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R E P O R T

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# Health Benefits for Medicare-Eligible Military Retirees

## Rationalizing TRICARE for Life

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## Summary

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The National Defense Authorization Act (NDAA) for fiscal year (FY) 2001 made sweeping changes to the way that health care furnished by civilian providers to Medicare-eligible military retirees is financed. The law directed the Department of Defense (DoD) to implement what is now commonly referred to as TRICARE for Life (TFL). As of October 1, 2001, TFL provides TRICARE as supplemental health insurance for all Medicare-eligible military retirees age 65 or older who are enrolled in Medicare Part B. As of 2003, approximately 1.6 million military retirees are eligible for TFL. In general, TRICARE for Life covers all cost-sharing for Medicare-covered services and standard TRICARE cost-sharing for services that are covered by TRICARE but not by Medicare. Thus, TFL provides Medicare-eligible military retirees with one of the most comprehensive health insurance benefit packages in the United States.

### Focus of This Study

This study was undertaken in the months preceding implementation of the TFL program. Given the limited time and resources for the study, we focused on three types of issues: those that DoD specifically asked us to examine, those related to services for which Medicare and TRICARE benefits differ significantly, and those of potential operational concern. Our goal was to identify areas that may pose policy and/or implementation problems. Where appropriate, we suggest policy options that DoD might consider in order to accomplish the following:

- Rationalize benefits by considering changes in the TFL benefit structure
- Promote ease of operations by improving compatibility with Medicare benefits
- Improve efficiency by promoting optimal use of direct-care services and limiting excessive liability for civilian care
- Improve the overall benefit package for Medicare-eligible military retirees.

### Data and Methodology

We relied on several sources of information in conducting this study. We began with a comprehensive review of relevant policy manuals, literature, and other materials on both the Medicare and TRICARE programs to document and compare the eligibility requirements, benefit definitions, and coverage policies within each program. As appropriate, RAND Cor-

poration staff received copies of internal DoD communications and briefing slides to inform the work. We also conducted a number of formal and informal interviews and discussions with key DoD officials, representatives from each of DoD Surgeons General offices (Army, Navy, and Air Force), and relevant non-DoD experts with regard to particular benefit areas, such as long-term care services.

As stated above, the initial work for this report was done prior to the implementation of TFL. Since the TFL implementation, we have not updated this report to include a discussion of actual experience under TFL or policy changes since TFL implementation; however, we updated our discussion of certain issues, such as post-acute care services and behavioral health issues, that we had originally identified as being problematic and that have been addressed in subsequent legislation. We note those issues, and other issues that remain potentially problematic, in our summary of findings for specific topics.

## **Benefit and Coverage Policies**

Most health care services that are covered benefits under TRICARE are also covered benefits under Medicare, and vice versa. However, because TFL benefits are based on the existing TRICARE program, they were not expressly designed to fit together with Medicare benefits (in contrast to privately purchased Medicare supplemental or “Medigap” policies, which do). As a result, there are benefit and coverage inconsistencies that pose operational challenges and are likely to lead to confusion and misunderstanding for beneficiaries. For example, there are some differences among the providers who can furnish certain services and the settings in which covered services can be provided. Some of these issues should be resolved by Section 705 of the FY2003 NDAA, which provides that a physician or other practitioner who is eligible to receive reimbursement for services under Medicare is also approved to provide care under TFL.

When a service or item is a benefit of both TRICARE and Medicare, TFL relies on Medicare’s determinations regarding medical necessity and eligibility for coverage. That is, if a dually covered service claim is denied for reimbursement from Medicare on the basis of lack of medical necessity, TRICARE will not consider the claim for TFL cost-sharing. In cases in which a Medicare claim is denied because it is for a service that is not covered by Medicare, TRICARE will accept the claim for processing and determine whether the item or service is eligible for cost-sharing or payment under current TRICARE policies. If a claim is denied due to lack of medical necessity and is appealable under Medicare, the denial cannot be appealed under TRICARE.

A potential concern for TFL is whether the coding specificity in Medicare’s claims determination is sufficient for TRICARE to distinguish between Medicare coverage and medical necessity determinations, establish its cost-sharing liability accurately, and afford the beneficiary sufficient appeal rights. TRICARE Management Activity (TMA)<sup>1</sup> has indicated that the claim denial codes used by the Medicare contractors should be sufficient for TRICARE’s purposes, but this hinges on an empirical question that will need to be evaluated in practice.

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<sup>1</sup> The TMA is an office within the Department of Defense with responsibility for overseeing the administration of health benefits to military dependents and retirees.

**Recommendation.** Claims for services for which Medicare and TRICARE coverage policies diverge need to be reviewed to assure that the claims adjudication and appeals processes for TFL beneficiaries are working as intended.

We examined in depth three areas that appear to have potentially significant benefit coordination issues: coverage of new and emerging technology, post-acute care services, and behavioral health care services. While legislation subsequent to the TFL implementation improved coordination of benefits between Medicare and TRICARE for post-acute care services and behavioral health services, some potential issues remain, which we discuss in the following subsections.

### **New and Emerging Technology**

Almost by definition, coverage policies for emerging technologies are continuously evolving in both Medicare and TRICARE as new technology is diffused and additional information becomes available on the safety and efficacy of specific technologies. Medicare's coverage policies for a particular technology at a particular point in time may conflict with those that TRICARE has established for beneficiaries under age 65. In addition, Medicare policies may vary geographically by contractor.

We believe that TFL will highlight coverage inconsistencies between TRICARE and Medicare and may create pressure for consistent "federal" coverage policy. As a general rule, there should be a clear rationale for why a certain technology is covered by one program and not the other.

**Recommendation.** TMA is not represented on the Center for Medicare and Medicaid Services (CMS) Medicare Coverage Advisory Committee (MCAC). Coordination between the two programs could be enhanced if TMA became an active participant in MCAC deliberations. TMA's participation in the committee would create the opportunity for TMA to have input into the coverage determination process and to make deliberate judgments regarding whether TRICARE's coverage policies should deviate from Medicare's.

### **Behavioral Health Services**

Differences in Medicare and TRICARE coverage policies for behavioral health services create complex issues in implementing TFL and make it likely that beneficiaries will find this area of their health coverage relatively confusing. However, benefit administration should be simplified since the elimination of the TRICARE preauthorization requirement for inpatient psychiatric care covered by Medicare Part A benefits, effective October 2003. However, TRICARE has a lifetime limit of three benefit periods for the coverage of substance abuse treatment services, which may remain problematic. Because TRICARE and Medicare define benefit periods differently, the determination of when and how the TRICARE limit is reached is likely to be somewhat complex and confusing to both providers and beneficiaries.

**Recommendation.** We recommend that DoD consider the impact of removing the three-benefit-period limit on substance abuse benefits for the TFL population. TFL decreases the financial barriers to outpatient mental health services for the dually eligible population and provides few financial incentives to limit care. TFL beneficiaries have unlimited access to medically necessary outpatient psychiatric treatment that will be covered 50 percent by Medicare and 50 percent by TRICARE. In addition, TRICARE provides TFL beneficiaries with pharmacy benefits that lack the limits imposed by standard Medigap plans.

**Recommendation.** DoD should conduct a close examination of mental health service utilization and costs to determine the impact of providing outpatient mental health care without cost-sharing or benefit limits. This examination should be conducted across the direct- and purchased-care systems.

### **TFL Beneficiary Cost-Sharing for Civilian Care**

TFL is being implemented without premiums, deductibles, or copayments. Compared with the health insurance options previously available to Medicare-eligible military retirees, TFL is likely to be of substantial value to most beneficiaries, with few or no drawbacks. At the same time, TFL will substantially increase federal spending, both because of the new benefits per se and because the absence of cost-sharing is likely to increase health care use by eliminating the incentives that cost-sharing gives beneficiaries to use care efficiently.

DoD and Medicare are likely to benefit if modest cost-sharing is introduced into TFL—for instance, such as the cost-sharing that military retirees under age 65 currently have under TRICARE Prime. Some amount of cost-sharing by beneficiaries is nearly universal in private group health insurance plans, including employer-sponsored retiree plans. For Medicare beneficiaries, supplemental coverage with modest cost-sharing substantially reduces the out-of-pocket costs that would arise under the standard Medicare benefit, while retaining some modest incentives to control health care use and costs.

By “modest” cost-sharing provisions, we envision primarily fixed-dollar copayments, on the order of \$10 per visit, for ambulatory care visits. Such copayments are similar in form and magnitude to those required in many employer-sponsored supplemental plans and Medicare+Choice HMOs (and in TRICARE for military retirees under age 65). They are also similar to the copayments currently required under DoD’s pharmacy benefit program. Fixed-dollar copayments have the advantage that they are easy to understand and administer; in many private plans, for instance, beneficiaries pay the copayment at the time of service, with no additional required paperwork.

All else being equal, the introduction of cost-sharing in TFL would likely serve to reduce the cost of the program to the federal government. However, this change could be made revenue neutral by applying the resulting savings toward other benefits for the covered population—such as enhanced post-acute or long-term care coverage or a reduction in the current TFL out-of-pocket maximum—thereby potentially increasing the overall value of the TFL benefit.

**Recommendation.** DoD should evaluate the effect of introducing into TFL modest cost-sharing for civilian care. Further research into the preferences of TFL beneficiaries and the likely consequences of introducing cost-sharing (versus continued free care) in TFL would help identify strategies to maximize the overall value of the TFL benefit.

### **Managing MTF Care Provided to TFL Beneficiaries**

Relatively little opportunity exists to implement managed care practices under standard Medicare and TFL. However, given the apparent desire of many TFL beneficiaries to receive care from military providers, DoD may have the opportunity to provide managed care for



some elderly beneficiaries via programs instituted at MTFs, such as TRICARE Plus. Where MTF capacity permits, TRICARE Plus is a primary care enrollment option for military retirees who are not enrolled in a Medicare+Choice plan. It allows some TFL beneficiaries to receive primary care from an MTF on the same priority basis as TRICARE Prime enrollees and to receive specialty care on a space-available basis.

We think it is likely that TRICARE Plus and similar programs will be well received by beneficiaries, especially because participation in them is voluntary. We also think it is plausible that such programs could improve clinical outcomes for some enrollees, relative to both standard Medicare and the current space-available policy. However, the scope of such improvements depends critically on how and for whom care management programs are implemented. DoD may be able to increase the likelihood of improved clinical outcomes by targeting TRICARE Plus enrollment to patients who are likely to benefit from primary care management and implementing effective care management programs for those patients.

Because DoD must assume full responsibility for the cost of care provided to Medicare-eligible beneficiaries at MTFs, DoD's patient care costs are almost certainly higher under TRICARE Plus than the costs of care provided under Medicare. On the other hand, treating Medicare-eligible beneficiaries in MTFs helps DoD to fulfill its readiness mission. How these factors balance on net is unknown.

**Recommendation.** Further research regarding the effects of MTF primary care management on patient outcomes and treatment costs, and regarding providers' case-mix preferences and the relationship between primary care management and readiness, should be conducted to determine the overall cost-effectiveness of TRICARE Plus from the perspective of DoD and the federal government, relative to alternative models for care management and readiness training.

## Models for Medicare Sharing in MTF Costs

DoD's new obligations for TFL beneficiaries raise issues related to the cost of furnishing direct care relative to making secondary payments for civilian care. These new obligations also raise the issue of whether Medicare should share in the costs of direct care services now that the traditional division of responsibilities for military retiree health care costs no longer exists.

Without Medicare cost-sharing for MTF care, DoD costs would be lower if TFL beneficiaries who are currently receiving MTF direct care instead obtain care from civilian providers; however, the shift could negatively affect physician retention and training, create excess capacity at some MTFs, and would run counter to the preferences of many TFL beneficiaries. Moreover, Medicare costs would increase substantially because the program would become the primary payer for civilian care that had previously been furnished by MTFs at no cost to Medicare. Thus, Medicare has an interest in assuring that direct care for TFL beneficiaries continues.

There is an overall federal interest in DoD continuing to provide direct care to TFL beneficiaries, assuming the incremental costs of MTF care are less than the total costs of civilian care. Medicare cost-sharing for MTF care would foster viewing TFL beneficiaries as a joint responsibility of DoD and Medicare and lead to finding ways to provide those beneficiaries with the highest-quality care at the least cost to the federal government. Cost-sharing

also would provide DoD with the financial resources to continue to provide direct care to TFL beneficiaries, and it has the potential to meet several policy goals: to give TFL beneficiaries the choice between direct and civilian care, to serve DoD readiness needs, and, most important, to provide high-quality health care services to TFL beneficiaries and the non-retiree military population at the least cost to the federal government. From the perspective of total federal outlays, however, a better understanding of how utilization by TFL beneficiaries who obtain care primarily from MTFs compares with utilization by TFL beneficiaries who obtain care solely through civilian providers is needed before policies are adopted that might encourage future expansion of MTF care for TFL beneficiaries.

**Recommendation.** Additional research, using a combined Medicare/DoD database for TFL beneficiaries, should be conducted to determine the cost implications of potential cost-sharing options for DoD and the Medicare program and total federal outlays. The research would provide the analyses that are needed to inform a policy discussion regarding appropriate cost-sharing arrangements between Medicare and DoD for TFL beneficiaries. In the end, the question of appropriate cost for direct care is likely to be answered through the political process, which should be supported by good information and analysis.

There are similar cost-sharing issues with the Department of Veterans Affairs (DVA). In keeping with the notion of a “federal program” beneficiary, consideration should be given to expanding the recommended analyses to include veterans who are DoD retirees and/or Medicare beneficiaries and extending the policy discussion to include the DVA.