

## 6. Discussion and Conclusions

As we noted earlier in this report, the DoD has a Congressional mandate to evaluate TSSD and make recommendations about its suitability as a permanent national program. The mandated evaluation was to include:

1. An analysis of the costs of the demonstration project to the United States and to the eligible individuals who participate in such a demonstration project
2. An assessment of the extent to which the demonstration project satisfies the requirements of such eligible individuals for the health care services available under the demonstration project
3. An assessment of the effect, if any, of the demonstration project on military medical readiness
4. A description of the rate of enrollment in the demonstration project of the individuals who were eligible to enroll in the demonstration project
5. An assessment of whether the demonstration project provides the most suitable model for a program to provide adequate health care services to the population consisting of eligible individuals
6. An evaluation of any other matters that the Secretary of Defense considers appropriate.

We address each of these points in turn in this chapter.

### Cost of the Demonstration Project

For most beneficiaries who lacked Medicare supplemental coverage, or who were paying for private Medigap coverage, the TSSD benefit had the potential to substantially reduce their out-of-pocket costs for medical care and significantly reduce the risk of catastrophic out-of-pocket costs, relative to the status quo. Because there was no meaningful way for us to assess the empirical effect of TSSD on health care costs (due to the very low enrollment), this conclusion about cost is based on our assessment of the actuarial value of the benefit in relation to its cost and the fact that enrollees overwhelmingly identified lower costs, good benefits, and prescription drug coverage as reasons for enrollment. TSSD represented a substantially more-generous benefit than any of the standard Medigap policies (particularly regarding prescription drugs), with generally

lower monthly premiums, guaranteed access for beneficiaries, and no medical underwriting.

At the same time, the relative benefits of TSSD would be reduced somewhat for beneficiaries who lack access to TRICARE network providers, both because the level of coverage is lower for nonnetwork providers and because many network providers would require TSSD beneficiaries to file claims for reimbursement. We found some geographic differences within and between the two TSSD demonstration sites in the availability of TRICARE network providers.

We note that TSSD included some cost-sharing by beneficiaries, which TFL does not. Cost-sharing has become a nearly universal feature of preretirement health insurance and of employer-sponsored Medicare supplements because it gives beneficiaries a financial incentive to reduce their health care use. The absence of cost-sharing provisions in TFL is likely to increase health care use and costs, relative to a program with modest cost-sharing, such as TSSD.

The evaluation plan did not call for measuring the costs of developing, implementing, and administering the demonstration program.

## **Suitability of Benefit Design**

If properly administered, TSSD seemed to be appropriate for meeting the supplemental health insurance needs of Medicare-eligible military beneficiaries. As with our findings regarding TSSD costs, this conclusion is based on our assessment of the actuarial value of the benefit and on beneficiaries' comments. Despite the limitations of the program, and the fact that the demonstration program seems to have never overcome the administrative hurdles associated with its start-up, 88 percent of enrollees identified themselves as "very satisfied" or "satisfied" with TSSD (although a substantial fraction of these were in the latter category).

In addition to the administrative problems identified by TMA, there appeared to be unresolved confusion about the program among beneficiaries. Both the administrative problems and the confusion are likely to have inhibited enrollment and frustrated enrollees. In addition, several features distinguish TSSD from TFL, the permanent national program introduced to meet the health insurance needs of this beneficiary population; in general, these distinguishing features made TSSD relatively less attractive than TFL for beneficiaries and may also have inhibited enrollment in TSSD. For instance, TSSD required a monthly premium, which TFL does not, and in many circumstances, TSSD beneficiaries

needed to file claims for reimbursement, whereas TFL claims are processed automatically.

TSSD also included modest cost-sharing by beneficiaries, whereas TFL eliminates virtually all cost-sharing. While modest cost-sharing can improve the efficiency of a health insurance program by giving beneficiaries a financial incentive to reduce their health care use (and particularly the use of relatively low-value services), in practice TSSD's cost-sharing rules were not transparent to beneficiaries. In particular, beneficiaries receiving care from providers outside the TRICARE network would need to know the provider's billed charges, the Medicare allowable charge, and the TRICARE allowable charge in order to calculate their out-of-pocket costs. In this sense, TSSD's design was unlikely to be efficient.

One feature TSSD and TFL have in common is the requirement that beneficiaries be enrolled in Medicare Part B. For elderly beneficiaries who may have opted out of Part B with the expectation that they would use MTF care, and in any case did so without knowing that Part B participation would subsequently be required for access to TSSD or TFL, the financial penalty associated with enrolling now may present an economic hardship. In practice, this penalty seems to have inhibited TSSD enrollment.

## **Military Medical Readiness**

TSSD as a demonstration program is unlikely to have had any effect on military medical readiness. By design, it was conducted outside of any MTF catchment area. That factor, plus the low enrollment, suggests that the military health care delivery system is unlikely to have been affected by TSSD in any substantive way.

As a national policy, TSSD could have affected medical readiness primarily by affecting the type and number of Medicare-eligible military beneficiaries seeking care at MTFs. However, given the scope and outcomes of the demonstration, there was no way to assess this issue definitively with respect to TSSD.

We note that possible diversion of elderly patients away from MTFs is also an issue for TFL, which, unlike TSSD, does not preclude beneficiaries from receiving care at MTFs, but which seems likely to reduce the relative attractiveness of MTF care for beneficiaries. Concern about this issue underlies the DoD's recent introduction of TRICARE Plus, a program that is intended to facilitate a stable

flow of elderly patients to MTFs by giving some Medicare-eligible military beneficiaries priority access to MTF primary-care providers.<sup>1</sup> A broader discussion of the role that Medicare-eligible patients play in military medical readiness is outside the scope of this project.

## Enrollment Rate

We have described the very low TSSD enrollment-rate patterns earlier in this report. Because of this outcome of the demonstration, a main focus of this evaluation was on the question of why enrollment rates were so low. A number of factors likely contributed to this outcome. One such factor is poor awareness and lack of understanding of the program. Half of the nonenrollees claimed not to have heard of TSSD prior to our survey. And focus group participants and survey respondents indicated that they confused TSSD with TRICARE Prime, where care is often provided at MTFs in many cases, so some identified their lack of proximity to an MTF as a reason for not enrolling. Some survey respondents indicated that they confused TSSD with TFL (for which they had just become eligible on October 1, 2001). One explanation for our finding that members of military retiree organizations were significantly more likely than other respondents to enroll in TSSD was that those organizations help disseminate information about the program.

Even among those who had heard of TSSD, a substantial fraction indicated that they were confused about the benefit design. Indeed, the benefit design was somewhat complex, particularly in the case of care received from providers outside the TRICARE network. Partly as a result of this confusion over the benefit design, beneficiaries seemed focused on the availability and quality of TRICARE network providers even though, in our view, the level of concern about provider availability and quality was out of proportion to the relative financial cost of using nonnetwork providers under TSSD. The focus on TSSD network providers may also have reflected a strong preference for avoiding claims paperwork and balance billing, which would further inhibit enrollment.

Another factor inhibiting enrollment may have been the cost of the program. Despite our assessment of the relatively high actuarial value of the TSSD benefit, beneficiaries (in both the survey and in open-ended comments) identified the program's costs as a reason for nonparticipation. It seems plausible that beneficiaries with employer-sponsored insurance or a generous

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<sup>1</sup>For additional information on TRICARE Plus, see <http://www.tricare.osd.mil/Plus/default.htm>.

Medicare+Choice HMO plan would have faced higher costs under TSSD. In addition, some poorer beneficiaries may have felt unable to bear the cost of the TSSD premium. Although overall enrollment rates were low, higher-income beneficiaries were significantly more likely to enroll. This is particularly true for beneficiaries who also would have faced a penalty in their Part B premium.

In our view, however, the most important factor affecting enrollment was the temporary nature of the demonstration. This issue was highlighted in our focus groups and by survey respondents. Beneficiaries with private or employer-sponsored supplemental coverage who considered enrolling in TSSD faced having to choose between paying two sets of premiums (and thus guaranteeing their access to their non-TSSD coverage if they chose to disenroll from TSSD or when the demonstration ended) or giving up their non-TSSD coverage and risking the possibility that they would have inferior supplemental coverage after TSSD. We note that beneficiaries in Medicare HMOs were less likely to be affected by this issue because of Medicare's policies governing enrollment in such plans. On the other hand, Medicare HMO enrollees in our sample appeared to be relatively satisfied with their coverage at the time of the survey, and empirically they were significantly less likely to enroll in TSSD.

The issue of Medigap reinstatement was highlighted in both our focus groups and in comments made by survey respondents. Focus group participants reported confusion about the conditions under which beneficiaries could reenroll in private Medigap programs at the conclusion of TSSD. Members of the RAND project team obtained information about the guidance given to program eligibles by staff members of the Iowa Foundation for Medical Care, who conducted informational meetings about the demonstration program in California and Texas. This information indicated that Medigap reinstatement rights were outlined in Section 4031 on Medigap Protections in the 1997 BBA. However, language in Section 722 of the fiscal year (FY) 1999 Defense Authorization Act lacks an explicit link between TSSD and any of the provisions in the 1997 BBA. This is in contrast to the language authorizing the FEHBP demonstration (Section 721 of the same legislation), which specifically states that enrollment in the FEHBP demonstration should be treated in the same way as enrollment in Medicare+Choice plans with respect to Medigap protections. To the extent that the BBA provisions do apply to TSSD, beneficiaries would have been entitled to return to Medigap plans A, B, C, or F, none of which cover prescription drugs, or to the beneficiary's last Medigap policy.

For reasons we described earlier, TSSD enrollees may have been overly optimistic about their rights to reinstate Medigap coverage at the end of the demonstration, particularly with respect to Medigap plans that cover

prescription drugs or other enhanced benefits such as skilled nursing care. The practical consequences of any misunderstanding by beneficiaries are likely to be minor due to the new TFL benefits because the TFL program essentially eliminates the need for and value of private Medigap insurance. However, the confusion expressed by beneficiaries underscores the importance of providing accurate and comprehensive information about the full range of potential implications for beneficiaries who participate in DoD-sponsored demonstration programs, especially in light of the mistrust of the government expressed by many focus group participants and survey respondents.

## **Suitability of TSSD as a Permanent Program**

When Congress instituted TFL, it deviated in many ways from the TSSD design. In addition to increasing the generosity of the health insurance benefit, Congress also altered the way it was administered. In particular, as with other private and employer-sponsored Medigap plans, coordination of claims between Medicare and TFL is automatic and does not require beneficiaries to file claims or deal with balance-billing.

In our view, the TFL model has substantial advantages for beneficiaries, relative to the TSSD model, in the way that it is designed, and these advantages are unlikely to present major drawbacks for Medicare or the DoD. On the other hand, TSSD included some cost-sharing requirements, whereas TFL almost entirely eliminates cost-sharing for Medicare-covered services. Modest cost-sharing is likely to reduce health care use and thus the costs to the DoD of the benefit. At the same time, there is little definitive evidence that modest cost-sharing requirements are likely to have substantial negative effects on beneficiaries' health status. TSSD also included financial incentives to beneficiaries to use TRICARE network providers. Such a preferred-provider design provides some opportunities to manage care to improve efficiency, at least in principle (given the outcomes of TSSD, we could not assess this empirically).

## **Other Relevant Issues**

The introduction of TFL significantly altered the policy context in which TSSD was being conducted, and with it our evaluation. We, therefore, focused on additional findings that may be relevant in the context of TFL.

- One key issue for TSSD, TFL, and other similar programs is the necessity for adequate decision support for beneficiaries. In TSSD—a demonstration

program being conducted in two relatively confined geographic areas and with a clearly defined population of eligible beneficiaries—the DoD encountered difficulties in educating eligible beneficiaries about the demonstration. We found that a substantial fraction of nonenrolled beneficiaries claimed not to have heard of the demonstration, despite the efforts of the DoD and its contractors to inform beneficiaries about the program. In addition, lack of information was identified as one of the most important factors inhibiting TSSD participation among nonenrollees.

- A second issue, which we identified from our enrollment models, is the extent to which beneficiaries are likely to substitute DoD insurance benefits for existing supplemental coverage. Beneficiaries with existing employer-sponsored coverage were particularly unlikely to enroll in TSSD, whereas beneficiaries who had previously been purchasing private Medigap were relatively likely to enroll. This is consistent with our expectations regarding the relative value to beneficiaries of the various insurance options. In general, TFL has both more-generous benefits and lower out-of-pocket costs than TSSD, and more important, more-generous benefits and lower out-of-pocket costs than any private Medigap plan, employer-sponsored supplement, or Medicare HMO. As a result, it seems likely that beneficiaries with any of these plans, including employer-sponsored coverage, will drop such coverage in favor of TFL.

## Conclusions

Given the existence of TFL and the accompanying pharmacy benefit program, the TRICARE Senior Supplement Demonstration is very unlikely to be implemented on a permanent national basis. However, in our view, the TSSD benefit design does present a viable model for a permanent national program for providing supplemental health insurance benefits to Medicare-eligible military retirees.

### *Advantages of TSSD*

The TSSD benefits were comprehensive, the costs to beneficiaries were relatively low compared with most privately purchased Medigap plans and were comparable with many employer-sponsored supplemental policies, and the program could be administered on a national basis (unlike some of the other demonstration models for this population, particularly TRICARE Senior Prime and the Uniformed Services Family Health Plan). In addition, the modest cost-sharing requirements and the preferred-provider benefit design were consistent

with many employer-sponsored supplemental policies, and unlike TFL in general, created some opportunities to further manage care and control program costs.

### *Areas for Improvement*

Some features of the TRICARE Senior Supplement design could be improved:

- One improvement would be to institute automatic claims processing between Medicare and TSSD, as is done with other Medigap and supplemental policies (and TFL). The current procedures not only deterred enrollment and frustrated enrollees, they were so difficult for the DoD to implement that TMA stopped marketing TSSD in the summer of 2000.
- A second improvement would be to make the out-of-pocket costs associated with the use of nonnetwork providers more transparent to beneficiaries. This issue becomes less important the larger the TRICARE network is, and a permanent national TRICARE Senior Supplement program might induce additional providers to join the TRICARE network.

### *Low Awareness Among Beneficiaries*

More generally, the findings from our evaluation highlight the difficulty of disseminating information about new, and complex, benefit programs. Despite efforts to publicize the program, awareness of TSSD seems to have been low among eligible beneficiaries, and understanding of the benefit design was imperfect even among enrollees.

### *Drawbacks Associated with a Temporary Demonstration*

Finally, the findings illustrate the difficulties associated with accurately assessing demand for a health insurance program through a temporary demonstration. Many beneficiaries who were eligible for TSSD appeared to be reluctant to switch plans because they were familiar with their current plan and in many cases were very satisfied with it. TSSD may not have been sufficiently attractive as a temporary benefit to warrant the costs of switching insurance and then having to switch again at the end of the demonstration.

Beneficiaries were also reluctant to risk the possibility that their post-demonstration benefits would be worse than the status quo, and indeed there was ambiguity about whether TSSD enrollees would have a statutory right to

return to their prior Medigap insurance after the demonstration. The impending availability of TFL should have reduced this concern (although TFL was not well understood at the time of our survey), but it may also have made beneficiaries more willing to retain their current coverage until TFL was available, rather than switching twice.

Future demonstration programs for this population would benefit from having these issues addressed as clearly and comprehensively as possible.

