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Healthcare Coverage and Disability Evaluation for Reserve Component Personnel

Research for the 11th Quadrennial
Review of Military Compensation

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Prepared for the Office of the Secretary of Defense
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Cover: A wounded U.S. Marine walks through the halls of the U.S. military's Ibn Sina Hospital in the Green Zone of Baghdad, 2004 (AP Photo/John Moore).

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Summary

The use of Reserve Component (RC) personnel has increased dramatically since September 11, 2001, and has remained high. Both Active Component (AC) and RC personnel serving on active duty for more than 30 days have comprehensive healthcare coverage, but other RC members are covered only for injuries or illness sustained in the line of duty. For other conditions, they must rely on their civilian healthcare coverage—if they have such coverage. A decade of combat, however, has focused the nation's attention on meeting the needs of service members—both AC and RC—whose military service has led to disability.

Legislation passed in 1965 required the President to review military compensation every four years. In light of the critical role the RC has played and is likely to continue to play in the future, the President asked the 11th Quadrennial Review of Military Compensation (QRMC) to examine compensation and benefits for RC personnel. As part of this review, RAND was asked to provide supporting analyses of the healthcare coverage provided for RC members, including participation in the TRS program, the potential effects of national health reform on coverage rates, and disability evaluation outcomes for RC members.

Findings on Healthcare Coverage

To assess the rates of health insurance coverage among RC members, we relied on the Status of Forces Survey of Reserve Component Personnel (SoF-R). This survey is administered to a sample of Selected Reserve members twice a year; every two years, the survey asks respondents whether they have health/medical insurance. The most recent SoF-R, fielded in January 2011, indicated that 30 percent of Selected Reserve members lack health insurance. Uninsured members are more likely to be unemployed or to work part time or for a small firm; they are also younger and have less education than those with insurance. The percentage of uninsured in the Selected Reserve population closely mirrors the percentage in the comparable civilian population.

We obtained data on TRS enrollment from the Defense Enrollment and Eligibility Reporting System (DEERS), the official enrollment file for TRICARE, the health-

care program serving active-duty service members, National Guard and Reserve members, retirees, families, and survivors. DEERS information about members is more limited than that provided by the SoF-R, but DEERS is more current and its TRS enrollment data are more reliable. The TRS program was initiated to offer insurance for RC members who lack a civilian option, and both TRS eligibility and affordability have changed significantly in recent years. Our analysis finds that TRS enrollment grew rapidly after the changes were implemented and included 8 percent of the eligible population in June 2010. While it is possible that insurance coverage in this population has not declined because of TRS, the evidence suggests that quite a few enrollees have access to civilian insurance that they find less attractive. Further, the characteristics of TRS enrollees do not match well with the characteristics of uninsured RC members.

Although at present the TRS program may not be significantly reducing the number of uninsured RC members, this may change if an individual insurance mandate and associated penalties are implemented in 2014 in accordance with the Patient Protection and Affordable Care Act (PPACA). To gain insight into the potential effects of PPACA on health insurance coverage of RC members in the absence of TRS, we applied results from the RAND COMPARE microsimulation model of health reform to estimate the changes in the percentage of RC members with insurance and in the sources of insurance. The model predicts how individuals and firms are likely to respond to healthcare policy changes, including those in PPACA, based on the economic theory of health decisionmaking and accumulated evidence from more modest policy changes (e.g., changes in Medicaid eligibility). Our analysis finds that health reform can be expected to increase the rate of insured RC members to 89 percent. The model projects that 12 percent will be eligible for Medicaid once eligibility is expanded, and another 12 percent will purchase coverage through state-level health insurance exchanges. Four-fifths of the latter will be eligible for a subsidy.

These projections do not factor in the availability of TRS. Many RC members who would otherwise purchase coverage from the health insurance exchanges are likely to find TRS more attractive financially. The TRS costs compare favorably with those of the health insurance plans that will be offered by the state health exchanges, even for members at income levels eligible for subsidies in the exchanges. In addition, some fraction of the 11 percent of RC members predicted to remain uninsured by the COMPARE model would enroll in TRS instead. TRS premiums for single and family coverage are, at worst, only slightly higher than the penalty for having no insurance under health reform. Therefore, there is a good chance that health reform will induce a further increase in TRS enrollment. This increase would be in addition to any increase in the number of RC members enrolling in TRS instead of taking up their employer coverage and could make it very difficult to achieve the goal of controlling the health costs of the Department of Defense (DoD).

DoD is already providing healthcare coverage to a majority of working-age military retirees and will have to assume a substantial role in covering RC members as well.

In 2007, the DoD Task Force on the Future of the Military Health System called attention to the increasing number of non–active-duty beneficiaries who choose TRICARE instead of employer benefits. The task force recommended considering a pilot program to test a benefit that would supplement rather than substitute for employer benefits. Such an initiative should include RC members in addition to retirees.

Findings on Disability Outcomes for RC Members

To examine the disposition of disability outcomes for RC members, we used data provided by the Army, Navy, and Air Force on all disability cases that were initiated in fiscal years 2007–2010 and for which an informal board decision had been made. The data capture the early effects of the important changes in the DoD and Department of Veterans Affairs (VA) disability evaluation systems that were made during that time. Our analysis finds that, as with healthcare, the major difference in disability evaluation of RC and AC members results from the line-of-duty requirement. AC members are considered to be continuously on duty, so the health problems that arise while they are in service are almost always a basis for disability benefits. RC members are not covered for disabilities that are not incurred or aggravated as a result of training or active service. Furthermore, RC members are only approximately one-third as likely to be referred to the Disability Evaluation System (DES) as AC members. Given this difference, war-related medical conditions are more common among RC members, but it is not possible to conclude from the available data whether all RC members with line-of-duty conditions are identified and evaluated for disability.

The rates of referral for post-traumatic stress disorder (PTSD) for RC and AC members who have deployed since 2001 are 1.4 per 1,000 members and 3.0 per 1,000 members, respectively. This difference is hard to understand given the evidence that the incidence of PTSD is at least as high in the RC. The identification of RC members who experience health consequences leading to disability resulting from deployment merits further investigation.

Once referred for disability evaluation, the process is the same across components, and there is little difference between RC and AC dispositions. For those with PTSD, the strict policy guidance of placement on the Temporary Disability Retirement List (TDRL) ensures equal outcomes. For others, once the medical condition captured by the Veteran Affairs Schedule of Rating Disabilities (VASRD) code is controlled for, the differences are only a few percentage points at most.