



CBO Report Concerning Health Care

The Congressional Budget Office (CBO) is releasing three volumes relating to health care financing and delivery. Volume One was released in December 2008, concerning key issues in analyzing major health insurance proposals. Volume Two are budget options for health care issues. Volume Three will be released in 2009 and will talk about budget options for non-health issues. None of the reports makes any recommendations. You can find the reports on their web site, www.cbo.gov.

BACKGROUND ON THE ISSUE:

The health options volume comprises 115 discrete options to alter federal programs, affect the private health insurance market, or both. It includes options that both reduce or increase spending or revenues. It provides estimates of budgetary impact for specific proposals.

Among the 115 health care options in the report, four options are related to veterans' health, and three are related to military health care.

Veterans' Health Care Options

- ★ (Option 28) End enrollment in VA medical care for priority groups 7 & 8
- ★ (Option 29) Reopen enrollment in VA medical care priority group 8 for 5 years
- ★ (Option 48) Support development of VistA to meet standards and encourage adoption
- ★ (Option 98) Require copayments for medical care by veterans without service connected disabilities

Military Health Care Options

- ★ (Option 95) Increase cost sharing for active duty family members
- ★ (Option 96) Introduce minimum out-of-pocket costs under TRICARE for Life
- ★ (Option 97) Increase cost sharing for retirees who are not yet eligible for Medicare

Causing quite a stir on blogs and forums is the military health care option (Option 96) that would introduce minimum out of pocket requirements under TRICARE for Life (TFL). Because the Defense Department is a passive payer in the program, it has virtually no means of controlling the program's costs, which amounted to about \$8 billion in 2008.

Under this recommended option, those on TFL would not cover any of the first \$525 of an enrollee's cost-sharing liabilities for calendar year 2011 and would limit coverage to 50% of the next \$4,725 in Medicare cost sharing that the

beneficiary incurred. These dollar amounts would be indexed to growth in average Medicare costs for later years. Defense Department would also need to establish procedures for collecting payments from TFL beneficiaries using military treatment facilities.

The report says the positives are that there would be a savings to the government of about \$14 billion through 2014, and about \$40 billion through 2019. It says 22% of those savings would come from a reduced demand rather than a transfer of spending from the government to the TFL beneficiaries. It says that TFL beneficiaries would be more aware of their out of pocket costs, and therefore promote a restraint in their use of medical services; that research has shown that a modest increase in cost sharing can reduce medical expenses without causing measurable increases in adverse health outcomes.

The report says the negatives include discouraging some patients from seeking preventive medical care or from managing their chronic conditions under close medical supervision, which might negatively affect their health.

Military health care is expensive. In fiscal 2006, TRICARE costs ran about \$36 billion. Estimates put health care costs at over \$64 billion by 2015, making up over 12% of that year's estimated defense budget.

OUR PERSPECTIVE:

For the last three fiscal years, the Defense Department has tried to balance the health care budget on the backs of the beneficiaries. And for the last three fiscal years, Congress and The Military Coalition members, including EANGUS, have fought any increases in fees, premiums, co-payments and deductibles, and successfully, too. Rest assured that we will remain vigilant and vibrant on Capitol Hill for next fiscal year as well.

EANGUS and The Military Coalition believe that the price for military health care, to include TFL, has already been paid in sacrifice, loss of quality of life, disruption in the lives of our members and families, diminished earnings, and other non-tangible ways that the average American cannot and will not pay.

We also believe there are inherent inefficiencies and potential for cost savings embedded in the bureaucracy of administering the TRICARE program, and that those inefficiencies and bureaucracy need to be addressed before considering financial encumbrances on beneficiaries.

Finally, suggested options and recommendations do not ensure any greater access to providers, increased quality of service, or better payments to providers. TRICARE is one of the lowest paying health care systems in payments to providers, prompting many not to accept TRICARE patients and compromising the provider's patriotism due to the low amount of payment.