# MILITARY HEALTHCARE BENEFIT DESIGN AND DELIVERY

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**Over the last decade, personnel costs have been the fastest rising component of the Department of Defense (DoD) budget, driven to a considerable degree by healthcare. Concerned about the impact of rising healthcare and other personnel costs on military readiness, the Congress established the Military Compensation and Retirement Modernization Commission (MCRMC) to perform a systematic review of the military compensation and retirement systems and to make recommendations for modernization.**

IDA was asked to support the MCRMC in their consideration of potential modifications to the provision of health-related services. We estimated the cost of an alternative way of providing care to a large segment of DoD's beneficiary population: dependents of military personnel, retirees, and their dependents.

Currently this population is served through a combination of care provided in DoD-owned and -operated facilities and care purchased in the private sector through the TRICARE system. Under TRICARE, DoD purchases care on a fee-for-service basis at no or very low cost to beneficiaries. The design of TRICARE does not encourage economical use of medical services by either patients or health care providers.

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We compared the cost of continuing to use TRICARE with the cost of providing health care through a system like the Federal Employees Health Benefit Program (FEHBP), the one available to DoD civilians and other U.S. government employees. The specific options available under FEHBP vary by state, but, in general, it offers a menu of plans with different characteristics regarding cost and coverage from which employees can choose.

Using the observed enrollment behavior of the FEHBP civilian population in conjunction with demographic data on the DoD beneficiary population, we developed a simple cohort-based methodology to predict the plan enrollment behavior that would result if DoD were to purchase healthcare through an FEHBP-like program. A series of analytically derived adjustments to FEHBP plan premiums to reflect the health risk of the DoD population was also developed. Plan choice and premiums were then used to construct the total cost of covering the relevant beneficiary population through this FEHBP-like model. The final cost estimate

indicated that the population could be covered for approximately $18 billion per year. This figure represents the estimated cost of delivering care in steady state equilibrium after allowing for a period of transition.

We then estimated the cost of covering the same beneficiary population under TRICARE. We included all costs incurred while delivering care that would be covered by premiums under a private health insurance model. We calculated the cost of coverage under TRICARE to be approximately $21.2 billion, suggesting budgetary cost savings in the range of $2 billion to $4 billion, with a best estimate of just over $3 billion.

These savings, however, do not reflect the full value of switching to a private health insurance model because benefit quality would rise under the new FEHBP-like benefit. To account for the increase in quality, we developed an analytical concept to approximate the full potential savings that would result if benefit quality were held constant between the current TRICARE model and the proposed FEHB like model. We call this concept the “full cost savings” from switching to private health insurance and estimated that it would equal about $7.5 billion.

The MCRMC recommended the adoption of an FEHBP-like plan in its report to the President and Congress.

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