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CHAPTER 12

TRICARE RESERVE SELECT: WOULD EXTENDING ELIGIBILITY TO ALL RESERVISTS BE COST EFFECTIVE?

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Introduction

Since 1990, the role of the reserve components of the U.S. military has evolved from primarily augmenting active forces during times of war to making ongoing contributions to operations overseas and at home on a regular basis. Previously, members of the guard and reserves rarely served beyond the time needed to fulfill their normal training and drill duties. Today, however, they face a much higher probability of involuntary activation, and are also volunteering for active duty more frequently.

Before 1990, reservists contributed fewer than one million duty days annually. After 1990, their number of active duty days grew rapidly, leveling off at approximately 13 million in the second half of the decade. During this time, a small but very important cadre of reservists started volunteering for service beyond their minimum duty days. This created, in effect, a part-time workforce that could be called upon to meet increased operational demands.

In response to the September 11, 2001 attacks and to support operations in Iraq and Afghanistan, reserve contributions to military operations increased even more, under a partial mobilization authorized by the President. About 75,000 reservists were serving on active duty six months after the September 11 attacks; that number almost tripled to 212,000 in the early phases of the war and remained high afterwards. As of September 2008, 116,000 reservists were serving on active duty.[1]

In the future, significant overseas operations will continue to require a substantial level of voluntary and involuntary reserve participation. To optimize the reserve components as a contingent workforce, capable of supplying personnel as needed, the Department of Defense (DOD) has implemented what it calls a *continuum of service*. Under this concept, reserve contributions could range from 0 to 365 days on active duty, while varying over time (U.S. Department of Defense 2002). Such

a fundamental change in the terms of reserve service will require corresponding changes in compensation and benefits as incentives for increased participation, and to fairly reward reservists who make significant contributions of their time. The reserve health benefit, in particular, needs reshaping to ensure adequate and appropriate coverage.

Until recently, the reserve health benefit reflected the standby role the reserve components played prior to 1990. It was not well suited to the patterns of reserve service in the 1990s, and was even more incongruent to the substantial reserve contributions after September 11. Under the reserve health care benefit, reserve members called to active duty for at least 30 days received comprehensive health benefits, including all needed health care services. Their families also became eligible for family coverage in TRICARE, the military's health plan.[2] Reservists who served on active duty for 30 days or less were not eligible for a family health benefit (although health care for the reservist is always provided for service-connected health conditions). In addition to TRICARE, many reserve families have civilian insurance coverage as well, obtained through their civilian employers or other sources. This coverage may or may not continue when the reservist is activated.

Beginning in 2004 and in each subsequent year, Congress has enacted a number of important health benefit enhancements intended to reflect the integral role played by reservists in military operations. For the first time, for example, a health benefit was established for some nonactivated reservists. When initially enacted in 2005, this benefit was available to members of the selected reserve based on each period of continuous service of 90 days in support of a contingency operation. Reservists and their dependents were eligible to enroll in a subsidized health plan for one year based on each 90-day period of service. The health plan is called TRICARE Reserve Select (TRS)[3] and includes a required premium contribution ($233 for family coverage and $75 for single coverage during 2005). Congress continues to review options to expand this benefit to make it available to all selected reserve members.

The reasons cited by members of Congress for these enhancements were:

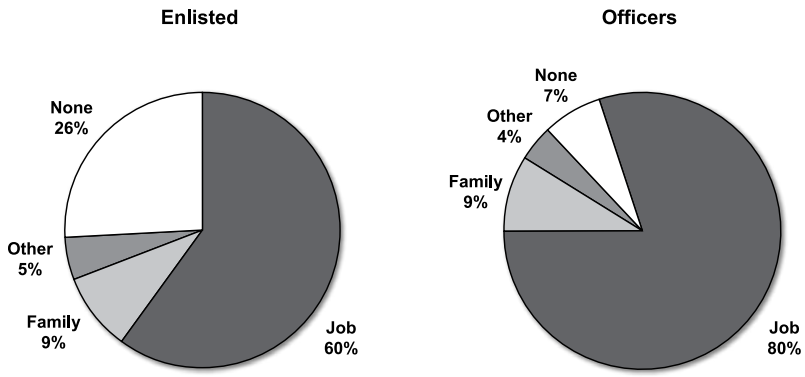
- **Adequate health coverage for all reservists.** Some reservists do not have civilian health insurance and an enhanced plan would provide them with an inexpensive health insurance option. And for those who do have other health insurance, more frequent activations often require moving from a civilian health plan to a military health plan and back again. At the very least, switching health plans is inconvenient during an already stressful period.
- **Medical readiness of deploying reservists.** Too many mobilized reservists either require medical treatment before they can deploy or are found to have medical conditions that preclude deployment. Some observers believe that lack of health insurance may be a contributing factor.

- **Robust recruiting and retention in the reserve components.** The reserve components face challenges in meeting their recruiting and retention goals. A more generous health benefit would enrich the reserve compensation package, although it is far from certain whether health benefits would be more cost effective in boosting recruiting and retention than other types of compensation.

This chapter draws on prior research and more recent data to discuss whether making TRS available to all reservists would meet the objectives listed above.[4] It also provides a general discussion of future costs if the TRS benefit were extended to all reservists. The chapter begins with descriptive information on uninsured reservists, which will serve as background for exploring the likely effectiveness of a more broadly available TRS, and concludes with observations based on actual experience in DOD in the first years of implementation.

Uninsured Reservists

When examining civilian health insurance coverage for reserve members, the data indicate that almost all officers have insurance, primarily through their employers (Figure 1). In contrast, only 74 percent of enlisted personnel have coverage. Overall, the survey showed that 22 percent of guard and reserve members in units (excluding military technicians since they are eligible for the Federal Employee Health Benefit Plan) had no health insurance in 2000. This figure dropped only slightly to 20 percent in the May 2003 Reserve Status of Forces Survey, but rose to 30 percent in the December 2006 Reserve Status of Forces Survey.[5]



Source: 2000 Survey of Reserve Component Personnel.

FIGURE 1. RESERVE AND GUARD CIVILIAN INSURANCE COVERAGE, 2000

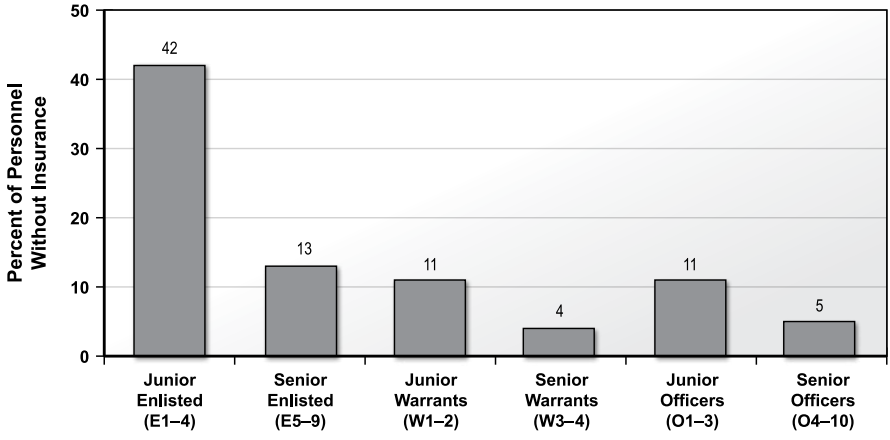
Whether TRS will significantly lower the percentage of reservists without coverage depends on who is uninsured and why. For example, 42 percent of junior enlisted personnel are without insurance (Figure 2). But only 13 percent of senior enlisted members, and 11 percent of junior officers, are uninsured. The number goes down even more among senior officers; only 5 percent lack coverage. These data are consistent with data from the May 2003 and December 2006 Reserve Status of Forces Survey.

Enlisted reservists without health insurance have relatively lower incomes than those with coverage (Figure 3). Almost 60 percent of the uninsured earned less than $2,000 per month in 2000, about twice the poverty level for a family of two. (This was also the average family size for enlisted reservists that year.) For these low-income families, even a small premium may be more than they are willing or able to pay for insurance. Income levels among insured reservists, in contrast, were significantly higher, with only 20 percent earning less than $2,000 per month.

To identify more comprehensive characteristics of the uninsured, we analyzed civilian health insurance coverage data from the 2000 reserve survey. The analysis identified several factors associated with a reservist's lack of health insurance, including:

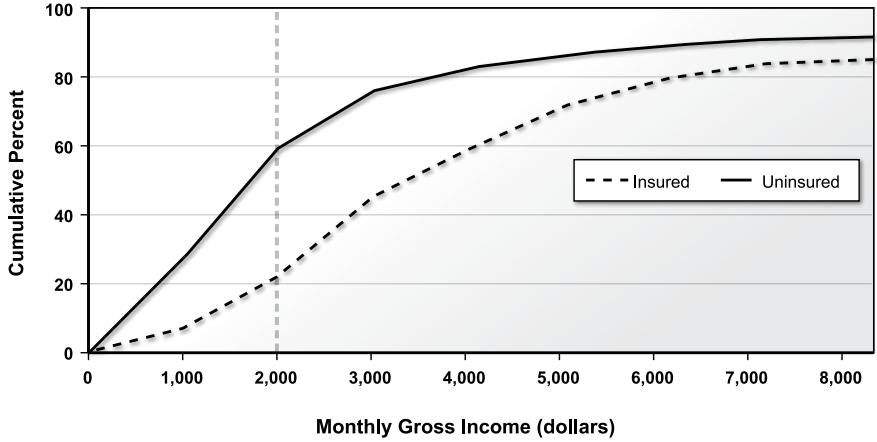
- Military status such as pay grade and reserve component.
- Demographic characteristics such as gender, age group, race, ethnicity, and educational attainment.
- Family characteristics such as marital status, number of dependents, and income.
- College enrollment or employment status. If employed, we examined the type of civilian business, including self-employment, public sector, private sector with fewer than 100 employees, private sector with 100 to 499 employees, private sector with 500 or more employees, and whether full or part time.
- Spouse's employment status and whether the spouse was working full or part time in a federal civilian job or a nonfederal civilian job.
- Location, such as whether the reservist resided in an urban, suburban, or rural area. Other research has shown that employer-sponsored health coverage is less prevalent in rural areas because of smaller firm sizes and lower wages in those areas (Coburn et al. 1998).

Due to the large disparity in coverage rates between enlisted personnel and officers, we anticipated that the relationships between some of these factors and insurance coverage might differ for the two populations. Therefore, we carried out separate enlisted and officer analyses (including warrant officers and commissioned officers). As anticipated, differences between the two populations were apparent.



Source: 2000 Survey of Reserve Component Personnel.

Figure 2. Percent of Reservists Without Civilian Health Insurance, 2000



Source: 2000 Survey of Reserve Component Personnel.

Figure 3. Income Distribution for Enlisted Reservists With and Without Civilian Health Insurance, 2000

For officers, who rarely lack insurance, there was little association between being uninsured and many of the factors in the analysis. For enlisted personnel, in contrast, the analysis showed significant relationships between being uninsured and all the characteristics listed above, with the exception of education. The prevalence of insurance among enlisted members increased with age and rank, and, consistent

with the results above, rates for all personnel increased with income. The likelihood of being insured varied only modestly based on a reservist's component. Compared to the Air National Guard, the Army Reserve had fewer enlisted members with insurance; the Naval Reserve, Marine Corps Reserve, and Air National Guard had more insured enlisted members.

Most noteworthy for both enlisted personnel and officers are the results related to reservists' employment (Table 1). Our analysis evaluated the likelihood of being uninsured based on employment characteristics such as whether and how much the member works, the type of employer, and spousal employment status. For each characteristic, a comparison group was identified: employed full time (employment status), employed by the federal government (employer type), and not employed (for spousal employment).

Table 1. Relationship Between Employment and Health Insurance Status (Difference in Probability of Being Uninsured)

	Officer	Enlisted
Employment Status		
Employed full time	—	—
Employed part time	**5.0%**	**10.7%**
Temporary employee	5.6	6.5
Unemployed	**16.1**	**20.6**
Employer Type		
Federal government	—	—
State government	-2.0	-0.7
Local government	0.3	-3.0
Large firm	**-1.7**	-0.5
Midsize firm	0.8	**3.6**
Small firm	0.2	**9.9**
Self-employed	**9.9**	**24.7**
Spouse Employment Status		
Not employed	—	—
Employed in federal job	1.2	-1.6
Employed in other job	-0.8	**-7.2**
Not Married	**6.5**	**4.3**

Note: Differences that are statistically significant at the .05 level are in bold type. A positive number means a group is more likely to be uninsured; a negative number means they are less likely to be uninsured (or more likely to be insured).

Compared to permanent full-time workers, part-time and temporary workers are more likely to be uninsured. However, the five to 10 percentage point spread among full-time, part-time, and temporary workers is dwarfed by differences between working members and the unemployed. Unemployed enlisted personnel were uninsured at a rate nearly 21 percentage points higher than enlisted personnel who were employed full time; the difference for officers—16 percentage points—is even more striking, considering the small number of officers who lack health insurance.

As expected, compared to members who work for large and public employers, those working for small private employers are less likely to have health insurance. The likelihood of being uninsured is even higher for self-employed reservists, especially in the enlisted ranks.

Nine percent of both enlisted and officer reservists get health insurance through a family member (Figure 1). Most of this insurance appears to be from a spouse's employer; in fact, for enlisted personnel the analysis shows that having a working spouse instead of a non-working spouse decreases the likelihood of being uninsured (Table 1). Single members are more likely to be uninsured.

Insurance coverage among reservists has been declining over time. The number of junior reservists without health insurance increased between 1992 and 2000—from 35 to 42 percent. It is possible that changes in the reserve population led to this decrease in insurance coverage. For example, those who work full time for large or public employers are more likely to have insurance than those who are self-employed or unemployed, or who work part time or for small private employers. Thus, if the fraction of reservists employed by large or public employers declined between 1992 and 2000, the fraction of reservists without insurance would have increased. Alternatively, the decline in coverage rates among reservists could have sprung from a general decline in insurance coverage by civilian employers. This would happen if some employers stopped offering coverage or fewer reservists took the coverage offered to them. Of course, both explanations could be valid.

Our analysis of the survey data over this period showed that the increase in uninsured reservists was entirely due to changes in the civilian insurance market. In other words, similar people working for similar employers were more likely to be uninsured in 2000 than in 1992. In fact, in the absence of these shifts in the civilian insurance market, changes in the composition of the reserve force over that period would have resulted in a decrease in the percentage of uninsured reservists, rather than the increase that actually occurred.

Clearly, gaps in health insurance coverage for reservists are a reflection of the nature of health insurance in the United States. Numerous studies have investigated why so many Americans are uninsured and evaluated the cost-effectiveness of policies designed to correct this situation. The ability or willingness to pay for insurance, for example, is one important factor in determining the number of people who are uninsured (McLaughlin 2004).[6]

Potential Outcomes of Universal TRS

Earlier we outlined three objectives of extending health benefits to nonactivated reservists: ensuring all reservists have health insurance, maintaining reservists' medical readiness for deployment, and enhancing recruitment and retention. The first two aspects focus on uninsured reservists. Our analysis so far has shown that uninsured reservists tend to be in the junior enlisted ranks and either unemployed or self-employed. Their incomes are relatively low. Would universal TRS reduce the number of uninsured reservists? If reservists do enroll, would universal TRS improve medical readiness? For all reservists, would universal TRS enhance recruiting and retention? Finally, would universal TRS be cost effective for DOD?

Would Universal TRS Reduce the Number of Uninsured Reservists?

If a military health plan were offered to all members of the guard and reserve, those without health insurance would participate if they valued the benefits more than the premium they would have to pay. The 2000 reserve survey included a question designed to measure reservists' willingness to pay for a military health plan. The question was very general: "If you could buy medical insurance through National Guard/Reserve participation, what is the maximum premium cost you would be willing to pay per month?" Possible responses to this question were defined in $50 increments from "Less than $100 per month" to "More than $300 per month."

A large fraction of uninsured reservists reported that they would be interested in purchasing health insurance if the monthly premium were under $100 (Figure 4). Yet survey results indicate that the monthly premium would have to be reduced to substantially below $100 to attract significant participation by uninsured reservists. Actual enrollment experience supports these survey results: enrollment in TRS is less than four percent of the members eligible to enroll in the program (30,000 members as of September 2008). Of those members who have enrolled in TRS, 62 percent elected family coverage (at the 2008 rate of $253 per month) and 38 percent elected single coverage (at $81 per month).

Uninsured reservists' limited willingness to pay for health insurance is not surprising. Numerous researchers have studied the demand for insurance among the uninsured, and among low-income workers in particular. These researchers have consistently concluded that very few of the uninsured are willing to pay even modest premiums for health insurance.[7] Healthy workers appear to place a relatively low value on protecting themselves against low-probability, high-cost illnesses (Ellis 1989, Marquis and Holmer 1996).

In fact, there is evidence that uninsured workers refrain from obtaining routine health care and receive uncompensated services when they need expensive health care (Johnson and Crystal 2000). State programs that offer low-cost health insurance

to reduce the number of uninsured have had modest success in expanding coverage rates at best, while crowding out some private health insurance (Kronick and Gilmer 2002). Expansions in Medicaid eligibility have also impacted private insurance (Cutler and Gruber 1996), in part because of low compliance with "Medicaid as second payer" provisions (Glied and Stabile 2001).

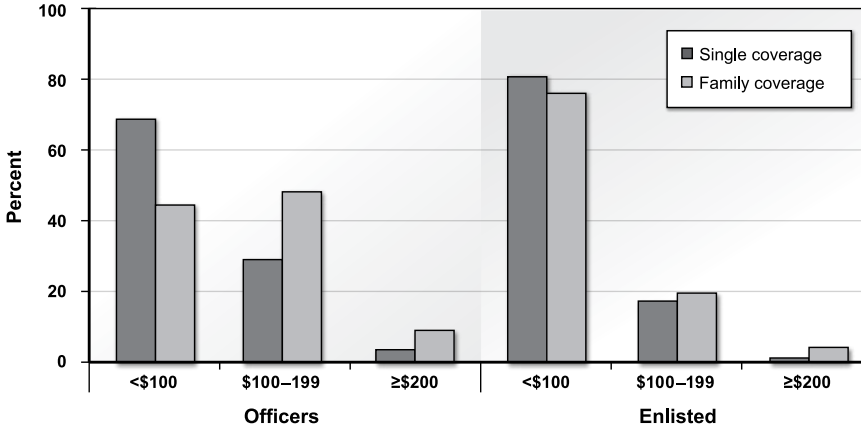


Figure 4. Uninsured Reservists' Willingness to Pay for a Military Health Plan

Thus, extending the current TRS benefit to all reservists would likely attract very few members to the program—principally those who are self-employed and therefore not eligible for employer-subsidized insurance, or who have family members with significant and costly health care needs. Eliminating or substantially reducing the premium could attract more of the uninsured, but, as discussed below, the costs for DOD would be extremely high.

Would Universal TRS Improve Medical Readiness?

For the 80 percent of reservists who have health insurance, universally available TRS is unlikely to have an appreciable effect on their health status and medical readiness to deploy. Some of these individuals may have insurance that requires substantial cost sharing for health care, but TRS is based on a TRICARE option that also requires cost sharing—an annual deductible of $150 per person and $300 per family with a cost share of 20 percent (or 15 percent for providers in the TRICARE network). Insured reservists who choose to drop more expensive civilian plans and enroll in TRS would likely increase their utilization of health care services, but the change would be modest.

Thus, the policy discussion has focused on the remaining 20 percent of reservists who are uninsured and whether lack of insurance has kept them from seeking the care needed to ensure their medical readiness.

In order for universally available TRS to increase reserve component readiness, uninsured reservists would have to avail themselves of the coverage, and having coverage would have to improve their health. The previous section concluded that universal availability of the current TRS benefit would not likely lead to universal coverage. Many reservists would view monthly TRS premiums as too high and choose not to participate. Even if TRS did enroll all uninsured reservists, it is far from certain that medical readiness would substantially improve.

Health insurance coverage is often believed to increase access to health care services, and thus improve the health status of the covered population. However, while most research in this area has examined differences in access to health care, it has not examined the actual impact on *health* (Ross and Mirowsky 2000). Hence, whether having health insurance has a positive effect on health is still an open question.

Moreover, most of the studies that do examine the relationship between health insurance and health status do not establish a causal relationship (Levy and Meltzer 2001), but rather analyze the association between the two. That is because the causal relationship between health and health insurance is likely to run in both directions—that is, while having insurance affects health, health status affects insurance coverage. Individuals with medical conditions, for example, may be more likely to have—and value—health insurance; young, healthy individuals may not see the need for insurance. Failing to take into account this relationship may lead to counterintuitive (and spurious) conclusions about the impact of health insurance on health. For example, several studies have found that people with publicly funded insurance are generally less healthy than the uninsured, even after considering observable socioeconomic factors (Ross and Mirowsky 2000).

But even the studies that take these causal relationships into account provide little evidence that insurance improves health. These studies, documented by Levy and Meltzer (2001), have usually analyzed situations where policy or other changes caused variations in coverage. Such situations offer opportunities to estimate the effects of insurance on health. However, these studies examine very particular and specific health outcomes (e.g., blood pressure or outcomes related to childbirth) in vulnerable populations (e.g., low-income individuals and the elderly). The bulk of the evidence from these studies points to a small positive effect of insurance coverage on health, but it is difficult to extrapolate that impact to a broader and more diverse population.

There are some studies that have tried to address the impact of health insurance on more general health outcomes in a broader spectrum of the population. The RAND

Health Insurance Study randomly assigned different levels of health insurance to a sample of families in six areas of the United States. The study followed those families for three to five years, collecting voluminous information on their health care utilization and health outcomes. One of the experimental options offered essentially no insurance and others provided insurance plans with different levels of cost sharing.[8] Members of families assigned to plans with higher cost sharing substantially decreased their health utilization, but the average individual within this group experienced little or no adverse effect on their health (Newhouse 1993). The most disadvantaged participants—those who were poor and sick when the study began—did experience modest adverse consequences, but these negative impacts were limited to 6 percent of the study population, and to individuals who were very different from military reservists.

In another study, Perry and Rosen (2001) analyzed how the self-employed and wage earners differ with respect to insurance coverage and health status. They found that, even though the self-employed are 25 percent less likely to have insurance, their health does not appear to be any worse than that of wage earners. Therefore, their study also suggests that the link between insurance coverage and health status is weaker than one might imagine, and that genetics, the environment, and health behaviors are likely to be more important determinants of overall health (Perry and Rosen 2001).

While reservists' general health status may not be overtly affected by insurance, it is possible that specific conditions precluding deployment could be identified and treated if reservists sought care more regularly due to having insurance. To see whether this might be the case, the Defense Manpower Data Center (DMDC) investigated the insurance status of reservists who were activated but not medically ready to deploy (that is, had a medical hold).[9] Overall, 80 percent of these reservists were insured—the same percentage as in the general reserve population. Based on this straightforward analysis, it does not appear that lack of health insurance is a major factor in the reserve components' medical readiness.

Would Universal TRS Enhance Recruiting and Retention?

Little research has been done regarding health benefits and the recruiting and retention of either active duty or reserve personnel. We can be certain, however, that any effect on personnel supply would correlate to the value military personnel and potential recruits place on such benefits.

In large part, the value of the TRS benefit to a reservist depends on whether he or she is already eligible for insurance from an employer or other source. As indicated earlier, reservists who are not eligible for other insurance would place a value on TRS equal to the difference between the benefit they derive from the plan and the premium contribution required to enroll. If few uninsured reservists enroll, we can infer that this value is small (or even negative).

Reservists who are eligible for other insurance would value TRS in the same way, but their valuation would be relative to the other insurance. These reservists would replace their current plan with TRS if they thought it offered better benefits, lower costs, or both. Therefore, the decision by an already insured, employed reservist to enroll in TRS would be analogous to an employee choosing between two different health care plans at work, except that the reservist would be choosing between plans offered by two different employers. If a significant number in this population enrolled in TRS, it would imply that its value to the reservist is relatively high. However, as discussed below, any contributions to recruiting and retention would come at a very high cost to DOD.

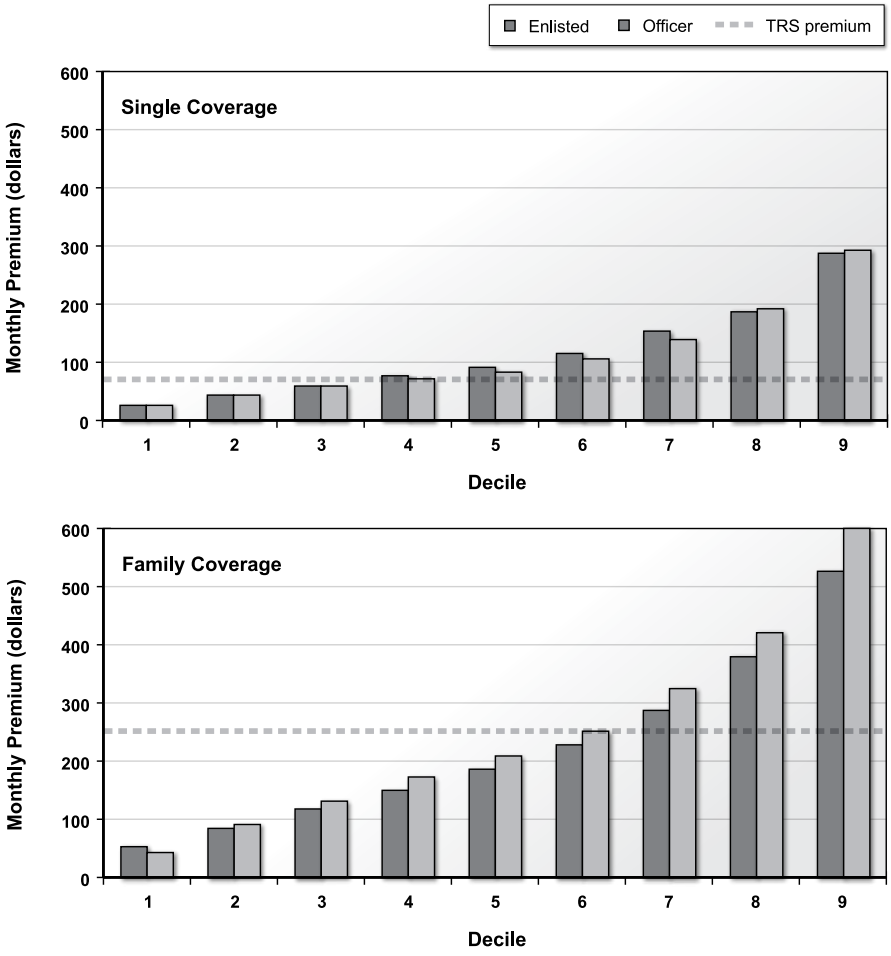
Studies of employee health plan choices consistently find that they are influenced by differences in premium contributions (the share of the premium the employee pays). A review of the literature (Scanlon et al. 1997) concludes that little is known about the effects of other factors, although plan benefits and provider choice appear to play a role. Sensitivity to the premium contribution is stronger for younger and healthier employees (those most likely to be reservists) than it is for older employees who have recently had a serious health problem (Strombom, Buchmueller, and Feldstein 2002).

Therefore, the demand among reservists for a universal TRS benefit would depend largely on the monthly contribution required, compared to their employers' health plans. Other factors affecting demand for the TRS plan might include how it compares to employer plans in terms of cost sharing; the range of medical services covered; provider choice, access, and quality; and the administrative burdens associated with enrollment and reimbursements. Although difficult to predict, the relative importance of these factors is likely to be lower than the importance of premium contributions.

In order to assess the value of TRS (or any other military health benefit) to already insured reservists, we need to know what they are paying for coverage supplied by their civilian employers. Since reserve surveys have not asked about employee premium contributions, we extrapolated those costs from the 2000 National Health Interview Survey (NHIS).[10]

The survey showed that the average employee premium contribution for employer-sponsored health insurance increased by 73 percent over this five-year period, but the *percentage of the premium* contributed by employees did not change. In other words, increased contributions were due to increases in the overall cost of health insurance, not to employers shifting greater portions of insurance costs onto employees.

Figure 5 shows estimated civilian employee premium contributions for enlisted and officer reservists, with and without dependants. The two graphs plot the distribution of employee premium contributions by decile. They depict which reservists are likely to pay higher or lower premium contributions at work compared to TRS.



Note: Imputed from the 2000 National Health Interview Survey and updated to 2005. Each decile reflects 10 percent of the population.

Figure 5. Distribution of Employee Premium Contributions, 2005

The upper graph in Figure 5 shows the distribution of employee premium contributions for single coverage; the lower graph depicts family coverage. Based on our extrapolations, looking at the 10th decile for single coverage, we see that 10 percent of enlisted reservists pay under $23 for their own insurance, while 10 percent of officers pay under $24. In the 20th decile, another 10 percent pay between $23 and $42 monthly. At the upper end of the distribution, 10 percent of enlisted and officer personnel pay more than $287. Workers at the upper end of the distribution are

almost certainly bearing the full cost of their insurance coverage (perhaps because they are self-employed). Across most of the distribution for single coverage, officers pay about 8 percent less for their insurance than enlisted personnel do.

These estimated premium contributions are naturally higher for family coverage because the health plans cover more people. In addition, employers typically require employees to contribute a larger share of the premium for family coverage than for single coverage—survey results indicate that employees pay only 16 percent of premiums for individual health plans, compared to 26 percent for insurance that also covers dependents. Across much of the distribution, the employee contribution for family coverage is about 125 percent higher than it is for single coverage.

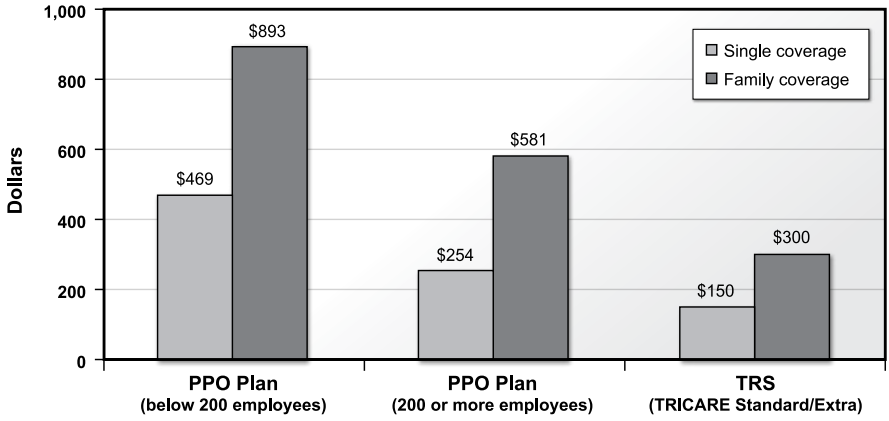
Among plans that cover dependents, 10 percent of enlisted personnel pay $56 or less, and 10 percent of officers pay $48 or less. Median premium payments for enlisted personnel and officers are $150 and $173, respectively, and the 90th percentile figures are $525 and $600, respectively. In contrast to single coverage, family coverage costs officers slightly more (generally, 11 percent) than it costs enlisted personnel. The exception is in the lowest percentile, where enlisted contributions are 14 percent higher than officer contributions.

For both single and family coverage, TRS premium contributions fall in the middle of the distribution of employer premium contributions. The TRS premium for single coverage is at the 40th percentile, while the family coverage premium is at the 60th percentile. Thus, if TRS eligibility included all reservists, a significant portion could conclude that TRS is a better value than their employer health plans—at least in terms of monthly premium payments.

In addition to premium levels, people also tend to pay attention to the cost sharing they face when choosing among different health plans. There are three elements in most cost sharing structures: a deductible, a copayment or coinsurance rate, and an out-of-pocket cap. Before the health plan begins to reimburse for care, individuals must first pay enough for their health care in a year to satisfy the deductible (an out-of-pocket expense to a maximum set under the plan before an insurance company shares in the cost of the care provided). Then they contribute to the cost of their care either by paying a flat amount (copayment) for each visit or a percentage of allowed charges (coinsurance rate). Coinsurance payments in particular may be capped so that an individual or family need not pay more than a set out-of-pocket amount each year.

The deductibles in TRICARE are considerably lower than those in a typical employer-sponsored preferred provider organization (Figure 6).[11] This result is not surprising, since TRICARE's deductibles have not been changed for many years,

whereas employer plans have increased their deductibles by substantial amounts over the past several years. Between 2001 and 2005, in fact, the deductible paid by the average employee for single or family coverage increased by 60 percent; the most recent survey data for 2008 show continuing double-digit annual increases in employee premiums.



Note: PPO deductibles apply to providers in the PPO's network.

Source: Kaiser Family Foundation and Health Research and Educational Trust 2005.

Figure 6. Comparison of Deductibles: Civilian Employer Plans Versus TRICARE

Rates for employer-sponsored plans are broken down by employer size, since small employers typically have less generous plans. The comparisons are made with TRICARE Standard and Extra, the options currently available through TRS. These two options constitute a preferred provider organization (PPO).

Coinsurance rates in TRICARE Standard and Extra (20 and 15 percent, respectively) compare favorably to those in similar employer plans, with little difference evident between military and civilian plans (Table 2). However, most employees are in health plans that rely on copayments of $20 or less per visit, rather than on coinsurance. Paying a share of the charges, rather than a flat rate per visit, may or may not result in higher out-of-pocket expenses for basic care; it usually results in much higher costs for specialized care. Although TRICARE limits this out-of-pocket cost to $1,000 per family per year, most families would probably fare better under the copayment system which is more prevalent in the civilian sector.

Table 2. Comparison of Out-of-Pocket Cost for Office Visits: Civilian Employer Health Plan Versus TRICARE

	Frequency of Payment Type	Usual Coinsurance Rates	Usual Copayments
Civilian Employer Plans			
Conventional Plan	22% copayment 57% coinsurance 10% both	20–25%	$10–15
PPO Plan	76% copayment 16% coinsurance 3% both	Evenly split between 10–15% and 20–25%	$10–20
TRICARE			
Standard/Extra	Coinsurance only	20%/15%	—

In terms of prescription drugs, survey results indicate that most employer health plans have established a three-tier copayment system, averaging between $10 for generic drugs to $35 for nongeneric drugs not on the preferred drug list. These costs are generally higher than prescription drug costs under TRICARE.

Given the complex design of many health plans and the differences in health care needs, it is difficult to conclude whether reservists are likely to find TRICARE cost sharing and coverage better or worse than in their employer health plans. Many reservists are likely to prefer the simpler-to-understand copayments of most employer plans to the coinsurance approach used in the TRICARE PPO. On the other hand, TRICARE deductibles are well below the deductible levels of most employer plans.

Thus, for many insured reservists, the value they place on TRS will depend primarily on the premium. At the TRS premium levels prevailing in 2005, this value is likely to be modest for most insured reservists. While many reservists are paying substantial premiums for employer insurance, survey data suggest that insured reservists are not interested in a military health plan unless premiums are quite low. In fact, there is generally little difference in willingness to pay for a military health benefit between uninsured and insured reservists (Figure 4 and Figure 7). Somewhat fewer insured officers are willing to pay substantial premiums; the opposite is true for enlisted reservists, but the difference is small.

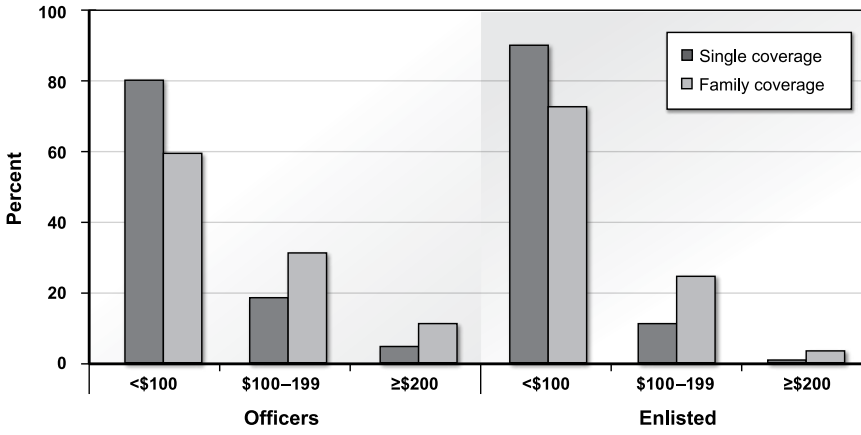


Figure 7. Insured Reservists' Willingness to Pay for a Military Health Plan

If many insured reservists are paying substantial premiums for employer insurance, why are they only interested in a military health benefit when it has a much lower premium than their current plan (not much more than $100/month)? There are two likely reasons. First, people are reluctant to change health plans. Most switches are associated with a job change or some other event that forces individuals to choose a different plan (Hosek and Marquis 1990). The results here may simply reflect this tendency to stay with one's health plan.

Second, reservists may prefer their civilian insurance over a military plan for reasons other than the premium. Some of these other reasons are apparent in responses to the November 2004 Reserve Status of Forces Survey, which asked respondents to compare TRICARE with civilian health care. The question did not refer specifically to TRS and was fielded before the program was implemented, so survey results should be interpreted cautiously (Figure 8). Over 40 percent said out-of-pocket costs were lower in TRICARE, while only 28 percent said costs were higher.[12] On all other dimensions, TRS was generally viewed as no better or worse than civilian health care. It is unclear how important these other considerations are in making a health plan choice, but they undoubtedly play a role, especially for individuals who already have insurance through their civilian employers.

In summary, about 40 percent of insured reservists may see a financial benefit in TRS over their employer health plans. However, because they are either reluctant to change to a new health plan, or have an unfavorable view of TRICARE, relatively few say they

would pay more than a modest premium for a military health plan. The evidence is far from definitive, but does suggest that most insured reservists put a relatively low value on TRS eligibility. Therefore, it seems unlikely that a universal TRS benefit would have a major impact on recruiting and retention among individuals with insurance.

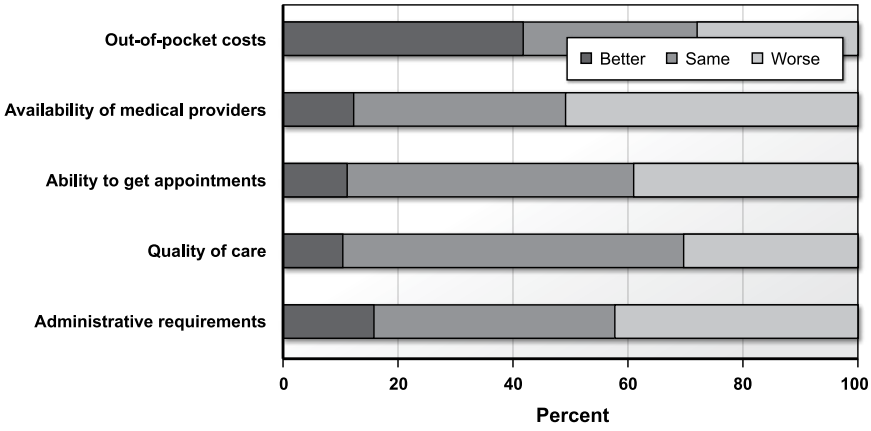


Figure 8. Reservists' Comparison of TRICARE With Civilian Health Care, 2004

One exception may be self-employed reservists who are insured. This group may see TRS as an extremely valuable benefit, since they otherwise pay the full premium for health insurance. Yet, as long as the probability of activation and deployment remains high, reserve participation exacts other high costs for self-employed workers; their businesses can suffer significant losses and disruptions during their absences. Self-employed reservists may decide that these potential costs negate any benefit associated with lower cost health care.

Would Universal TRS Be Cost Effective?

As the above discussion suggests, it does not appear likely that large numbers of reservists would enroll in TRS *so long as the TRS premium is similar to those in employer health plans.* If that proved true, and participation remained relatively low, the cost to DOD of offering universal TRS would be modest. However, in that scenario, there would almost inevitably be pressure on Congress to decrease premium costs in order to increase participation. If premium contributions were reduced below premiums in civilian health plans, enrollment and costs could become substantial.

Uninsured reservists would be more likely to enroll if, over time, the TRS premium contribution became more affordable. But since it appears that uninsured individuals are unwilling to pay very much for health insurance, the premium would have

to be quite low to attract new enrollees, which would generate substantial costs to DOD. Thus, the cost-benefit ratio for the uninsured population would be very high.

Participation could also increase among reservists with employer-sponsored insurance, if civilian employers offered incentives to reservist employees to enroll in TRS in lieu of their employee health benefit. However, in a recent survey of military retirees, only 10 percent of respondents eligible for a civilian employer health plan reported that their employer offered an incentive to take up other insurance instead (Mariano et al. 2007).

The employer savings derived from reserve employees using TRS could be sizeable, especially for employees with family coverage. Thus, firms that employ a number of reservists may wish to encourage them to switch to a universally available TRS system. The survey data indicate that in 2005, private sector employers paid $8,200 on average in health insurance costs for employees with family coverage.[13] Employers could offer employees an incentive that would totally offset the cost of TRS (almost $2,800 annually) and still realize $5,400 in savings per employee. DOD would assume the total family cost of TRS, minus premium contributions, when a reservist shifts out of employer insurance into TRICARE—about $8,000 annually. This represents a significant increase in a reservist's total compensation, and the cost to DOD substantially exceeds the benefit to the reservist, which is merely the employer incentive he or she receives for switching health plans.

The ratio of DOD cost to reservist benefit will be highly unfavorable for insured reservists who shift into TRS, because most of the benefit accrues to the employer in the form of lower health premium payments, not to the reservist. Of course, DOD may want to provide a benefit to employers whose employees serve in the reserves. However, there are many other ways to compensate employers outside of TRS, which is a costly benefit and applies only to employers who provide health benefits.

Predicting participation in TRS over time, and the consequent costs of the program to DOD, is nearly impossible. But if there is substantial participation, it is clear that costs will substantially exceed the benefits to reservists, and to DOD.

Other Policy Considerations

Emerging concepts for a more flexible and responsive reserve capability will require new personnel management practices and a variable compensation scale. Since health coverage is a key element of any compensation system, it would be prudent to carefully consider other policy alternatives that could advance the goals listed at the beginning of this chapter.[14]

A recent innovation in health benefits—a defined contribution health plan—may be better suited for this purpose than TRS. Properly designed, such a program could be

effective at a lower cost than TRS. Consumer-directed plans usually consist of two major components (Lipold 2003):

- Unlimited catastrophic coverage for medical expenses beyond a relatively high deductible (e.g., $2,000 or more per family). Once the individual or family satisfies this deductible, the plan provides comprehensive coverage, often without further cost sharing. Thus, the catastrophic component of the plan protects enrollees against unusually high health care bills.
- A tax-free health savings account (HSA), funded annually through employer and/or employee contributions and managed by the employee. The HSA is used to purchase medical services subject to the catastrophic deductible. Unused funds "roll over" to the following year, and in some cases the employee may be given the option to retain his or her HSA for future use when leaving the company.

These plans may also include wellness programs, extensive information to help enrollees make good decisions about when and where to seek care, and discounts negotiated with certain providers. The employer determines the total contribution it will make per employee for single and family coverage. A portion of the total is allocated to cover the premium for the high-deductible plan and the remainder is placed in the HSA.

The efficacy of consumer-directed health plans has been extensively debated, with the most salient arguments summarized in Katz (2003) and Lipold (2003). Such debates will become better informed as these plans become more prevalent. Currently, defined contribution plans constitute only about 4 percent of the total employee health care market. For the past several years, the Kaiser survey has asked employers whether they offer a "high-deductible" plan. In 2005, one in three of the largest firms included a high-deductible plan among the options they offered employees, although only one in 10 packaged it with an HSA (Claxton et al. 2005). High-deductible plans are most prevalent among the largest firms—those with more than 5,000 employees (Figure 9). It is too early to tell whether this kind of health plan will survive as a standard option in employer programs (Christianson et al. 2002).

How might a defined contribution plan for military reservists be structured? Reservists who serve the minimum number of days would be eligible only for catastrophic coverage (i.e., a high-deductible plan without any DOD contribution to an HSA), although they might be allowed to fund an account themselves using pre-tax dollars. This plan would provide uninsured reservists with significant financial protection against major illness or accidents. Similar to TRICARE, the military plan would cover catastrophic costs not covered by existing employer-sponsored insurance. Reservists who are only eligible for catastrophic coverage and retain their employer insurance would rarely use the military plan, but they would have a safety net if

they were to lose their employer coverage. Some of these members might drop their employer coverage, as they would be protected in case of serious illness, but most would probably elect to keep it.

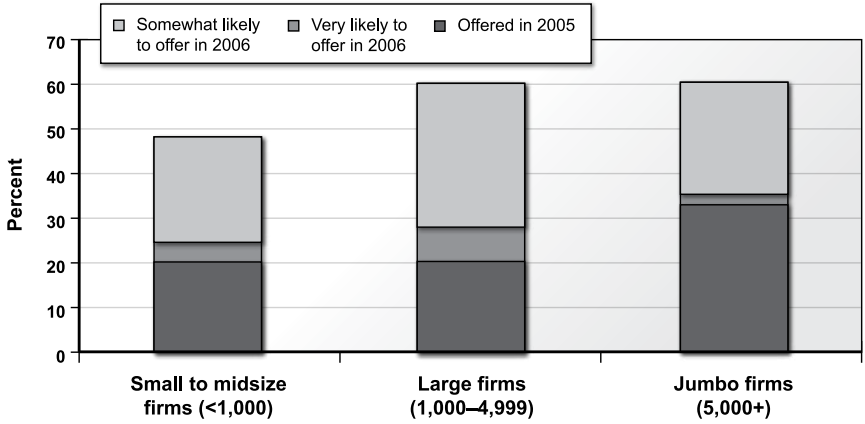


FIGURE 9. PREVALENCE OF HIGH-DEDUCTIBLE PLANS IN CIVILIAN FIRMS

Reservists who serve more than the minimum number of days would earn DOD contributions to an HSA in proportion to their level of service. Those with employer coverage could use the HSA funds to cover their premium contributions for that coverage, while those without insurance could use the funds to cover their health care expenses up to the catastrophic deductible. Unexpended account balances would carry over from year to year, providing greater benefits to members who accumulate more service. Further, the scale could be designed so that full-time service would earn reservists the equivalent of the TRICARE benefit. Upon a reservist's retirement, unspent HSA balances could be converted to other purposes, such as a retirement annuity, or could be used to cover any premium payments for health coverage during retirement.

A defined contribution plan could be managed by the TRICARE contractors, or DOD could contract with one of the major health insurance companies that already market this kind of medical insurance. In fact, two of the three current TRICARE contractors market high-deductible, HSA plans.

Concluding Comments

Reflecting a trend in the general population, more reservists are uninsured now than a decade ago. Data from the most recent Reserve Status of Forces Survey show that 30 percent lack health coverage except when they are mobilized for at least 30 days and become eligible for military health coverage. Until the nation achieves universal

health coverage or the military extends some kind of benefit, a substantial minority of guard and reserve members will continue to go without insurance. That number may continue to grow, as it has over the past decade, if the costs of civilian insurance continue to rise.

Although substantial changes have occurred in reserve health care coverage since this analysis was conducted, its principal findings and conclusions remain valid. The TRS benefit, established in 2005, has been enhanced to provide nearly universal coverage to all members of the selected reserve. Yet the number of uninsured reservists has not significantly changed. Further, there is no evidence that the increase in health care coverage has improved medical readiness or had an effect on recruiting and retention. In fact, very few reserve members have enrolled in TRS—less than 4 percent of those eligible.

Recently, the monthly premiums for TRS were significantly reduced compared to premiums in the three previous years. In 2009, the monthly premium will be $47.51 for single coverage and $180.17 for family coverage (compared to $81 and $253, respectively). This is below the average employee contribution in 2008 for similar employer plans, which was $61 for single coverage and $279 for family coverage. It remains to be seen whether this reduction in premiums will have a significant impact on the goals identified in this chapter. The objectives of the TRS program are laudable, but the health care changes enacted thus far have not had an appreciable impact on force management. Based on the outcomes to date, DOD may want to consider other policy options to achieve its health-care-related goals.

Notes

1. Archived online at http://www.dod.mil/releases/archive.html.
2. The health benefit available to activated reservists has remained essentially the same since TRICARE was established in the mid-1990s. All activated guard and reserve members are automatically enrolled in a military health maintenance organization (HMO) plan, called TRICARE Prime. Their health care is provided at military treatment facilities (MTFs), except when the MTFs arrange for supplemental civilian health services or the duty location is not near an MTF. Dependents of these personnel are also eligible for TRICARE coverage. If the member's orders are for more than 30 days and less than 180 days, family coverage includes the TRICARE Standard and Extra options. TRICARE Standard is a fee-for-service plan with an annual deductible and 20 percent cost share. TRICARE Extra is a similar benefit, but has lower cost sharing for services from providers who have contracted to be part of a TRICARE provider network. If the reserve or guard member has orders for 180 or more days of active duty service, the family is also eligible for TRICARE Prime. To use this plan, the family must complete enrollment and give up their eligibility for the Standard and Extra options.

3. TRS offers eligibility for TRICARE Standard and Extra; TRICARE Prime is not available through TRS.
4. Data provided by the Office of the Assistant Secretary of Defense for Reserve Affairs.
5. The correspondence of insurance coverage for members of the same family is very high. For example, for families with an insured head of household in the 2000 National Health Interview Survey, 80 percent of spouses and 93 percent of children also had insurance. In families where the head of household was uninsured, 35 percent of the children had insurance but only 4 percent of the spouses did. The higher rate of coverage among children is likely due to the State Children's Health Insurance Program, created by the Balanced Budget Act of 1997. The children of many low-income reservists are probably eligible for coverage under this program.
6. See also a more recent study by Abraham, Gaynor, and Vogt 2002.
7. See Chernew et al. 1997, Feldman et al. 1989, Marquis and Long 2001, Royalty and Solomon 1999, and Strombom et al. 2002.
8. Families assigned to the less generous plans were protected from catastrophic health costs and paid a lump sum each year equal to what they could lose under the plan, compared to a more generous health plan. The lump sum was additional income and families spent it as they would any other additional income—that is, not necessarily on health care.
9. DMDC matched a list of all reservists placed on medical hold with a list of respondents to the May 2003 survey. There were 150 individuals who appeared on both lists.
10. Using a propensity score method, we identified civilians in the NHIS who most resembled the general reservist population, as well as specific reserve subpopulations, defined by characteristics such as rank and family type. The resulting estimates are adjusted for inflation to 2005 using data from an annual survey of employers, documented in the Kaiser Family Foundation and Health Research and Educational Trust (2005).
11. PPOs enroll 61 percent of covered individuals in employee health plans.
12. It is likely that many respondents were thinking of the TRICARE benefit for activated reservists, which does not require a premium contribution and includes an HMO option in which care is free. It is possible that a smaller fraction would consider actual TRS to be better.
13. Kaiser Family Foundation and Health Research and Educational Trust (2005).
14. In addition to those discussed in this section, the Commission on the National Guard and Reserves, in their January 31, 2008 Final Report to Congress and the Secretary of Defense, advanced several other possibilities. One recommendation urges Congress to amend the law to permit reserve component members to participate in the Federal Employees Health Benefits Program. A second is to establish a program that provides

an activated service member with a stipend (or provides the stipend directly to the employer) for the cost of keeping the member's family in the employer's health insurance plan during the period of activation.

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