Reserves (SELRES) population (shown in Table 7) and ranks specific uninsured rates from the PHA (show in Table 30).

#### **The OHI Population**

The OHI population is calculated by subtracting the TRICARE enrolled population and the estimated uninsured population from the total population. This residual population is then split into FEHB users and all other OHI users based on the FEHB population estimates provided in Appendix A. Our estimates for these populations are shown in Table C-6.

OHI: Estimated FEHB Enrolled (Non-activated RCSMs)						
	Total RCSMs	RCSMs w/out Dependents	RCSM w Dependents	Dependents		
EJ	6,252	3,708	2,544	5,033		
ES	38,224	8,747	29,476	71,416		
WO	4,087	1,047	3,040	7,454		
OJ	6,660	693	5,968	16,395		
OS	2,587	300	2,288	5,842		
Total	57,810	14,495	43,315	106,140		
	ОН	II: All Other Health Insurance (N	Ion-activated RCSMs)			
	Total RCSMs	RCSMs w/out Dependents	RCSM w Dependents	Dependents		
EJ	136,555	112,024	24,530	46,529		
ES	124,242	45,891	78,351	196,367		
WO	4,981	741	4,240	11,120		
OJ	18,881	9,234	9,648	22,859		
OS	20,842	2,825	18,016	51,086		

Table C-6. Estimate RCSM Population with OHI, FY 2022

*Note*: The FEHB eligible population is taken from Table A-1 in Appendix A. The "All Other Health Insurance" population is estimated as the residual (total population less all TRICARE enrollees, uninsured, and FEHB-eligible).

Unfortunately, our administrative data sources do not provide any additional information on sources of OHI, such as whether the RCSM has an employer-sponsored plan, uses their spouse's or parents' plan, purchases an individual plan from the Affordable Care Act (ACA) Marketplace, etc. For more detailed information on OHI options, we reviewed various survey options. The Millennium Cohort Study (MSC) appeared to be the best survey data available because it allowed us to specifically examine the RCSM population. We obtained a cross-section of data for 2019 through 2022. Table C-7 shows how RCSMs answered the question, "What kind of health insurance do you currently have?"

What kind of health insurance do you currently have? Mark all that apply:						
	Yes	No	Percent			
TRICARE	10,356	6,423	62%			
Employer, School, or Other	6,358	10,421	38%			
VA Coverage	2,334	14,445	14%			
Medicaid	608	16,171	4%			
Medicare	249	16,530	1%			
No Coverage	410	16,369	2%			

Table C-7. Response to MCS Health Coverage Question, FY 2019–21

*Note*: Sample size is 18,292. Non-response rate for this question was 4 percent.

The MCS data show just over 60 percent of RCSMs reporting coverage through TRICARE. This percentage is slightly higher than the 58 percent suggested by our 2022 PHA data sample and our administrative user data. The 38 percent for OHI is consistent with the PHA. The uninsured rate of 2 percent is much lower than the uninsured rate we derived from the PHA. Given the small sample size, we use the uninsured rate from the PHA.

#### **The Non-TRICARE Enrolled Population Dental**

We were unable to find any data sources that provided estimates of private dental insurance (or the dental uninsured) for the RCSM population. The PHA does not ask about dental insurance coverage.

### Appendix D. Average Cost Elements

The Military Health System (MHS) Management Analysis and Reporting Tool (MART) (also known as M2) contains data on the cost of all medical and dental care produced within the MHS (direct care), all medical and dental care claims paid through the TRICARE programs (purchased care), and all pharmaceuticals. We used these data to construct estimates of the Department of Defense's (DoD's) total medical and dental spending for the Reserve component service member (RCSM) population and to produce average cost estimates for our cost model. The data sources and methodology are described below in greater detail. The actual average cost elements are contained in Chapter 5.

The first step in constructing our average medical cost elements was to construct the estimated total cost of all healthcare. This procedure required summing all direct-care cost (inpatient, outpatient, and drugs) and purchased-care claims (inpatient, outpatient) and drugs). All pharmacy cost data are available in the Pharmacy Data Transaction Service (PDTS) file, but some costs are also reported in direct-care and purchased-care data so we must apply restrictions to avoid double counting. The direct-care inpatient and outpatient data include the cost of pharmaceuticals provided by military treatment facilities (MTFs). To avoid double counting, we removed these costs from the PDTS data.<sup>1</sup> For purchased care, we removed pharmacy costs from the outpatient claims and relied on PDTS data.<sup>2</sup> For direct care, accurate data were not available for 2022 due to the MHS GENESIS rollout. To address this issue, we used cost data from 2018 and inflated them to 2022 dollars using the Defense Health Program (DHP) Deflator.<sup>3</sup> Table D-1 reports the source of each data element and details on the cost variables used. The same procedure is used for constructing aggregate dental costs for direct and purchased care.

<sup>&</sup>lt;sup>1</sup> We applied a filter to the PDTS data query excluding costs from source system equal to C, D, or V (direct care administered drugs, drugs from direct care pharmacies, and drugs paid for by VA for dual eligible).

<sup>&</sup>lt;sup>2</sup> We filtered pharmacy costs from purchased care claims by applying the filter program indicator code not equal to "D" for Drugs.

<sup>&</sup>lt;sup>3</sup> We selected 2018 because it was the most recent year without significant MHS GENSIS impacts. The DHP deflator is available in Table 5-7 of the National Defense Budget available here: https://comptroller.defense.gov/Portals/45/Documents/defbudget/FY2024/FY24\_Green\_Book.pdf.

System	Category	Source	Data Year*	Cost Variable
Direct Care	Inpatient	Standard Inpatient Data Record (SIDR)	2018	Full cost
	Outpatient	Comprehensive Ambulatory/Professional Encounter Record (CAPER)	2018	Full cost
	Dental	Medical Expense Performance and Reporting System (MEPRS) and Direct Care Dental Encounter Data (DED)	2018	Allocated total dental expense*
Purchased Care	Inpatient	TRICARE Encounter Data Institutional (TED-I)	2022	TRICARE paid
	Outpatient	TRICARE Encounter Data Non- Institutional (TED-NI)	2022	TRICARE paid
	Dental	Purchased Care Dental	2022	Amount paid
Purchased Care*	Pharmacy	Pharmacy Data Transaction Service (PDTS)	2022	Paid by TRICARE

#### Table D-1. Data Sources for Cost Elements

Source: 2018 data were used for direct-care data to avoid data quality issues created by MHS GENESIS rollout.

<sup>5</sup> Direct-care pharmacy costs are filtered out of the PDTS data because they are included in the direct-care inpatient and outpatient costs. PDTS costs include drugs obtained through the mail order pharmacy program, retail pharmacies, and other non-direct-care pharmacy sources. Total dental expenditures were identified from MEPRS but were not available by beneficiary group. We estimated expenditures for the RCSM beneficiary groups by allocated total expense based on dental weighted values from the DED file.

To develop cost elements specific to the RCSM population discussed in Chapter 3 and Appendix C, we constructed total costs for six specific beneficiary groups:

- Active RCSMs (Beneficiary category = Guard/Reserve on Active Duty (GRD))
- Dependents of Active RCSMs (Beneficiary category = Dependent of Guard/Reserve on Active Duty (DGR))
- Non-active RCSMs Using TRS (Beneficiary category = Inactive Guard/Reserve (IGR); HCDP = 306)
- Dependents of Non-active RCSMs Using TRS (Beneficiary category = IDG; HCDP = 306)
- Non-active RCSMs Using Other TRICARE Benefits (e.g., Transitional Assistance Management Program (TAMP), Early Alert, etc.) (Beneficiary category = IGR; HCDP ≠ 306)
- Dependents of Non-active RCSMs Using Other TRICARE Benefits (Beneficiary category = IDG; HCDP ≠ 306)

The total costs were then divided by the number of beneficiaries in each category to obtain average annual cost estimates for each beneficiary type.<sup>4</sup> The average cost for the RCSMs (or sponsors) were further stratified by officer/enlisted and age group. To generate rank-group-specific average costs, we constructed weighted averages of our average agebased estimates by applying the age distribution of each rank group.<sup>5</sup> For the dependent beneficiary categories, we constructed average costs for enlisted and officer dependents.

<sup>&</sup>lt;sup>4</sup> Average costs for direct care were constructed using 2018 cost data and populations counts. They were then inflated to 2022 dollars. Average costs for purchased care were constructed using 2022 cost data and population counts.

<sup>&</sup>lt;sup>5</sup> A rank group variable is available in M2, but we found significant problems with cost allocation to rank group for the direct-care data.

## Appendix E. Health Plan Elasticities

#### **Literature Review**

There is a large academic literature investigating how all categories of health spending and utilization respond to changes in prices or out of pocket (OOP) costs like copayments and deductibles (e.g., outpatient spending, inpatient spending, pharmaceutical spending, etc.).<sup>1</sup> One body of work in this literature focuses specifically on how demand for health insurance plans changes with changes in plan prices (or premiums). This literature often estimates elasticities using data from a single large employer. Researchers examine how employees change their health plan enrollment decisions as premium rates change. Table E-1 summarizes the range of elasticities produced by this literature. The studies are drawn from a major survey of the literature and are thought to be fairly comprehensive.<sup>2</sup> The range of elasticity estimates reported in the table is -.14 to .97. One study, Goldberg et al. (2015) produced elasticity estimates specific to military retirees, with estimates based on retiree use of TRICARE versus other health insurance (OHI). While the midpoint of the literature is roughly -.4, we used an elasticity of -.6 for our model; we selected this parameter value because it is closer to the TRICARE-specific elasticity found in Goldberg et al. (2015).

<sup>&</sup>lt;sup>1</sup> See "The elasticity of demand for health care a review of the literature and its application to the military health system," for an excellent review of this literature, https://www.rand.org/pubs/monograph reports/MR1355.html.

<sup>&</sup>lt;sup>2</sup> Jonas B. Pendzialek, Dusan Simic, and Stephanie Stock, "Differences in price elasticities of demand for health insurance: a systematic review," *The European Journal of Health Economics* 17 (2016): 5–21.

Citation	Data Source (Data Points)	Number of Plan Choices	Price Elasticity
Buchmueller (2006)	Data of retirees of a single employer (total 724)	3	-0.14 to -0.37
Buchmueller et al. (2013)	Data of University of Michigan retirees (total 3,182)	8	-0.02 to -0.07
Cutler and Reber (1998)	Data of Harvard University employees	2	-0.3 to -0.60
Liu and Christianson	Data from the Healthcare Group of Arizona and from	2	Without prior Insurance: - 0.12 to -0.14
(1998)	a researcher's survey (total 653)		With prior insurance: - 0.42 to -0.51
Royalty and Solomon (1999)	Data of University of Stanford employees	5	-0.45 to -0.76
Royalty and Solomon (1998)	Data of University of Stanford employees	2	-0.29 to -0.97
Feldman et al. (1989)	Data of 20 Minneapolis firms	2	-0.15 to -0.53
Short and Taylor (1989)	Data from 1977 National Medical Care Expenditure Survey (NMCES)	2	-0.05
Barringer and Mitchell (1994)	Data of a single company with four plans from employee payroll benefit	4	-0.1 to -0.2
Hosek et al. (1995)	Data of military personnel	2	-0.6
Marquis and Phelps (1987)	Data of families in RAND health insurance experiment	Not stated	-0.6
Goldberg et al. (2015)	Data from military individual-level data (181,153 observations)	3	-0.68
Abraham, Vogt, and Gaynor (2002)	Data from medical expenditure panel survey, cross-section and two- earner households	2	-0.13 to -0.14

Table E-1 Surve	v of Hoalth Plan	Prico Elasticita	. Estimatos
Table E-1. Surve	y ul nealth Flai		

*Source*: The table is reproduced from Jonas B. Pendzialek, Dusan Simic, and Stephanie Stock (2016) and supplemented with additional studies.

#### **Estimating Take-up Rates with Elasticities**

We used a simple methodology to derive our elasticity-based take-up rates, which form our best estimates of take-up behavior. The methodology requires three primary input variables: our baseline number of current TRICARE Reserve Select (TRS) users, the expected price change in TRS premiums relative to other health insurance (OHI) premiums, and our elasticity of -.6. To derive the number of new uptakes, we multiplied baseline takers by the price change and the elasticity. For example, if there were 100,000 TRS users and the expected price change was 50 percent, new takers would be calculated as:  $-.6^{*}-.5^{*}100,000 = 30,000$ .

To calculate the final number of TRS takers, we would add the baseline users, the estimated new takers, and the uninsured to obtain our new estimate of TRS takers. We would then divide the new estimate of TRS takers by the eligible population to obtain our predicted take-up rates. The actual calculations are carried out at the rank group level. Table E-2 shows the take-up rates derived using this methodology for the different policy reform scenarios.

		-				
	Premium-Free TRS (RCSM Only)		Premiun (RCSM and	Premium-Free TRS (RCSM and Dependents)		TRICARE me Remote
	Single RCSM	RCSM Families	Single RCSM	RCSM Families	Single RCSM	RCSM Families
EJ	41%	66%	41%	71%	43%	72%
ES	43%	64%	43%	69%	47%	71%
WO	35%	47%	35%	52%	39%	53%
OJ	51%	80%	51%	86%	57%	88%
OS	51%	69%	51%	75%	57%	77%
Total	42%	66%	42%	71%	45%	73%

Table E-2. Elasticity-Based Take Rates Used in Best Estimates

# Appendix F. PHA Data

IDA received Periodic Health Assessment (PHA) data for the last two months of fiscal year (FY) 2021 and all months of FY 2022. IDA selected FY 2022 as the principal year for our analysis. Table F-1shows the total number of unique observations in the PHA data for FY 2022 by Service and component.

Table F-1. FY 2022 Sample by Service and Component					
Service	Component	Unique Obs.	Percent		
	AGR	58,702	9.1		
Army	Guard	257,279	40.0		
	Reserve	106,575	16.6		
Navy	AGR	11,924	1.9		
	Reserve	34,884	5.4		
Marinaa	AGR	3,444	0.5		
Marmes	Reserve	21,323	3.3		
	AGR	25,289	3.9		
Air Force	Guard	71,752	11.2		
	Reserve	47,727	7.4		
Coast Cuard	AGR	1,009	0.2		
Coast Guard	Reserve	3,449	0.5		
Total		643,357	100.0%		

Next, we used the individual-level data to construct individual medical readiness (IMR) rates. Table F-2 shows IMR rates by Service and component, based on the individual-level PHA data.

Service	Component	Count	Fully	Partially	Not Ready
	AGR	56,639	71.1%	22.3%	6.5%
Army	Guard	250,007	66.6%	24.0%	9.4%
	Reserve	103,876	40.1%	58.1%	1.8%
Nova	AGR	11,923	72.8%	20.4%	6.7%
Navy	Reserve	34,882	70.7%	23.4%	5.8%
NA subscription	AGR	3,444	63.2%	30.7%	6.0%
wannes	Reserve	21,321	43.5%	50.0%	6.5%
	AGR	25,289	73.7%	23.7%	2.6%
Air Force	Guard	71,751	65.8%	31.4%	2.7%
	Reserve	47,726	66.2%	31.0%	2.7%
Coast Guard	AGR	1,009	68.1%	24.2%	7.7%
	Reserve	3,446	76.1%	11.9%	12.0%
Total		631,313	62.4%	31.6%	6.0%

Table F-2. Individual-level PHA Sample IMR Rates by Service and Component

IDA further dived into the characteristics of Reserve component service members (RCSMs), stratifying by readiness status and by insurance status. To determine readiness status, IDA used a dichotomous definition of readiness: (1) "medically ready" if a service member is fully medically ready or partially medically ready, or (2) "not-ready" if a service member is not medically ready. Table F-3 provides the demographic characteristics of our FY 2022 sample stratified by readiness status.

		Overall Readiness Rate %	Has Insurance Readiness Rate %	No Insurance Readiness Rate %
Age Categories	Count			
18-24	157,167	92.7	92.7	92.6
25-29	105,463	94.1	94.1	93.9
30-34	90,006	94.5	94.5	93.3
35-39	75,305	94.7	94.7	93.8
40-44	46,748	94.9	94.9	93.2
45-50	26,198	94.5	94.6	92.8
50+	32,457	93.9	93.9	92.3
Total	533,344	93.9	94.0	93.1
Gender				
Female	109,943	88.0	88.2	85.9
Male	423,445	95.4	95.5	94.7
Total	533,388	93.9	94.0	93.1
Rank Group				
JE (E1-E4)	223,390	92.6	92.6	92.7
SE (E5-E9)	216,530	94.1	94.1	94.0
JO (01-03)	45,923	96.0	96.0	94.8
SO (O4-O10)	39,156	97.1	97.1	95.7
WO (W1-W5)	8,391	95.6	95.5	96.3
Total	533,390	93.9	94.0	93.1
Service				
Army	353,750	92.8	90.2	90.4
Navy	35,052	94.2	94.1	94.6
Marines	21,392	93.5	93.1	95.4
Air Force	119,693	97.3	97.2	97.5
Coast Guard	3,500	88.1	88.0	86.7
Total	410,194	93.0	93.0	92.6
Status				
AGR	252	95.6	95.6	100.0
Guard	321,956	92.1	92.3	90.4
Reserve	211,182	96.7	96.6	97.5
Total	533,390	93.9	94.0	93.1

Table F-3. Demographics of PHA Sample and Their IMR Rates by Insurance Status,FY 2022

### Appendix G. Feasibility Analysis

Table 47 in Chapter 8 reports our family medicine access scores for large Defense Health Agency (DHA) market areas. To determine if our model data produced a similar market ranking to the market rankings based on survey data, we discussed the data available in the Annual Evaluation of the TRICARE Program. Figure G-1 provides the data. We conclude our model produces a similar market ranking, but with notable differences. Future work should continue to explore ways to validate and improve the TRICARE Network Assessment Model based on additional survey or administrative data sources.



*Source*: These data were taken from the fiscal year (FY) 2023 Annual Evaluation of the TRICARE Program (pg. 92); they are not specific to the TRICARE network. However, the data include direct care.

Figure G-1. JOES "Getting Care When Needed" Access Scores by Market, FY 2022

#### Family Medicine Results for Select States

#### Virginia

To provide greater detail on access among select states, Figure G-2 depicts spatial access to family medicine providers in Virginia. Notably, higher-access areas are evident

in densely populated metropolitan regions, particularly in Northern Virginia and Richmond, as indicated by the darker orange shading of ZIP Code areas. Interestingly, there are also unexpected areas of higher access, such as Highland in the Northwest, despite its lower population.



Figure G-2. Family Medicine Accessibility for TRICARE Beneficiaries in Virginia

Table G-1 offers a quantitative breakdown of accessibility levels across Virginia, derived from TRICARE beneficiary counts and segmented into five tiers. Overall, under 8 percent of Virginia beneficiaries are located in low- or very-low-access areas, while over 70 percent are in high- or very-high-access areas.

	Accessibility, %					
Area	Very Low	Low	Moderate	High	Very High	
Overall	4.1	3.6	21.4	52.9	18.0	
Prime Service Areas	3.4	2.6	21.2	55.8	17.0	
Non-Prime Service Areas	12.8	15.4	23.4	18.7	29.7	

 Table G-1. Weighted Percentages of TRICARE Beneficiaries' Accessibility to Family

 Medicine Providers in Virginia

#### Kentucky

Kentucky displayed significant areas of moderate to high levels of accessibility for family medicine services. Figure G-3 provides a visual representation of the access categories in Kentucky.



Figure G-3. Family Medicine Accessibility for TRICARE Beneficiaries in Kentucky

Table G-2 provides a quantitative breakdown of accessibility levels across Kentucky, as determined by TRICARE beneficiary counts, categorizing accessibility into five tiers. Overall, only 10 percent of beneficiaries are in low-/very-low-access areas, while 70 percent are in high-/very-high-access areas.

	Accessibility, %					
Area	Very Low	Low	Moderate	High	Very High	
Overall	2.8	7.2	20.0	35.4	34.7	
Prime Service Areas	1.8	5.8	18.8	40.1	33.5	
Non-Prime Service Areas	5.1	10.5	23.0	23.6	37.8	

 Table G-2. Weighted Percentages of TRICARE Beneficiaries' Accessibility to Family

 Medicine Providers in Kentucky

#### Texas

Texas displayed significant areas of moderate to high levels of accessibility for family medicine services, along with pockets of low and very low access. Figure G-4 provides a visual representation of the access categories in Texas.



Figure G-4. Family Medicine Accessibility for TRICARE Beneficiaries in Texas

Table G-3 provides a quantitative breakdown of accessibility levels across Kentucky, as determined by TRICARE beneficiary counts, categorizing accessibility into five tiers. Overall, roughly16 percent of beneficiaries reside in low-/very-low-access areas, while roughly 50 percent reside in high-/very-high-access areas.

	Accessibility, %						
Area	Very Low	Low	Moderate	High	Very High		
Overall	9.5	7.4	32.5	31.3	19.3		
Prime Service Areas	8.6	6.7	34.2	32.6	18.0		
Non-Prime Service Areas	14.0	10.9	24.1	25.0	26.0		

 Table G-3. Weighted Percentage of TRICARE Beneficiaries Accessibility to Family

 Medicine Providers in Texas

#### Minnesota

Minnesota was selected to represent a State with limited military presence. Minnesota displayed significant areas of moderate to high levels of accessibility for family medicine services, along with pockets of low and very low access. Figure G-5 provides a visual representation of the access categories in Minnesota.



Figure G-5. Family Medicine Accessibility for TRICARE Beneficiaries in Minnesota

Table G-4 provides a quantitative breakdown of accessibility levels across Minnesota, as determined by TRICARE beneficiary counts, categorizing accessibility into five tiers. Overall, roughly 24 percent of beneficiaries reside in low-/very-low-access areas, while roughly 45 percent reside in high-/very-high-access areas.

Medicine Fronders in Minnesota							
	Accessibility, %						
Area	Very Low	Low	Moderate	High	Very High		
Overall	10.8	13.2	30.4	30.4	15.2		
Prime Service Areas	2.9	7.8	2.3	85.7	1.3		
Non-Prime Service Areas	10.8	13.3	30.6	29.9	15.3		

 Table G-4. Weighted Percentages of TRICARE Beneficiaries' Accessibility to Family

 Medicine Providers in Minnesota

#### North Carolina

North Carolina is another State with a large military footprint. North Carolina displayed significant areas of high levels of accessibility for family medicine services, along with pockets of low and very low access. Figure G-6 provides a visual representation of the access categories in North Carolina.



Figure G-6. Family Medicine Accessibility for TRICARE Beneficiaries in North Carolina

Table G-5 provides a quantitative breakdown of accessibility levels across North Carolina, as determined by TRICARE beneficiary counts, categorizing accessibility into five tiers. Overall, roughly 14 percent of beneficiaries reside in low-/very-low-access areas, while roughly 73 percent reside in high-/very-high-access areas.

Medicine i Toviders in North Carolina								
	Accessibility, %							
Area	Very Low	Low	Moderate	High	Very High			
Overall	6.3	7.0	14.0	39.2	33.6			
Prime Service Areas	7.2	7.6	11.8	40.2	33.3			
Non-Prime Service Areas	4.5	6.0	18.3	37.1	34.1			

 Table G-5. Weighted Percentages of TRICARE Beneficiaries' Accessibility to Family

 Medicine Providers in North Carolina

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# Abbreviations

AC	Active Components
ACA	Affordable Care Act
AD	Active Duty
ADDP	Active Duty Dental Program
ANG	Air National Guard
ARNG	Army National Guard
BCBS	Blue Cross Blue Shield
BH	Behavioral Health
CAPE	Cost Assessment and Program Evaluation
CAPER	Comprehensive Ambulatory/Professional Encounter Record
CBO	Congressional Budget Office
CRS	Congressional Research Service
DED	Direct Care Dental Encounter Data
DEER	Defense Enrollment Eligibility Reporting System
DGR	Dependent of Guard/Reserve on Active Duty
DHA	Defense Health Agency
DLMC	Deployment Limiting Medical Conditions
DMDC	Defense Manpower Data Center
DNA	Deoxyribonucleic Acid
DoD	Department of Defense
DoDI	Department of Defense Instruction
DRC	Dental Readiness Classification
FEHB	Federal Employees Health Benefit
FMR	Fully Medically Ready
FTE	Full Time Equivalents
FTS	Full-Time Support
FY	Fiscal Year
GEHA	Government Employees Health Association
GRD	Guard/Reserve on Active Duty
HDHP	High-Deductible Health Plan
HIV	Human Immunodeficiency Virus

HMO	Health Maintenance Organization
IDA	Institute for Defense Analyses
IGD	Dependent of Inactive Guard/Reserve
IGR	Inactive Guard/Reserve
IMR	Individual Medical Readiness
KFF	Kaiser Family Foundation
MEPRS	Medical Expense Performance and Reporting System
MGMA	Medical Group Management Association
MHA	Mental Health Exam
MHS	Military Health System
MHS MART	Military Health System Management Analysis and Reporting Tool
MRI	Medically Ready Indeterminate
MSC	Millennium Cohort Study
MSO	Military Service Organizations
MT	Military Technicians
MTF	Military Treatment Facility
NDAA	National Defense Authorization Act
NGAUS	National Guard Association of the United States
NMR	Not Medically Ready
OHI	Other Health Insurance
OOP	Out-of-Pocket
OSD	Office of the Secretary of Defense
PDTS	Pharmacy Data Transaction Service
РНА	Periodic Health Assessment
PMR	Partially Medically Ready
POS	Point of Service
PPO	Preferred Provider Organization
PSA	Prime Service Area
RC	Reserve Component
RCSM	Reserve Component Service Member
RHRP	Reserve Health Readiness Program
ROA	Reserve Organization of America
RSM	Reserve Master file
SELRES	Selected Reserve
SIDR	Standard Inpatient Data Record
SME	Subject Matter Experts

Status Quo
Transitional Assistance Management Program
TRICARE Dental Program
TRICARE Encounter Data Institutional
TRICARE Encounter Data Non-Institutional
Total Force Medically Ready
TRICARE Reserve Select
United States Code
Air Force Reserve
United States Army Reserve
United States Coast Guard Reserve
United States Marine Corps Reserve
United States Navy Reserve
Department of Veterans Affairs

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