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NAVAL POSTGRADUATE SCHOOL

MONTEREY, CALIFORNIA

MBA PROFESSIONAL REPORT

**MEDICARE & MEDICAID VS. TRICARE:
A BENEFITS AND COST COMPARISON**

By: Colin Engels
September 2014

Advisors: David R. Henderson
Michael J. Dixon

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**MEDICARE & MEDICAID VS. TRICARE: A BENEFITS AND COST
COMPARISON**

Colin Engels, Lieutenant Commander, United States Navy

Submitted in partial fulfillment of the requirements for the degree of

MASTER OF BUSINESS ADMINISTRATION

from the

**NAVAL POSTGRADUATE SCHOOL
September 2014**

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ABSTRACT

The current fiscal environment for the Department of Defense (DOD) is constrained. TRICARE and the military health system is an area where DOD military leaders have expressed serious concern over the balance between rising costs and retention. Medicare and Medicaid face similar budgetary challenges as spending for both these federal programs continues to rise.

The purpose of this research was to determine the similarities and differences in coverage provided between TRICARE, Medicare, and Medicaid, compare costs and provider payment rates, and analyze cost implications for the federal budget. This research project accomplished the following: 1) determined that TRICARE and Medicare exhibited almost identical provider payment rates across all three of the states compared in this study, 2) determined that Medicaid payment rates in California and Connecticut are higher than TRICARE while rates in Mississippi are lower, 3) determined that TRICARE exhibited lower per capita spending and lower spending growth rates than Medicare or Medicaid.

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LIST OF ACRONYMS AND ABBREVIATIONS

ADFM	active duty dependent family member
ADSM	active duty service member
AMA	American Medical Association
CBPP	Center on Budget and Policy Priorities
CBO	Congressional Budget Office
CHIP	Children’s Health Insurance Program
CMAC	CHAMPUS National Pricing System
CMS	Centers for Medicare & Medicaid Services
CPT	current procedural terminology
DCAS	Defense Casualty Analysis System
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DHCS	California Department of Health Care Services
DMDC	Defense Manpower Data Center
DOD	Department of Defense
DOM	Mississippi Division of Medicaid
DSS	Connecticut Department of Social Services
ECHO	Extended Care Health Option
FDA	Food and Drug Administration
FMAP	Federal Medical Assistance Percentages
GDP	gross domestic product
GPO	Government Printing Office
GWOT	global war on terror
HCPCS	Healthcare Common Procedure Coding System
HHS	Department of Health and Human Services
HI	hospital insurance
HMO	health management organization
KFF	Henry J. Kaiser Family Foundation
MPFS	Medicare Physician Fee Schedule
MTF	military treatment facility

PCM/PCP	primary care manager/provider
PHC	Partnership Healthplan of California
PPO	preferred provider organization
PSA	prime service area
SHCP	Supplemental Health Care Program
SPOC	service point of contact
TAMP	Transitional Assistance Management Program
TPRADFM	TRICARE Prime Remote for active duty dependent family members
VA	Department of Veterans Affairs

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I. INTRODUCTION

TRICARE is a federally funded health insurance plan, which, in its four major forms (TRICARE Prime, TRICARE Standard/Extra, TRICARE Overseas, and TRICARE For Life), provides health care coverage for active, reserve, and retired members of the four U.S. military branches, the Coast Guard, and military dependents. Commissioned members of the Public Health Service and the National Oceanic and Atmospheric Administration are also covered. Overall administration and supervision of the TRICARE program falls to the Defense Health Agency (DHA). TRICARE provides coverage via government contracts negotiated with major corporate health insurers such as Humana and United Healthcare. Each of the four TRICARE regions, North, South, West, and Overseas, is contracted out to a different insurer. Presently, the North region is administered by Health Net, the South region by Humana, the West region by United Healthcare, and Overseas by International SOS (Defense Health Agency [DHA], 2012b).

A breakdown of personnel covered by TRICARE is provided below:

- 1.8 million—Members of the four military branches, Coast Guard, and commissioned members of the Public Health Service and National Oceanic and Atmospheric Administration
- 2.6 million—Dependents of current service members
- 5.2 million—Retired service members and their families (Congressional Budget Office [CBO], 2014)

Medicare and Medicaid (including the Children's Health Insurance Program or CHIP) are two major federal health insurance entitlement programs that also place significant strain on federal budgets. A 2013 report by the Center on Budget and Policy Priorities (CBPP) states that these programs accounted for 21 percent or \$732 billion of the 2012 federal budget (p. 1). Of that \$732 billion, more than 66 percent, or \$472 billion, is attributable to Medicare (CBPP, 2013). The CBPP (2013) report further shows that in the same year, Medicare provided health coverage to over 48 million Americans who were over the age of 65 or disabled. Medicaid provided coverage to over 60 million low-

income children, parents, elderly, and disabled during the same period (CBPP, 2013). It is important to note that Medicaid and CHIP require matching funds from state governments. The next section discusses the background of the research study.

A. BACKGROUND

The following section is an overview of TRICARE, Medicare and Medicaid programs.

1. TRICARE

In a November 2013 *Washington Post* article by Walter Pincus, each of the Joint Chiefs of Staff was quoted as voicing concern over the growing percentage of Department of Defense (DOD) costs related to personnel. Specifically, the service chiefs pointed out that pay and benefits were growing at an unsustainable rate and that TRICARE alone accounted for much of that growth. A January 2014 Congressional Budget Office (CBO) report supports the validity of these concerns. The CBO (2014, p.1) report states that TRICARE costs as a percentage of the DOD budget increased from six percent to slightly less than 10 percent between 2000 and 2012. Furthermore, according to the same CBO (2014, p. 1) report, total TRICARE spending was \$52 billion in 2012 and TRICARE spending as a percentage of the DOD budget could climb to 11 percent by 2028.

According to the CBO (2014), cost increases in TRICARE have occurred for several reasons. First, measures taken by lawmakers to expand TRICARE benefits have added to cost growth. Expansions of coverage to retirees and their families through the 2002 creation of TRICARE For Life, a program designed to significantly reduce or eliminate out-of-pocket expenses for Medicare-eligible retirees, has added to TRICARE program costs. Furthermore, extensions of TRICARE benefits to National Guard and reserve military members not on active duty have also added to costs. Lawmakers' goal with these two steeply priced steps was to boost recruiting and incentivize retention during a period of sustained combat operations. Second, TRICARE's relatively low out-of-pocket expenses (when compared to the average civilian medical insurance plan) incentivize the utilization of the program. Thirdly, prolonged worldwide conflict centered

primarily in Iraq and Afghanistan has generated a large population of wounded military members. The care of these wounded has increased medical costs.

2. Medicare and Medicaid

Medicare and Medicaid face cost growth and budget pressures similar to TRICARE. CBO (2012) cost projections for these programs show that by 2037 their aggregate cost as a percentage of gross domestic product (GDP), will double to 10 percent. As cited in the CBPP article (Van de Water, 2013), the *2013 Annual Report* issued by the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds indicated that enactment of the Affordable Care Act had enabled the hospital insurance (HI) portion of Medicare to remain solvent (i.e., able to pay 100 percent of obligations) until 2026 at which time the HI program would be able to cover only 87 percent of obligations. The CBPP article (Van de Water, 2013), which cites the *2013 Annual Report*, does point out that despite improvements in the solvency lifespan of Medicare, the program still faces significant financial challenges.

A 2013 report issued by the Henry J. Kaiser Family Foundation (KFF) on CBO cost projections for Medicaid notes that program costs are expected to increase at an average rate of eight percent year over the next decade (2012–2023). This growth is expected to push total federal budget costs to \$510 billion in 2023 (KFF, 2013, p. 5). Enrollment in Medicaid is also expected to increase by 20 million to a total of 91 million beneficiaries over the same time period (KFF, 2013, p. 6). These numbers indicate that Medicaid is facing financial challenges that mirror those faced by Medicare, and present Congress with similar policy difficulties. The next section discusses the purpose of this research study.

B. PURPOSE OF RESEARCH

The purpose of this research is to determine the similarities and differences in coverage provided between TRICARE, Medicare, and Medicaid, compare costs and provider payment rates, analyze cost implications for the federal budget, and develop

recommendations on how to efficiently reduce TRICARE costs to DOD. The following section provides an overview of the problem which motivated the researcher to conduct the study.

C. PROBLEM

On November 7, 2013, General Ray Odierno, Army Chief of Staff stated before the Senate Armed Services Committee, “The cost of [an Army] soldier has doubled since 2001; it’s going to almost double again by 2025. We can’t go on like this, so we have to come up with [new] compensation packages” (Pincus, 2013, p. 1)

The *Washington Post* article that includes General Odierno’s quote provides an even more poignant analysis of his statement (Pincus, 2013). The article postulates the DOD budget will break under the weight of personnel costs unless decisive action is taken to reduce those costs in the short term and control their growth in the long term. The article goes on to say that Congress has ignored warnings from President Barack Obama and Defense Secretaries Chuck Hagel and Robert Gates over the last three years that effort must be made to reduce costs. The article states that in particular, the cost of health care benefits for retired military members and their families must be reduced. In opposition to this, Congress has sided with retirees and their lobbyists who point out the benefits are a promise that must be kept (Pincus, 2013, p. 1).

At the same November 7 Senate Armed Services Committee hearing, each of the service chiefs from the Navy, Marine Corps, and Air Force lent his voice to General Odierno’s call for change (Pincus, 2013). Admiral Jonathan Greenert, Chief of Naval Operations stated:

About 50 percent of every Defense Department dollar goes to personnel predominantly as compensation. And if we keep going this way, it’ll be at 60, and then it’ll be at 70 in about a decade plus. . . . I think it’s our responsibility to take a hard look at it. (Pincus, 2013, p. 2)

Marine Commandant, General James Amos had similar concerns:

‘I pay 62 cents on the dollar right now for manpower,’ said Gen. James Amos, the Marine Corps commandant. ‘That’s not because Marines are

more expensive; it's just my portion of the budget is smaller. That's going to go well over 70 percent by the end of [the next five years] if something is not done." (Pincus, 2013, p. 2)

Air Force Chief of Staff General Mark Welsh III voiced his own concern that personnel cost increases are a threat to readiness and modernization (Pincus, 2013).

These warnings from the service chiefs must be taken seriously. The logical conclusion is that this information was presented to Congress only after considerable research and analysis was conducted by appropriate DOD experts. An even more sobering thought is that these warnings are coming on the heels of the recent sequestration. Furthermore, the sequestration, which shut down most government agencies and services, continues to affect government operations. Additional rounds of budget cuts are expected over the course of the next several fiscal years. Consequently, conducting research to uncover potential efficiencies in DOD personnel operations (particularly health care) has become a priority. The next section lists the research questions that are answered by the research study.

D. RESEARCH QUESTIONS

This research study answers two major questions that lead to a number of recommendations that help to reduce costs and improve efficiency in the military health system. This study answers the following two research questions regarding TRICARE:

- How does TRICARE compare to the other major federal medical insurance programs (Medicare and Medicaid) in regard to covered services, costs, and provider payment rates?
- What similarities and differences exist between TRICARE, Medicare, and Medicaid?

The next section lists the objectives of this research study.

E. OBJECTIVES

The following five objectives are addressed in this research study:

- Answer the two research questions
- Compare a targeted sample of covered services offered by TRICARE, Medicare, and Medicaid to determine the differing provider payment rates between each program

- Review covered services offered by TRICARE, Medicare, and Medicaid to determine any differences in benefits between each program
- Provide recommendations to aid DOD in maintaining the financial integrity of TRICARE
- Outline areas for further research and follow on TRICARE studies

The following section discusses the methodology used in conducting this research study.

F. METHODOLOGY

This research study includes a literature review of TRICARE, Medicare, and Medicaid benefits documentation. In addition, a review of Congressional Budget Office (CBO) Medicare and Medicaid cost projections and TRICARE cost reduction recommendations, is conducted. An analysis of CBO projections performed by the Henry J. Kaiser Family Foundation (KFF) is presented. Furthermore, articles published by the Center on Budget and Policy Priorities (CBPP) providing a summary breakdown of federal government spending and research results on the continued financial viability of Medicare are used. A targeted sample of 25 matching medical procedures was selected from the American Medical Association's (AMA, 2011) *Current Procedural Terminology (CPT) 4th Edition 2012* based on continuity across all three programs and identical Healthcare Common Procedure Coding System (HCPCS) codes. These medical procedure codes are compared for payment rate variances. Differences in rates across programs for particular coded medical procedures are noted and investigation conducted to determine the reason for the difference. Chapter III, the methodology describes the details of how the documentation reviews are carried out. The following section outlines the benefits and limitations of this research study.

G. BENEFITS AND LIMITATIONS OF THE STUDY

One benefit of this research study is that it sheds light on the TRICARE military health insurance system. This study also shows how the costs to taxpayers to maintain TRICARE relate to other analogous taxpayer funded medical insurance programs. This research puts the costs of TRICARE in perspective for decision makers, beneficiaries, and other major stakeholders. Another benefit of this research project is to provide

recommendations for DOD to improve the financial viability of TRICARE and sustain the program over the long term. Finally, this research study provides insight to the five objectives previously noted.

One of the limitations of this research study is that the format of the medical procedure rate data among the Medicare, Medicaid, and TRICARE programs does not lend itself easily to statistical analysis. This limitation stemmed primarily from variations in the delivery method (physician, nurse practitioner, hospital, office, etc.) for identical medical procedure codes. These variations result in differing rates charged for the same procedure code. Furthermore, the structure of the Medicaid and CHIP program (a partially federally funded medical insurance program with state matching funds and administration) required limiting testing and research to three states' Medicaid programs (California, Connecticut, and Mississippi). Another limitation of this research study centers on the complexity of the programs themselves. Each of the cited federal medical insurance programs is governed by innumerable regulations and laws contained in thousands of pages of documentation. This complexity limits the depth to which this research study can go based on finite resources available to include time. This research project also excludes research of dental or pharmacy programs in order to limit the scope of the project and comply with project timelines. The next section discusses how this report is organized.

H. ORGANIZATION OF THE REPORT

This research project consists of five chapters. Chapter I includes the background on the fiscal issues facing TRICARE, Medicare, and Medicaid, purpose of the research, the problem, and the research questions. Chapter I also discusses the objectives of the research project, the methodology, and the benefits and limitations of the study. Chapter II consists of a literature review that summarizes the benefits provided by each of the three medical insurance programs and a summary of how each program operates. Further, in conjunction with data analysis in Chapter IV, Chapter II helps answer the two research questions. Chapter III covers the methodology of this research study. Chapter IV provides an analytical comparison of a targeted sample of compiled payment rate data for varying medical procedures covered by TRICARE, Medicare, and Medicaid. Chapter IV

additionally includes analysis on the financial sustainability of each program as contained in federal agency projections, actuarial reports, and think-tank analyses. The data analysis also provides information on existing federal cost saving proposals. These cost saving proposals serve as a basis for some of the recommendations to be put forth in this study. Chapter V, which is the last chapter, includes the summary, conclusion, and areas for further research. The next section provides a summary of topics discussed in Chapter I.

I. SUMMARY

In this chapter, the background of TRICARE, Medicare, and Medicaid, purpose of the research, problem, and the research questions are discussed. This chapter also discusses the methodology, benefits and limitations of this study, and the organization of the report. In addition, this chapter also details the five objectives of this research report. The five objectives include the following:

- Answer the two research questions
- Compare a targeted sample of covered services offered by TRICARE, Medicare, and Medicaid to determine the differing provider payment rates between each program
- Review covered services offered by TRICARE, Medicare, and Medicaid to determine any differences in benefits between each program
- Provide recommendations to aid DOD in maintaining the financial integrity of TRICARE
- Outline areas for further research and follow on TRICARE studies

This research project accomplished the following: 1) determined that TRICARE and Medicare exhibited almost identical provider payment rates across all three of the states compared in this study, 2) determined that Medicaid payment rates in California and Connecticut are higher than TRICARE while rates in Mississippi are lower, 3) determined that TRICARE exhibited lower per capita spending and lower spending growth rates than Medicare or Medicaid. Chapter II discusses a literature review of documentation available to TRICARE, Medicare, and Medicaid beneficiaries, summarizes the operations of each program, and provides lists of covered services and benefits for each program.

II. LITERATURE REVIEW

A. INTRODUCTION

Per CBO projections, military health care as a percentage of the overall DOD budget has almost doubled in the last 12 years, going from six percent of the DOD budget to 10 percent (CBO, 2014, p. 1). During that same period, funding levels for military health care increased 130 percent (CBO, 2014, p. 1). Current CBO estimates indicate that military health care spending as a percentage of the DOD budget will increase to 11 percent by 2028 (CBO, 2014, p. 8). These numbers illuminate the need to take a critical look at military health care spending. The goal must be to find cost saving opportunities and reduce or arrest cost growth while maintaining the quality of care currently in place.

This daunting task is complicated by the fact that wounded U.S. troops come with a hefty price tag for their expensive, albeit necessary, care. This fact resulted from almost 15 years of worldwide sustained combat operations. The problem culminated in 2007 with the unearthing of substandard conditions at Walter Reed Army Medical Center (Priest & Hull, 2007). This scandal highlighted the inadequate capacity of the military health system, particularly in the realm of mental health care, for dealing with the volume of combat wounded resulting from low intensity warfare. According to the Defense Manpower Data Center's (DMDC) Defense Casualty Analysis System (DCAS), almost 52,000 U.S. troops have been wounded in prosecuting the global war on terror (GWOT) since 2001 (DMDC, 2014). Many of those troops have been severely wounded and will require a lifetime of care. It is important to note that troops who are separated from the military services for medical reasons have the costs of their care transferred to the Department of Veterans Affairs (VA) though the initial costs for their treatment are borne by DOD.

Furthermore, the growing cost of military retiree's health care is placing added burden on the DOD budget. The current military health care system for military retirees and their families provides free care to retirees who are not Medicare eligible and utilize military medical facilities. For non-Medicare eligible retirees and their families who do

not use military medical facilities, TRICARE Prime, Extra, and Standard are available based on predetermined provider payment sharing rates. For retirees and their families who are Medicare eligible, TRICARE For Life reduces or eliminates most out-of-pocket expenses for medical care with various rules regarding eligibility, enrollment, and rate sharing.

This chapter consists of a literature review that summarizes the benefits provided by each of the three federally funded medical insurance programs (TRICARE, Medicare, and Medicaid). The literature review also provides information on covered services, rate shares, coinsurance, and premiums required for those services, and insurance models (HMO, PPO, etc.) used by each program. The following section discusses the benefits provided by TRICARE, Medicare, and Medicaid, the services covered by each program, and how each program operates.

B. PLAN BENEFITS AND COVERED SERVICES

The next section provides an overview of the TRICARE program.

1. TRICARE

TRICARE Prime, TRICARE Standard/Extra, and TRICARE Overseas also have coverage subsets that expand offered care based on specific eligibility criteria. These subsets are addressed in conjunction with discussion of each program type. For all TRICARE programs, eligibility is determined through review and verification of data contained in the Defense Enrollment Eligibility Reporting System (DEERS). DEERS is a computerized database of active, reserve, and retired U.S. service members, their dependents, DOD active contractors, and others who are entitled to DOD benefits such as TRICARE. The next section provides an overview of TRICARE Prime.

a. TRICARE Prime

TRICARE Prime functions similar to a health management organization (HMO). Under TRICARE Prime, out-of-pocket expenses to the beneficiary are minimized as long as the beneficiary uses health care providers authorized by TRICARE, also known as “in-network” providers. Using health care providers outside the required network of health

care providers results in a substantial increase in the percentage of incurred expenses that are passed on to the beneficiary. TRICARE Prime enrollment is mandatory for active duty service members (ADSM) and optional for active duty dependent family members (ADFM) that reside in a prime service area (PSA). PSAs are usually designated as areas within 50 miles of a military medical facility (DHA, 2013b, p. 5). TRICARE Prime eligibility within a PSA is extended to the following military personnel and dependents:

- ADFMs
- Transitional survivors
- Certain former spouses (not remarried and previously married to sponsor for greater than 20 years of active service)
- Retirees, family members, and survivors (based on specific eligibility requirements, which will be covered later)
- National Guard and Reserve members on active duty for greater than 30 days (includes family members)
- Medal of Honor recipients and their families (DHA, 2013b, p. 5)

ADSMs and ADFMs (including National Guard and Reserve members called to active duty for greater than 30 days) may also be eligible for TRICARE Prime Remote or TRICARE Prime Remote for active duty dependent family members (TPRADFM) (DHA, 2013b, p. 6). TRICARE Prime Remote is generally meant to provide coverage for eligible service and family members who live outside the 50-mile radius (or one hour drive) of a military medical facility. TRICARE Prime Remote provides coverage identical to TRICARE Prime and functions primarily as a mechanism to expedite approval of the larger than average out-of-network health care provider billings generated by beneficiaries located outside PSAs.

Enrolling in either TRICARE Prime or TRICARE Prime Remote is accomplished by submitting a “TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form” (DD Form 2876) to the regional TRICARE contractor (DHA, 2013b, p. 15). The regional contractor listing is listed in Table 1.

Table 1. TRICARE Regional Contractors List (after DHA, 2013b)

Region	Contractor
North	Health Net Federal Services LLC
South	Humana Military, a division of Humana Government Business
West	UnitedHealthcare Military & Veterans
Overseas	International SOS, Inc.

TRICARE Prime and Prime Remote beneficiaries who are not ADSMs or ADFMs are required to pay annual enrollment fees (DHA, 2013b, p. 11). Typically, these beneficiaries are military retirees, family members, and survivors. Annual enrollment fees for medically retired service members, their family members, and survivors are frozen at the time of enrollment and are not subject to the annual enrollment fee increase, which occurs each new fiscal year (DHA, 2013b, p. 11). Furthermore, any enrollment fees paid by eligible beneficiaries are applied to the catastrophic cap associated with the beneficiary’s eligibility group (e.g., retiree, retiree family member, and survivor). Enrollment fees are waived for retirees who are enrolled in Medicare Part B (if still on active duty).

TRICARE Prime care is most often managed at the lowest level by the beneficiary’s chosen primary care manager (PCM). A PCM is usually a physician or medical facility/practice designated by TRICARE as being responsible for coordinating primary care for TRICARE Prime and Prime Remote beneficiaries. TRICARE providers fall into two types, 1) network and 2) non-network. Non-network providers are further broken down into 1) participating and 2) nonparticipating. Major differences between these designations center on the rate share assumed by the beneficiary when utilizing a particular provider. Table 2 provides additional detail on TRICARE providers (all program types).

Table 2. TRICARE Authorized Provider Detail (from DHA, 2013b)

TRICARE-Authorized Providers		
<ul style="list-style-type: none"> • TRICARE-authorized providers meet TRICARE licensing and certification requirements and are certified by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers may include doctors, hospitals, ancillary providers (e.g., laboratories, radiology centers), and pharmacies that meet TRICARE requirements. If you see a provider that is not TRICARE-authorized, you are responsible for the full cost of care. • There are two types of TRICARE-authorized providers: network and non-network. 		
Network Providers	Non-Network Providers	
<ul style="list-style-type: none"> • Regional contractors have established networks and you may be assigned a primary care manager (PCM) who is part of the TRICARE network. • When specialty care is needed, your best option is for your PCM to coordinate care with a network provider. • TRICARE network providers: <ul style="list-style-type: none"> • Have a signed agreement with your regional contractor to provide care • Agree to file claims for you 	<ul style="list-style-type: none"> • Non-network providers do not have a signed agreement with your regional contractor and are considered “out of network.” In most cases, you will not receive care from non-network providers unless authorized by your regional contractor. You may seek care from a non-network provider in an emergency or if you are using the point-of-service (POS) option (<i>using the POS option results in higher out-of-pocket costs</i>). • There are two types of non-network providers: participating and nonparticipating. 	
	Participating	Nonparticipating
	<ul style="list-style-type: none"> • Using a participating provider is your best option if you are seeing a non-network provider. • Participating providers: <ul style="list-style-type: none"> • May choose to participate on a claim-by-claim basis • Have agreed to accept payment directly from TRICARE and accept the TRICARE-allowable charge (<i>less any applicable patient costs paid by you</i>) as payment in full for their services 	<ul style="list-style-type: none"> • If you visit a nonparticipating provider, you may have to pay the provider first and later file a claim with TRICARE for reimbursement. • Nonparticipating providers: <ul style="list-style-type: none"> • Have not agreed to accept the TRICARE-allowable charge or file your claims • Have the legal right to charge you up to 15 percent above the TRICARE-allowable charge for services

TRICARE Prime Remote beneficiaries have care coordinated by a service point of contact (SPOC) (DHA, 2013b). The SPOC reviews requests for care and bases the approval determination on service specific guidelines and clinic standards. Based on the SPOCs approval decision, beneficiaries will receive care from a civilian provider or at a military medical facility. In cases where the SPOC determines that ADSM’s care is related to “fitness for duty” (which requires treatment at a military medical facility) and

care at a military medical facility is not available, the SPOC may assign the ADSM to receive care under the Supplemental Health Care Program (SHCP). SHCP allows ADSMs and certain other personnel to receive “fitness for duty” care from civilian providers using TRICARE Prime payment rules (DHA, 2013b, p. 8).

U.S. Department of Veterans Affairs (VA) health care facilities have signed agreements with TRICARE regional contractors to serve as TRICARE network providers (DHA, 2013b, p. 11). VA medical facilities have established processes for handling TRICARE beneficiary billing and medical claims and are not considered military medical facilities. Retirees and ADSMs who have VA medical benefits but choose to use TRICARE to pay for medical treatment at VA facilities can incur substantial out-of-pocket expenses. This issue arises because by law TRICARE can pay only up to 20 percent of the contracted rate for VA care (DHA, 2013b, p. 11). It is important to note these facts in order to make clear that VA benefits and medical facilities are distinctly different from TRICARE benefits and military medical facilities. The next section details how TRICARE Prime beneficiaries obtain care.

(1) Getting Care

For TRICARE Prime beneficiaries, primary care and specialty care appointments are generally coordinated through the beneficiary’s PCM. For primary care, beneficiaries will normally be seen by their PCM. PCMs will also handle urgent care appointments (non-emergency care requiring treatment in 24 to 48 hours). For specialty care, the beneficiary’s PCM must submit a care referral to the TRICARE regional contractor for approval. Once TRICARE provides an authorization, the beneficiary can be seen by the assigned specialist. In cases where emergency care is needed (defined as threat to life, limb, sight, or safety) no referral is required; however the beneficiary should contact his PCM within 24 hours.

Table 3 provides specifics on the various definitions and examples of care under TRICARE rules. It is important to note that these definitions are universal in U.S. health care terminology and are not specific to TRICARE.

Table 3. TRICARE Healthcare Definitions (from DHA, 2013b)

Type of Care	Definition	Primary Care Manager Role	Examples
Emergency	TRICARE defines an emergency as a serious medical condition that the average person would consider to be a threat to life, limb, sight, or safety.	You do not need to call your primary care manager (PCM) before receiving emergency medical care. Your PCM must be notified within 24 hours or on the next business day following admission.	No pulse, severe bleeding, spinal cord or back injury, chest pain, broken bone, inability to breathe
Urgent	Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but does require professional attention within 24 hours. Urgent care services require a referral if you do not see your PCM for care.	Call your PCM first for appropriate guidance.	Minor cuts, migraine headache, urinary tract infection, sprain, earache, rising fever
Routine	Routine (<i>primary</i>) care is general health care and includes general office visits. Routine care also includes preventive care to help keep you healthy.	You will receive most of your routine care from your PCM.	Treatment of symptoms, chronic or acute illnesses and diseases, follow-up care for an ongoing medical condition
Specialty Care	Specialty care consists of specialized medical services provided by a physician specialist. Specialty care providers offer treatment that your PCM cannot provide.	Your PCM will refer you to another health care provider for care he or she cannot provide and will coordinate the referral request with your regional contractor when necessary.	Cardiology, dermatology, gastroenterology, obstetrics

TRICARE Prime Remote beneficiaries may seek primary, urgent, and specialty care from any TRICARE authorized provider. Emergency care does not require a referral though the TRICARE Prime Remote beneficiary must contact the SPOC as soon as possible. In cases where ADSMs require nonemergency care while on travel or in between duty stations, ADSMs should seek care at the nearest military medical facility. If no military medical facility is available, the ADSM must contact the regional contractor directly to obtain an authorization to seek care from a civilian provider. TRICARE Prime ADFMs, retirees, and other dependent beneficiaries may seek care from a military treatment facility (MTF) on a space available basis. It is important to note that ADSMs

always receive first priority when seeking care at any military medical facility to include MTFs. An MTF can be defined as a large medical center administered by DOD that provides primary, urgent, emergency, and specialty medical care.

Clinical preventative services and outpatient behavioral health care for a medically diagnosed and covered condition do not require a PCM referral (DHA, 2013b, p. 13). These services must be rendered by a network provider authorized under TRICARE regulations to see patients independently. Behavioral health visits require prior authorization from the regional contractor after the ninth visit in a fiscal year (October 1–September 30). ADSMs must seek prior authorization for any civilian care except emergency care.

TRICARE Prime and Prime Remote also incorporate access to care standards. These include:

- The wait time for an urgent care appointment should not exceed 24 hours (one day).
- The wait time for a routine appointment should not exceed one week (seven days).
- The wait time for a specialty care appointment or wellness visit should not exceed four weeks (28 days).
- The travel time for a routine appointment should not exceed 30 minutes.
- The travel time for a specialty care appointment should not exceed one hour (DHA, 2013b, p. 14).

These standards are used as a benchmark for determining TRICARE authorized providers and can be waived only by non-active duty beneficiaries. Waiver of access standards occurs in cases where a beneficiary desires to be seen at a military medical facility that is located more than 30 minutes away (by automobile) from the beneficiary's domicile. No waiver of access standards by ADSMs is required or authorized. The next section discusses the medical services covered by TRICARE Prime.

(2) Covered Services

Medical services covered by TRICARE Prime and Prime Remote include a vast range of medical conditions and procedures. Outpatient mental health treatment for previously diagnosed mental health conditions does not require a referral or authorization

for non-active duty beneficiaries up to eight visits/treatments per fiscal year. ADSMs seeking outpatient mental treatment outside military medical facilities must have prior authorization. Authorization from the TRICARE regional contractor is required upon the ninth and subsequent outpatient visit and for any inpatient mental health treatment excluding emergency care. Continuing inpatient care following an emergency does require authorization. Outpatient and inpatient treatment for substance abuse is valid for 365 days and requires prior authorization from the regional contractor. Smoking cessation counseling is also covered and requires no referral or prior authorization.

TRICARE Prime and Prime Remote also cover clinical preventative services as shown in Table 4.

Table 4. Preventative Clinical Services Covered By TRICARE (from DHA, 2013b)

Service	Description
Comprehensive Health Promotion and Disease Prevention Examinations	<p>Adult: A comprehensive clinical preventive examination is covered if it includes an immunization, Pap test, mammogram, colon cancer screening, or prostate cancer screening. Beneficiaries in each of the following age groups may receive one comprehensive clinical preventive examination without receiving an immunization, Pap test, mammogram, colon cancer screening, or prostate cancer screening (<i>one examination per age group</i>): 18–39 and 40–64.</p> <p>Pediatric: A comprehensive clinical preventive examination is covered if it includes an immunization. Beneficiaries in each of the following age groups may receive one comprehensive clinical preventive examination without receiving an immunization (<i>one examination per age group</i>): 2–4, 5–11, 12–17. School enrollment physicals for children ages 5–11 are also covered.</p>

TRICARE Prime and Prime Remote further cover several specific health screening evaluations if those screenings are performed at the same time as a beneficiary receives a comprehensive preventative examination. All of these procedures are classified as preventative wellness visits and are used to detect serious medical problems at earlier stages where the cost of treatment is expected to be less. These exams include procedures such as colonoscopy, mammograms, digital prostate exams, Pap tests, cholesterol testing, and hearing tests.

Maternity care is covered as well. Treatment includes obstetric visits and post-natal care up to six weeks after delivery. Routine ultrasound screenings are not covered but ultrasounds deemed medically necessary (emergency) are covered. Hospice (end-of-life care) is covered for beneficiaries located within the U.S. and U.S. territories.

Extended Care Health Option (ECHO) coverage provides long-term care to ADFMs who are diagnosed with severe mental and/or physical disabilities that restrict the ability of the ADFMs to care for themselves (DHA, 2013b, p. 23). These services include basic self-care skills training, special education, in-home medical care, special equipment/adaptive devices and training in the use of such devices, institutional care, and transportation. All ECHO care must be authorized through the regional contractor and the ADFM must be enrolled in the military's Exceptional Family Member Program. The next section details how beneficiaries can make changes to their TRICARE Prime coverage.

(3) Changes to TRICARE Coverage

TRICARE Prime and Prime Remote coverage is portable and can be rescinded based on changes in military status (retirement or discharge), failure to pay enrollment fees, or voluntary disenrollment. ADSMs and ADFMs must transfer TRICARE Prime or Prime Remote benefits upon arriving in a new TRICARE region by contacting the regional contractor. All other TRICARE Prime beneficiaries can transfer benefits by changing PCMs upon arrival in the new PSA.

ADSMs and ADFMs leaving active military service under honorable conditions are given 180 days of TRICARE Prime coverage under the Transitional Assistance Management Program (TAMP) (DHA, 2013b, p. 30). ADSMs that retire from military service and are eligible for Medicare are generally shifted to TRICARE For Life upon enrolling in Medicare Parts A and B. Medicare enrollment should be accomplished prior to leaving active service to avoid enrollment premium penalties. Retirees who are not eligible for Medicare can remain on TRICARE Prime but must pay annual enrollment fees. These retirees will also experience changes in coverage and some increases in out-of-pocket expenses (covered later). ADSMs and ADFMs discharged from active military service under other than honorable conditions will lose coverage on the day of discharge.

Surviving spouses of ADSMs receive TRICARE Prime coverage for three years following the ADSM's death if they are under the age of 55 and do not remarry. Surviving children are eligible for TRICARE Prime coverage up to the age of 21 unless they are enrolled as full-time students (eligible up to age 23) or are disabled, or the surviving parent remarries (TRICARE coverage ends). Keeping DEERS information updated is critical to ensuring continuity of coverage in all circumstances. The next section provides an overview of TRICARE Standard/Extra.

b. TRICARE Standard/Extra

TRICARE Standard/Extra functions similar to a preferred provider organization (PPO). The insurer and the insured share the expense of covered medical services based on a defined percentage schedule subject to specific rules governing provider choice. The major difference between TRICARE Standard and TRICARE Extra centers on the rate share of services assumed by beneficiaries. TRICARE Standard allows beneficiaries to use health care providers outside the TRICARE health care provider network while assuming a larger rate share for services rendered. TRICARE Extra beneficiaries use providers within the TRICARE network and consequently pay a smaller rate share. It is important to note that health care providers that are outside the TRICARE network may charge up to 15 percent above the allowable rate set by TRICARE (see Table 2). The beneficiary is obligated to pay this amount. TRICARE Standard and Extra can be used by beneficiaries interchangeably without restriction with all patient rate shares counting toward the annual deductible and catastrophic cap (covered later). Table 5 outlines rate share percentages for each program.

Table 5. Rate Share Percentages for TRICARE Standard and Extra
(from DHA, 2012b)

	TRICARE Standard	TRICARE Extra
Provider type	TRICARE-authorized, non-network	TRICARE-authorized, TRICARE network
Outpatient cost-share, after deductible is met	<ul style="list-style-type: none"> • Active duty dependent family members (ADFM) and TRICARE Reserve Select (TRS): 20% of the TRICARE-allowable charge • Retirees, their families, TRICARE Retired Reserve (TRR), and all others: 25% of the TRICARE-allowable charge 	<ul style="list-style-type: none"> • ADFM and TRS: 15% of the negotiated rate • Retirees, their families, TRR, and all others: 20% of the negotiated rate

TRICARE Standard/Extra eligibility rules mirror those of TRICARE Prime with the exception that ADSMs may not enroll in TRICARE Standard/Extra. TRICARE Reserve Select and TRICARE Retired Reserve are premium-based options that fall under the umbrella of TRICARE Standard/Extra. These plans are available to members of the drilling reserve or members who have retired from the drilling reserve respectively. Like TRICARE Prime and Prime Remote, eligibility for TRICARE Standard/Extra is determined by review and verification of beneficiary data contained in DEERS. Enrollment in TRICARE Standard and Extra is automatic for eligible beneficiaries. The next section discusses how TRICARE Standard/Extra beneficiaries obtain care and what services are covered by the program.

(1) Getting Care and Covered Services

TRICARE Standard and Extra beneficiaries may see authorized TRICARE providers (see Table 2) for most types of care without a referral. Typically, only the following types of care require prior authorization from the regional contractor (see Table 1) although this list is not all-inclusive:

- Extended Care Health Option services
- Home health services
- Hospice care

- Non-emergency inpatient admissions for substance abuse disorders or behavioral health
- Outpatient behavioral health visits beyond the eighth visit in a fiscal year

TRICARE Standard and Extra use care type definitions identical to those used for TRICARE Prime (see Table 3).

TRICARE Standard and Extra beneficiaries with a service-connected disability may use their VA or TRICARE benefits when seeking medical care. Travel beyond 100 miles from the beneficiary’s location to obtain necessary medical care to treat a combat-related disability can also be reimbursed by TRICARE (DHA, 2012b, p. 10). Additionally, the travel expenses of a non-medical attendant are also reimbursable. A non-medical attendant is defined as any individual over the age of 21 years of age, typically a parent or guardian, who accompanies the combat disabled beneficiary.

TRICARE Standard and Extra beneficiaries, similar to those in TRICARE Prime, may seek care at an MTF on a space available basis. TRICARE Standard and Extra beneficiaries that receive care at a MTF or any other military medical facility do not generally incur out-of-pocket expense. Availability at military medical facilities for TRICARE Standard and Extra beneficiaries is strictly limited. Table 6 outlines the ranking of priority for TRICARE beneficiaries seeking medical care at an MTF.

Table 6. MTF Appointment Priorities (from DHA, 2012b)

1	Active duty service members
2	Active duty dependent family members (ADFM)s enrolled in TRICARE Prime
3	Retired service members, their families, and all others enrolled in TRICARE Prime
4	ADFM)s not enrolled in TRICARE Prime and TRICARE Reserve Select beneficiaries
5	Retired service members and their families not enrolled in TRICARE Prime, TRICARE Retired Reserve beneficiaries, and all other eligible beneficiaries

Outpatient and inpatient mental health care is covered per rules similar to those in TRICARE Prime. The only differences stem from rate shares incurred by beneficiaries

(see Table 5). Mental health care providers can be 1) certified psychiatric nurse specialists, 2) mental health counselors, 3) pastoral counselors, 4) certified marriage and family therapists, 5) licensed clinical social workers, 6) clinical psychologists, or 7) psychiatrists (DHA, 2012b, p. 11). TRICARE Standard and Extra maternity care, hospice care and smoking cessation are also covered based on the established rate share percentages of TRICARE Standard and Extra. TRICARE Standard and Extra further provides ECHO coverage. The next section discusses how TRICARE Standard/Extra beneficiaries make changes to their coverage.

(2) Changes to TRICARE Coverage

The rules governing eligibility for changes in TRICARE Standard and Extra coverage and the procedures for affecting those changes do not differ from the rules and procedures for TRICARE Prime. TRICARE rules and procedures for changing coverage to include portability are standardized across TRICARE plan types with minor differences as noted in this study. Maintaining up-to-date information in DEERS to maintain eligibility for TRICARE is required. The following section discusses TRICARE For Life.

c. TRICARE For Life

TRICARE For Life provides health care coverage to military retirees (and their eligible dependents) who are eligible for and enrolled in Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance). The program is designed to reduce or eliminate the out-of-pocket medical care expenses associated with Medicare for eligible beneficiaries. TRICARE For Life essentially functions as secondary insurance for military retirees and family members enrolled in Medicare with specific restrictions (covered later).

Retirees and spouses who do not qualify for premium-free Medicare Part A do not require Medicare Part B to remain TRICARE eligible but do not qualify for TRICARE For Life. Military retirees not meeting the eligibility requirements of Medicare may enroll in either TRICARE Prime (if in a PSA) or TRICARE Standard/Extra. TRICARE For Life eligible beneficiaries include:

- Active duty retirees, family members, and survivors
- Certain former spouses (not remarried and previously married to sponsor for greater than 20 years of active service)
- Retired National Guard and Reserve members
- Medal of Honor recipients and their families (DHA, 2013a, p. 4)

As Medicare plays a role in TRICARE For Life eligibility, this section outlines some aspects of the Medicare program without explaining details that will be explained later in this paper. Medicare is a health insurance entitlement that is fully funded by the federal government and administered by the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Eligibility is determined by the Social Security Administration and falls into three broad categories:

- People age 65 and older
- People under age 65 with certain disabilities
- People with end-stage renal disease (DHA, 2013a, p. 4)

Eligibility for Medicare Part A also requires the applicant or spouse to have at least 40 quarters or 10 years of credible work history (DHA, 2013a, p. 5). Credible work is defined as employment that required the applicant to pay federal payroll taxes. If the applicant is not eligible for Medicare Part A but the spouse is eligible and over 62 years old, then the applicant must file for benefits under the spouse's Social Security Number. If the ineligible applicant's spouse is not 62 or older, then the applicant should file for benefits under Medicare Part B at age 65 and file for Medicare Part A two months prior to the spouse reaching age 62.

Medicare Part B is premium-based. Like Part A, Part B requires applicants to file for benefits within a defined enrollment period to avoid paying a late enrollment surcharge. ADSMs and ADFMs (except for those with end-stage renal disease) have a special enrollment period, which extends from the time the ADSM is on active duty (at or after age 65) to eight months after the ADSM leaves active service or TRICARE benefits end, whichever comes first. It is important to note that to avoid a break in TRICARE coverage, ADSMs (65 or older) and ADFMs must sign up for Medicare Part B prior to the ADSMs departure from active service.

Disabled retirees under age 65 receiving Social Security disability benefits are eligible for Medicare after receiving disability benefits for 25 months. Retirees under age 65 who have amyotrophic lateral sclerosis (Lou Gehrig's Disease) are automatically enrolled in Medicare Parts A and B when Social Security disability benefits start. Disabled retirees receiving Social Security disability benefits who return to work will remain TRICARE eligible so long as Part B premiums are paid. Medicare eligibility can continue for up to eight years and six months after Social Security benefits are suspended. Retirees under the age of 65 who resided in Lincoln County, Montana for at least six months in the last 10 years preceding a diagnosis of mesothelioma (type of lung cancer) are also Medicare eligible. Retirees under age 65 with end-stage renal disease are eligible for Medicare at the time of diagnosis but must enroll in Medicare Parts A and B as soon as they are eligible. The next section discusses how TRICARE For Life participants obtain care and what services are covered by the program.

(1) Getting Care and Covered Services

TRICARE For Life beneficiaries may seek care from any provider they choose with varying rate shares based on the Medicare network authorization status of the selected provider and whether the rendered service is covered. There are three main types of provider:

- Medicare-participating providers
- Medicare non-participating providers
- Medicare opt-out providers

Medicare-participating providers have agreed to accept all Medicare payment rates and cannot bill amounts above agreed rates. Medicare non-participating providers agree to accept Medicare payment but do not agree to accept Medicare payment rates. Non-participating providers may bill up to 15 percent above Medicare rates, an expense for which the TRICARE For Life beneficiary is responsible. Medicare opt-out providers cannot bill Medicare; therefore, the beneficiary is responsible for the full balance minus the TRICARE covered portion if the service is covered by TRICARE.

For services covered by both Medicare and TRICARE, TRICARE For Life pays the remaining balance of the covered service once Medicare pays its established rate

share. If Medicare does not pay, then TRICARE For Life does not generally pay either. If care that is normally covered by Medicare is rendered by a provider that does not participate in Medicare, then TRICARE For Life will pay a percentage of the bill (typically 20 percent of the TRICARE allowable charge) and the beneficiary is responsible for paying the balance. This includes care rendered at a VA facility as VA is not a Medicare authorized provider. In cases where medical services are covered by Medicare only or by neither TRICARE nor Medicare, the TRICARE beneficiary remains responsible for the balance unpaid by TRICARE or the full balance, depending on the circumstances. If a medical service is covered by TRICARE but not Medicare, then TRICARE assumes responsibility as the primary payer with the beneficiary assuming rate shares as shown in Table 5. Table 7 provides an overview of payment responsibilities as they relate to the beneficiary, Medicare, and TRICARE.

Table 7. TRICARE For Life Out-of-Pocket Expenses (from DHA, 2013a)

Type of Service	Medicare Pays	TRICARE Pays	You Pay
Covered by TRICARE and Medicare	Medicare-authorized amount	TRICARE-allowable amount	Nothing
Covered by Medicare only	Medicare-authorized amount	Nothing	Medicare deductible and rate-share
Covered by TRICARE only	Nothing	TRICARE-allowable amount	TRICARE deductible and rate-share
Not covered by TRICARE or Medicare	Nothing	Nothing	Billed charges (<i>which may exceed the Medicare- or TRICARE-allowable amount</i>)

TRICARE For Life beneficiaries may also seek care at a military medical facility. Appointment availability for TRICARE For Life beneficiaries is strictly limited and is done on a space available basis only. Table 6 lists appointment priorities at military medical facilities.

TRICARE For Life also covers emergency, urgent, and behavioral health care based on established rate shares. Typically, both Medicare and TRICARE cover these

services with the beneficiary incurring little to no out-of-pocket expense. Medicare does not cover mental health care provided by non-participating providers so TRICARE For Life becomes the primary insurance in these cases.

Because TRICARE For Life does not have regional contractors, medical services that require prior authorization are routed through the TRICARE For Life contractor, Wisconsin Physician Services. The following services require beneficiaries to obtain authorization prior to seeking care:

- Extended Care Health Option services
- Home health care
- Hospice care
- Nonemergency inpatient treatment of behavioral health problems or substance abuse
- Outpatient behavioral health treatment beyond eight visits in a fiscal year
- Transplants—organ and stem cell

The next section discusses how TRICARE For Life beneficiaries make changes to their coverage.

(2) Changes to TRICARE coverage

The rules governing eligibility or changes in TRICARE For Life coverage and the procedures for affecting those changes do not differ from the rules and procedures for TRICARE Prime or TRICARE Standard/Extra. TRICARE rules and procedures for changing coverage to include portability are standardized across TRICARE plan types with minor differences as noted in this study. Maintaining up-to-date information in DEERS to maintain eligibility for TRICARE is required. The next section discusses TRICARE Overseas.

d. TRICARE Overseas

TRICARE Overseas encompasses all of the TRICARE plans and sets the rules and regulations by which TRICARE beneficiaries obtain and pay for medical care outside the U.S. or its outlying territories. Beneficiaries who are enrolled in any TRICARE plan (TRICARE Prime, Prime Remote, Standard/Extra, etc.) simply switch over to the

TRICARE Overseas version of their assigned health insurance plan. Table 8 shows which version of TRICARE Overseas various TRICARE beneficiaries are eligible for.

Table 8. TRICARE Overseas Program Options by Beneficiary Type
(from DHA, 2012a)

Beneficiary Type	Program Options
Active duty service members	<ul style="list-style-type: none"> • TRICARE Overseas Program (TOP) Prime • TOP Prime Remote • TRICARE Active Duty Dental Program (ADDP)
Active duty dependent family members and transitional survivors	<ul style="list-style-type: none"> • TOP Prime • TOP Prime Remote • TOP Standard • TRICARE Young Adult (TYA) • TRICARE For Life (TFL) (<i>if entitled to Medicare Part A and have Part B</i>) • TRICARE Dental Program
Retired service members and family members, survivors, Medal of Honor recipients, certain unremarried former spouses, and others	<ul style="list-style-type: none"> • TOP Standard • TYA • TFL (<i>if entitled to Medicare Part A and have Part B</i>) • Enhanced-Overseas TRICARE Retiree Dental Program • TRICARE Plus (<i>depending on military treatment facility availability</i>)

Eligibility for TRICARE Overseas benefits is determined by verification of information contained in DEERS (as with all other TRICARE plans) and the type of orders that the ADSM receives. The orders must assign the ADSM to a duty station outside the United States and its outlying territories. The orders must also allow ADFMs sponsored by the ADSM (TRICARE beneficiaries) to accompany the ADSM to his or her assigned duty station. Other procedures for enrollment and terms for eligibility reflect the terms and procedures required by the beneficiary's version of TRICARE (Prime, Standard/Extra, etc.). The next section discusses how TRICARE Overseas beneficiaries obtain care and what services the program covers.

(1) Getting Care and Covered Services

TRICARE Overseas versions of each TRICARE plan provide coverage and payment rules identical to those in the U.S. with some exceptions. First, the TRICARE

Overseas regional contractor (see Table 1) provides a list of TRICARE authorized providers. Using host nation providers not on this list can result in significant out-of-pocket expenses for the TRICARE beneficiary. This is because the rules in the U.S. limiting TRICARE out-of network provider billing amounts to 115 percent of TRICARE allowable charges do not apply outside the U.S. Second, in certain countries such as the Philippines, use of out-of-network providers is prohibited (DHA, 2012a). This rule is used to ensure that TRICARE beneficiaries receive medical care that meets established standards. Third, TRICARE beneficiaries utilize a Global TRICARE Service Center, which is equipped to answer beneficiary questions and coordinate authorization for medical care worldwide (DHA, 2012a). There are also TRICARE area offices that can coordinate authorization for medical care in specific world regions.

ADSMs and accompanying ADFMs stationed in Canada can receive free medical care from a Canadian Forces health facility (similar to a U.S. MTF) under the TRICARE and DOD reciprocal care agreement (DHA, 2012a). Canadian Forces health facilities are located in the following Canadian provinces and territories:

- Alberta
- British Columbia
- Manitoba
- New Brunswick
- Newfoundland and Labrador
- Northwest Territories
- Nova Scotia
- Ontario
- Quebec
- Saskatchewan (DHA, 2012a, p. 17)

Medical procedures that require prior authorization are identical under all TRICARE health insurance plans including TRICARE Overseas. In certain circumstances, TRICARE Overseas will authorize aeromedical evacuation of beneficiaries in order to ensure that proper care is administered by certified providers. Aeromedical evacuation should be coordinated through the TRICARE Global Service

Center, MTF, or Canadian Forces Health Facility. The next section shows how TRICARE Overseas beneficiaries make changes to their coverage.

(2) Changes to TRICARE Coverage

TRICARE Overseas procedures for transferring coverage when moving do not differ from procedures under other TRICARE plans. TRICARE Overseas beneficiaries that move to the U.S. or outlying U.S. territories must enroll in one of TRICARE's other plans. TRICARE Overseas beneficiaries transferring to another overseas duty station can transfer coverage by contacting the TRICARE Overseas regional contractor. The next section provides an overview of the Medicare program.

2. Medicare

Medicare is a health insurance plan funded by the federal government and administered by the Centers for Medicare & Medicaid Services (CMS), an agency of the Department of Health and Human Services (HHS). Coverage is determined by three main factors: 1) federal and state laws, 2) national coverage decisions made by Medicare, and 3) local coverage decisions made by companies in each state that process Medicare claims and determine if procedures are medically necessary. Medicare is comprised of four major parts. Each part provides a different subset of health coverage. The four Medicare parts are:

- Part A (Hospital Insurance)
- Part B (Medical Insurance)
- Part C (Medicare Advantage)
- Part D (Medicare Prescription Drug Coverage) (CMS, 2013a, p. 15)

This research study focuses on Medicare Parts A and B and sections of Part C, which include provisions from Parts A and B. Medicare Part D is not included in order to normalize the comparison to TRICARE and limit the scope of the study. The next section discusses Medicare Part A.

a. Medicare Part A

The hospital insurance portion of Medicare covers medical services such as:

- Inpatient care in hospitals
- Skilled nursing facility care
- Hospice care
- Home health care

Part A operates like a PPO and provides payment for medical care based on percentage rate shares depending on the service rendered. Certain deductibles, coinsurance, and copayments also apply. General patient copayments, coinsurance, and deductibles for Part A covered services for providers that accept Medicare include:

- Home health care—\$0 for home health services; 20 percent for the Medicare approved amount for durable medical equipment (wheelchair, walker, etc.)
- Hospice care—\$0 for hospice care; five percent of the Medicare approved amount for respite care (care provided by third party in lieu of absent regular caregiver)
- Inpatient hospital care—\$1,216 deductible for each period of inpatient hospitalization with no break greater than 60 days (benefit period); \$0 coinsurance for each day 1 to 60 of benefit period; \$304 coinsurance for each day 61 to 90 of benefit period; \$608 coinsurance for each day beyond 90 of benefit period; 20 percent for Medicare approved amount for inpatient mental health care providers
- Skilled nursing facility care—\$0 coinsurance for each day 1 to 20 of benefit period; \$152 coinsurance for each day 21 to 100; beyond day 100 of benefit period the insured assumes all expenses (CMS, 2013a)

People receiving Social Security or Railroad Retirement Board benefits will automatically be enrolled in Medicare Part A starting the first day of the month they turn 65 or the first day of the prior month if their birthday falls on the first of the month. People that are disabled, under 65, and receiving Social Security or Railroad Retirement Board disability benefits will automatically be enrolled in Medicare Part A after receiving benefits for 24 months. People diagnosed with amyotrophic lateral sclerosis (Lou Gehrig's Disease) will automatically be enrolled in Part A in the same month that disability benefits begin. People with end-stage renal disease must sign up for Part A during an initial enrollment period. It is important to note that recipients of Medicare Part A must be U.S. citizens or lawfully present in the U.S.

All others eligible for Part A must sign up during an initial enrollment period. The initial enrollment period runs for a seven month period beginning three months before the applicant turns 65, includes the applicant's birth month, and then runs three months after the applicant turns 65. If the applicant enrolls prior to his or her birth month then coverage starts on the first of the month she or he turns 65. If the applicant's birthday falls on the first of the month then coverage starts on the first of the month prior to the applicant's birth month. If the applicant enrolls during the initial enrollment period for Part A, but after his or her birth month then coverage can be delayed up to three months.

If the applicant fails to sign up for Part A during the initial enrollment period then the applicant must enroll during a general enrollment period, which runs annually from January 1–March 31. Coverage will then start on July 1 of that year. Applicants who do not qualify for premium-free Part A will be assessed a late enrollment penalty equal to 10 percent of the monthly premium. The higher premium must be paid for twice the number of years that the applicant was initially eligible for Part A but did not enroll.

Applicants covered by health insurance through their place of employment when they turn 65 are eligible for a special enrollment period. The special enrollment period extends from anytime the applicant turns 65 and is still employed until eight months after the applicant's coverage ends or the applicant's leaves the employer, whichever comes first. This special enrollment period applies to TRICARE recipients on active duty at the time they turn 65.

Most applicants who paid Medicare taxes during their working years are eligible for premium-free Part A. Those who are not eligible for premium-free Part A may purchase Part A if:

- The applicant is 65 or over and is enrolled in Medicare Part B plus meets the citizenship and residency requirements.
- The applicant is under 65 and lost Part A due to returning to work (suspension of disability payments) and the 8.5 year grace period for granting Part A to recipients with suspended disability payments has expired.

The monthly premium for Medicare Part A is currently set at \$426 but recipients with limited financial resources can apply through their state of residence to receive assistance

with paying the premium based on an income based sliding scale (CMS, 2013a). The next section discusses how Medicare beneficiaries obtain care and the services the program covers.

(1) Getting Care and Covered Services

Health care providers (physicians, nurse practitioners, etc.) are divided into three groups under Medicare. These are: 1) participants, 2) non-participants, and 3) health care providers who contract privately with recipients. Medicare Part A recipients may receive care from any of these health care providers. Medicare participating providers have agreed to or are required by law to accept standardized payment rates established by Medicare for services rendered. This is called “assignment.” Medicare non-participating providers have no agreement with Medicare but do accept Medicare payment rates for certain services they provide. These providers can also charge more than Medicare allows but this amount is limited by law for most services. Private contract providers enter into individual agreements with patients and cannot file claims with Medicare or accept Medicare payments for services. Private contracts are prohibited by law for emergency and urgent care.

Part A coverage includes blood transfusions beyond the third unit of blood if the transfusing hospital charges for the blood. As specified earlier in this section, home health care is provided at no expense to the beneficiary. Home health care is limited to patients who are diagnosed as homebound due to medical conditions. Part A also fully covers the expense of hospice care for a patient diagnosed as terminally ill with less than six months to live by his or her doctor and a hospice physician. As Medicare does not cover long-term room and board, hospice care must normally be rendered in the patient’s home or other residential facility such as a nursing home. Respite care is provided in five day increments. Respite care is defined as care rendered by a trained medical professional in order to allow an uncompensated regular caregiver (usually a family member) to rest or see to personal business. The next section discusses Medicare Part B.

b. Medicare Part B

The medical insurance part of Medicare covers medical services such as:

- Clinical research
- Ambulance services
- Durable medical equipment
- Mental health care (inpatient, outpatient, and partial hospitalization)
- Second opinion before surgery

In general, Part B covers care that is classified as medically necessary or preventative. Unlike Medicare Part A, Part B is premium-based for all recipients with the premium determined by the adjusted gross income of the applicant in the two years prior to enrolling. The monthly premium was set at \$104.90 for most Part B enrollees in 2014. Table 9 shows the full schedule of 2014 Part B income based premiums.

Table 9. Medicare Part B Premiums by Income (from CMS, 2013a)

If yearly income for 2012 (for what you pay in 2014) was:			Monthly premium (in 2014)
File individual tax return	File joint tax return	File married & separate tax return	
\$85,000 or less	\$170,000 or less	\$85,000 or less	\$104.90
Above \$85,000 up to \$107,00	Above \$170,000 up to \$214,000	Not applicable	\$146.90
Above \$107,000 up to \$160,000	Above \$214,000 up to \$320,000	Not applicable	\$209.80
Above \$160,000 up to \$214,000	Above \$320,000 up to \$428,000	Above \$85,000 up to \$129,000	\$272.70
Above \$214,000	Above \$428,000	Above \$129,000	\$335.70

Medicare Part B does not usually require rate shares, coinsurance or copayments for preventative services. Part B does have a 20 percent rate share for most other services and does require an annual deductible of \$147. Part B also puts strict limits on the frequency of various exams and screenings. Typically these limits are based on whether the patient presents with particular risk factors, and restrict the number of times a particular procedure can be performed on a patient in a defined time period. A general list of services that do require patient rate share, copayment, or coinsurance for providers that accept Medicare includes:

- 20 percent of the Medicare-approved amount and annual deductible apply—1) ambulance services; 2) chiropractic care; 3) clinical research study; 4) diabetes self-management training; 5) diabetes supplies; 6) durable medical equipment; 7) emergency services; 8) kidney disease education services; 9) outpatient mental health care; 10) occupational therapy; 11) physical therapy; 12) second surgical opinions; 13) speech therapy
- 20 percent of the Medicare approved amount, hospital copayment, and annual deductible apply—1) cardiac rehabilitation; 2) chemotherapy; 3) polyp or tissue removal during colonoscopy and screening barium enema; 4) defibrillator implant; 5) electrocardiogram; 6) foot exams and treatment; 7) glaucoma test; 8) hearing and balance exams; 9) kidney dialysis service and supplies; 10) digital rectal exam; 11) pulmonary rehabilitation; and 12) urgent care
- Eyeglasses—if prescribed after cataract surgery 20 percent of Medicare approved amount and annual deductible apply (CMS, 2013a)

Part B enrollment and eligibility rules are the same as those for Part A, including rules regarding enrollment periods. Late enrollment penalties can also be levied against applicants. The Part B penalty is set to equal 10 percent of the monthly premium for each full 12-month period the applicant was eligible for Part B but did not enroll (CMS, 2013a, p. 94). The applicants must pay the penalty the entire time that they have Part B. The following section details how Medicare Part B beneficiaries obtain care and what services the program covers.

(1) Getting Care and Covered Services

Like Part A recipients, Part B recipients may receive care from health care providers that are categorized as Medicare participants (assignment), non-participants, or contract privately (see Chapter II, Section A. Medicare Part A, Subsection (1) Getting Care and Covered Services of this research study for a clarifying description of the three Medicare health care provider groups). In addition to covered services mentioned earlier in Section B. Medicare Part B, the following services are covered by Medicare Part B and do not require patient rate share, coinsurance, or copayment if the provider accepts Medicare (assignment): 1) abdominal aortic aneurysm screening (patient must be between 65 and 75 and have family history or smoked at least 100 cigarettes in a lifetime); 2) alcohol misuse screening and counseling; 3) bone density screening; 4)

mammogram; 5) cardiovascular behavior therapy; 6) cervical and vaginal cancer screening; 7) colorectal cancer screening; 8) diabetes screening; 9) HIV screening; 10) lab services; 11) nutrition counseling; and 12) annual physicals (CMS, 2013a, p. 35). The next section discusses Medicare Part C.

c. Medicare Part C

Medicare Part C offers both Part A and Part B (defined as Original Medicare) coverage through private insurance carriers that are approved by Medicare (CMS, 2013a, p. 15). Depending on the plan selected by the recipient, additional coverage may be offered and additional monthly premiums may be levied. Medicare Part C, also known as Medicare Advantage, operates under the same rules as Original Medicare and must offer a minimum level of service equal to coverage and payment rates offered through Original Medicare (Parts A and B). Medicare Advantage plans (Part C) fall into six categories:

- Health maintenance organization (HMO) plans—Requires recipients to select a primary care manager (PCM) and use in-network care providers, and utilizes referrals to authorize specialty and other non-emergency, non-routine care.
- Preferred provider organization (PPO) plans—Allow recipients to use a greater range of providers with varying rate share percentages based on the provider’s participation in the PPO network.
- Private fee-for-service plans—Allows recipients to see any provider that agrees to provide treatment. The plan designates what the provider is paid and what the patient owes for service.
- Special needs plans—Provides coverage for recipients that need focused and specialized care, usually for chronic illnesses.
- HMO point-of-service plans—HMO Medicare Advantage plans that allow recipients to see certain out-of-network providers at an increased expense to the patient.
- Medical savings account plans—Combines a high deductible insurance plan with regular deposits from Medicare in a special bank account, which is used to pay for medical services (CMS, 2013a, p. 73).

Medicare applicants desiring to enroll in a Medicare Advantage plan or change an existing plan can do so during their initial enrollment period or annually from October 15 to December 7 (CMS, 2013a). Part C coverage will start on January 1 of the new calendar year. From January 1 to February 14 recipients that are enrolled in Part C can switch to

Original Medicare. Original Medicare coverage will begin on the first of the month following receipt of the recipient’s application. The next section discusses the Medicaid program.

3. Medicaid

Medicaid is a federally mandated medical insurance program that provides access to care based on the income and family status of applicants. Medicaid is jointly funded by the federal government and each state government. At the federal level, Medicaid is managed and administered by the Centers for Medicare and Medicaid Services (CMS). At the state level, each state government manages and administers Medicaid as dictated in its unique Medicaid State Plan within the confines of broad federal guidelines. To limit scope, this research study focuses on the Medicaid programs of three states, California, Connecticut, and Mississippi.

Eligibility standards vary based on state rules. Per federal guidelines, states set eligibility based on income in relation to the federal poverty level and residency. Federal regulations also require Medicaid recipients meet provisions for immigration status and documentation of U.S. citizenship. Table 10 gives state income eligibility standards as a percentage of the federal poverty level.

Table 10. State Medicaid Income Eligibility Standards (from CMS, 2014b)

State	Children			Pregnant Women	Adults	
	Medicaid Age 0-1	Medicaid Age 1-5	Medicaid Age 6-18	Medicaid	Parents	Other Adults
California	261%	261%	261%	208%	133%	133%
Connecticut	196%	196%	196%	258%	196%	133%
Mississippi	194%	143%	133%	194%	24%	0%

Table 11 outlines federal poverty level standards for the 48 contiguous U.S. states (the federal poverty level in Alaska and Hawaii is higher than the continental U.S.).

Table 11. State Annual Income Poverty Guideline (from CMS, 2014b)

Family Size	Percent of Poverty Guideline				
	100%	133%	150%	200%	250%
1	11,670.00	15,521.10	17,505.00	23,340.00	29,175.00
2	15,730.00	20,920.90	23,595.00	31,460.00	39,325.00
3	19,790.00	26,320.70	29,685.00	39,580.00	49,475.00
4	23,850.00	31,720.50	35,775.00	47,700.00	59,625.00
5	27,910.00	37,120.30	41,865.00	55,820.00	69,775.00
6	31,970.00	42,520.10	47,955.00	63,940.00	79,925.00
7	36,030.00	47,919.90	54,045.00	72,060.00	90,075.00
8	40,090.00	53,319.70	60,135.00	80,180.00	100,225.00

The matching funds provided to state Medicaid programs by the federal government are calculated annually by the Office of the Secretary of Health and Human Services and published as the Federal Medical Assistance Percentages (FMAP) pursuant to the Social Security Act (Government Printing Office [GPO], 2012). These percentages represent the dollar value of federal funds remunerated to state Medicaid programs as a percent of total Medicaid expenditures made by that state. The FMAP for California, Connecticut, and Mississippi are as follows:

- California—50.00 percent
- Connecticut—50.00 percent
- Mississippi—73.05 percent (GPO, 2012, p. 3)

These percentages vary based on the per capita income of each state and are adjusted on a three-year cycle. The percentages range from 50 percent in higher per capita income states to 75 percent in lower per capita income states (the maximum possible is 82 percent) (GPO, 2012).

Benefits offered by Medicaid consist of mandatory coverage items and optional coverage items, which may be implemented at the discretion of each state. Table 12 presents a general categorized list of mandatory and optional covered services.

Table 12. Medicaid Mandatory and Optional Benefits (after CMS, n.d.)

Mandatory Benefits	Optional Benefits
<ul style="list-style-type: none"> • Inpatient & Outpatient hospital services • Nursing Facility & Home health services • Lab & X-ray services • Family planning services • Nurse midwife services • Physician services • Certified Pediatric and Family Nurse Practitioner services • Transportation to medical care 	<ul style="list-style-type: none"> • Clinic services • Physical & Occupational therapy • Speech, hearing, and language disorder services • Respiratory care • Podiatry services • Prosthetics • Chiropractic services • Hospice care
<ul style="list-style-type: none"> • Comprehensive physical exams, preventative lab and diagnostic tests, immunizations, and health education (recipients under 21) • Tobacco use cessation counseling for pregnant women 	<ul style="list-style-type: none"> • Other, diagnostic, screening, preventative, and rehabilitative services • Intermediate facility care for the mentally handicapped

It is important to note that in cases where a patient is covered by Medicare and Medicaid, Medicare serves as the primary insurance provider. The next section discusses Medi-Cal, the State of California’s Medicaid program.

a. California

The State of California’s Medicaid program, titled Medi-Cal, operates as a managed care plan and is overseen by the State of California Department of Health Care Services (DHCS, 1987). As with other HMOs, Medi-Cal recipients choose a health care provider that functions as a Primary Care Provider (PCP) upon enrollment. There is no out-of-pocket expense for recipients, and premiums for higher income recipients are 13 dollars per covered child up to a maximum of 39 dollars. Medi-Cal is also a diversified health insurance plan in that it consists of multiple Health Plan Partners (insurance carriers) that are licensed by the State of California to provide coverage to Medi-Cal recipients. The two largest coverage areas are Los Angeles and San Francisco.

In total, Medi-Cal offers 21 different health plans based on the county in which the recipient resides. Most of these plans are offered through private insurers and some are public plans administered by local government. To limit scope to a manageable number of plan reviews, this research study focuses on coverage plans offered in the Los Angeles area (public and private option), San Francisco area (public and private option), and a general private option that offers coverage to multiple California communities outside the Los Angeles and San Francisco areas. The next section details how Medi-Cal functions in the Los Angeles area.

(1) Los Angeles.

The Medi-Cal program in Los Angeles is called L.A. Care and is administered by four insurance providers. Three of these insurance providers are private corporations and one is a government agency. These are:

- Anthem Blue Cross (private)
- Care1st Health Plan (private)
- Kaiser Permanente (private)
- L.A. Care Health Plan (government) (L.A. Care Health Plan, 2013, p. 6)

This research study reviews the Anthem Blue Cross and L.A. Care Health Plans. It is important to note that coverage provided under both the private and public L.A. Care options is identical. There is no structural difference between the plans other than which organization processes claims and customer inquiries. Furthermore, the L.A. Care Health Plan (a government entity) administers all Medi-Cal programs in the Los Angeles area through partnerships with the other three private entities while directly providing its own Medi-Cal program.

The procedure for enrolling in Medi-Cal plans offered in Los Angeles is identical across plans. Applicants can contact the Los Angeles County Department of Public Social Services (phone, mail, or in person) or apply online through the State of California's Covered California website (L.A. Care Health Plan, 2013). Once eligibility is determined by the Department of Public Social Services, the applicant can choose a L.A. Care plan. Enrollment processing can take up to 45 days so applicants awaiting eligibility determination are granted transitional Medi-Cal benefits through California

DHCS (L.A. Care Health Plan, 2013). Once eligibility is determined and the application is approved, coverage takes effect on the first day of the month following approval.

As mentioned in the first paragraph of Section A. California, L.A. Care functions under a HMO model where patients receive categories of care as defined in Table 3. Routine care is provided to recipients by their PCP. Emergency care and urgent care are provided without need for a referral. Specialty care requires a referral from the recipient's PCP. If the recipient requests a second opinion then he or she can do so through her PCP, assigned specialist, or insurance provider. Further, L.A. Care recipients can change PCPs at any time for any reason by selecting a new in-network PCP. Recipients can also change health plans within L.A. Care at any time for any reason. Health plan changes will be effective on the first of the month following the change if the change is requested prior to the twentieth day of the month of request. Changes requested after the twentieth day will become effective on the first day of the month following the month after the month of request (e.g., a request made on 21 September becomes effective 1 November).

In most cases, L.A. Care plans do not provide care outside of the Los Angeles area. Emergency care, urgent care, family planning services, and sexually transmitted disease testing are exceptions to this policy. Emergency care, family planning services, and sexually transmitted disease testing can be obtained from any licensed provider. Urgent care provided outside the Los Angeles area should be coordinated through the recipient's PCP (L.A. Care Health Plan, 2013). Recipients may also seek care from an in-network obstetrician or gynecologist without a referral (L.A. Care Health Plan, 2013).

L.A. Care plans also offer continuity of care benefits. This allows recipients to continue seeing their current health care provider for a specified period of time under certain conditions despite insurance changes. These conditions include pregnancy, terminal illness, or aftercare following a covered surgery.

Other medical services covered under L.A. Care include items such as:

- Alcohol/drug abuse intervention and education
- Clinical trials
- Long-term care (nursing facility, home health care, and hospice)

- Physical, speech, and occupational therapy
- Diabetes services including medical equipment and education
- Durable medical equipment
- Hearing aids and exams
- Inpatient and outpatient hospital care
- Mastectomy including reconstructive surgery
- Prosthetics and orthotics
- Medical transport
- Maternity care
- Radiology services, lab services, and diagnostic tests (Anthem Blue Cross & L.A. Care Health Plan, 2013)

Certain medical services are made available to L.A. Care recipients via state funded Medi-Cal initiatives and are provided directly through Medi-Cal. These are:

- Acupuncture
- Outpatient alcohol and drug abuse treatment
- Chiropractic services
- Major organ transplants
- Outpatient mental health services
- Inpatient mental health services through the Los Angeles County Department of Mental Health (Anthem Blue Cross & L.A. Care Health Plan, 2013)

L.A. Care does not cover medical services such as non-reconstructive cosmetic surgery, fertility treatment, or hospital inpatient personal comfort items such as telephones and televisions (Anthem Blue Cross & L.A. Care Health Plan, 2013). The next section details how Medi-Cal operates in the San Francisco area.

(2) San Francisco

The Medi-Cal program offered in the San Francisco area is administered through a non-profit managed care organization and Kaiser Permanente, a private health insurance corporation (Partnership Healthplan of California [PHC], 2013). Both managed care plans operate under an umbrella program called Partnership HealthPlan of California

(PHC). PHC is governed by a board of commissioners consisting of locally elected officials, provider representatives, and patient advocates that meet monthly to set policy.

Applicants can enroll in PHC through the applicable County Office of Health & Human Services (phone, mail, fax, or in person) (PHC, 2013). Online enrollment is also available through the state's Covered California website or the CalWIN Consortium website (PHC, 2013). The CalWIN Consortium is a real-time computer network implemented by San Francisco area counties to streamline access to public assistance programs.

As a managed care plan, PHC requires recipients to choose a PCP. Referral requirements matching L.A. Care (listed in section (1) Los Angeles) apply. Medical services covered by PHC are identical to those offered under L.A. Care. Excluded medical services are also identical to services not covered under L.A. Care. Inpatient mental health services are provided by county mental health departments. The next section discusses how Medi-Cal functions in several other parts of California.

(3) California Counties

The Medi-Cal health plan offered to the majority of rural California communities and small metropolitan areas is titled Anthem Blue Cross Partnership Plan. Plan rules and enrollment for the Anthem Blue Cross Partnership Plan are the same as other Medi-Cal health plans. Covered medical services as well as excluded services are also identical to coverage and exclusions listed under the Los Angeles section (Anthem Blue Cross, 2013). The next section discusses, Husky Health, the State of Connecticut's Medicaid program.

b. Connecticut

The State of Connecticut provides Medicaid health insurance coverage through Husky Health plans. All Husky Health plans are publicly administered by the Connecticut Department of Social Services (DSS) and are managed care plans that operate under the HMO model where recipients choose a PCP that supervises the types of care provided (DSS, 1988). There are no out-of-pocket expenses for recipients.

Enrollment for applicants requires eligibility determination and application for specific benefits. Application approval and eligibility determination is performed by Connecticut DSS. Applicants can apply through the Department of Social Services via mail, by phone, in person, or by using the state ConnectCT website (DSS, 2013).

Husky Health is comprised of four plans, Husky A, B, C, and D. Each of these plans has different eligibility criteria based on age, physical disability, and income (DSS, 1988). It is important to note that Husky B covers uninsured people under the age of 19 that reside in higher income households (185–323 percent of the federal poverty level) (DSS, 2013). Husky B is not a Medicaid program and will not be covered in this research study. Husky A covers children (under 19 years old), their parents or related caregiver and pregnant women based on income levels in Table 11 (DSS, 2013). Husky C covers people 65 and over or 19–64 years old with blindness or other permanent disabilities (DSS, 2013). Husky D provides coverage to people 19–64 years old (low income adults) based on income levels in Table 11 (DSS, 2013).

Husky Health recipients must use in-network health care providers listed as part of the Connecticut Medical Assistance Program. Connecticut Medical Assistance Program providers contract with the Connecticut DSS to accept the payment terms and amounts offered by Husky Health (DSS, 2013). Prior authorization from the recipient's PCP is required for a number of services such as:

- Laboratory services and diagnostic tests
- Long term care (nursing facility, home health care, hospice, etc.)
- Inpatient and outpatient hospital services
- Ambulatory surgery
- Durable medical equipment
- Kidney disease treatment including dialysis
- Physical, occupational, and speech therapy
- Hearing aids and exams
- Orthotics and prosthetics
- Chiropractic care
- Maternity care (DSS, 2013)

Routine care provided through the PCP, emergency care, urgent care, specialist physician care, and family planning services do not require prior authorization. Inpatient and outpatient behavioral health services are provided through the Connecticut Behavioral Health Partnership, a contracted administrative division of the private insurance corporation ValueOptions CT.

The Husky Health coverage area is limited to Connecticut with the exception of urgent care and emergency care. Medical services received outside of Connecticut are not covered by Husky Health. Other medical services not covered by Husky Health include:

- Non-reconstructive cosmetic surgery
- Experimental procedures
- Weight reduction treatment (does not include treatment for medically diagnosed obesity, which is covered)
- Infertility treatment
- Educational services (DSS, 2013)

The educational services exclusion does not include health education mandated as part of Medicaid by CMS. The next section discusses the State of Mississippi's Medicaid program.

c. Mississippi

The State of Mississippi provides Medicaid health insurance coverage through two different managed care programs. Mississippi Medicaid is the public option health insurance plan administered by the Mississippi Division of Medicaid (DOM, [1991]). The Mississippi Coordinated Access Network or MississippiCAN is the Medicaid private health insurance option (DOM, 1991). MississippiCAN is broken down into two additional managed care plans, the UnitedHealthcare Community Plan and the Magnolia Health Plan (DOM, n.d.). Benefits and eligibility rules differ between Mississippi Medicaid and each MississippiCAN plan. All Medicaid programs in Mississippi are supervised by the Mississippi DOM with most medical treatment referrals processed through the recipients PCP.

Applicants can enroll in Mississippi Medicaid (public option) or the MississippiCAN (private option) plans online through the state’s Medicaid.ms.gov website or through the federal Healthcare.gov website. Applicants can also enroll through DOM via mail, phone, fax, email, or in person. An open enrollment period runs annually from October 1–December 15 and exists to allow current recipients to change plans.

Eligibility for each program is determined by the age of the applicant and other factors. Mississippi Medicaid is reserved for children 0–19 years old that are receiving Supplemental Security Income, disabled and living at home, foster children, or children that are orphans. MississippiCAN plans are for all other recipients.

There are no out-of-pocket expenses for MississippiCAN plans. Mississippi Medicaid requires varying co-pays for services for recipients over 18. All Medicaid programs in Mississippi offer medical transport and inpatient and outpatient behavioral health services. Co-pay amounts for Mississippi Medicaid include the following:

- Ambulance—\$3.00 per trip
- Home Health—\$3.00 per visit
- Hospital Inpatient—\$10.00 per day
- Hospital Outpatient—\$3.00 per visit
- Office Visit—\$3.00 per visit
- Durable Medical Equipment, Orthotics, and Prosthetics—up to \$3.00 (DOM, 2012)

Table 13 highlights key coverage differences between Mississippi Medicaid, Magnolia Health Plan, and UnitedHealthcare Community Plan.

Table 13. Mississippi Medicaid Program Coverage Plans (from DOM, n.d.)

Health Plans	Mississippi Medicaid	Magnolia Health Plan	UnitedHealthcare Community Plan
Benefits & Services			
Co-pays	Yes	No	No
Office Visits	Adults - 12 per year Children - 12 per year (<i>Under 21 eligible for more if medically necessary</i>)	No Limits	No Limits
Hospital Outpatient Visits (ER Visits)	No Limits	No Limits	No Limits
Home Health Services	Adults - 25 per year Children - 25 per year (<i>Under 21 eligible for more if medically necessary</i>)	Adults - 25 per year Children - 25 per year (<i>Under 21 eligible for more if medically necessary</i>)	Adults - 25 per year Children - 25 per year (<i>Under 21 eligible for more if medically necessary</i>)
Reward Program	No	Prepaid MasterCard for receiving selective screenings and preventative services	Prepaid MasterCard for seeing PCP within 90 days of joining. Farm-to-Fork weekly fresh vegetable distribution.
24/7 Nurse Advice Line	No	Yes	Yes
Disease Management	No	Yes	Access to programs for members who have one of the following problems: Diabetes, Asthma, COPD, Heart Disease, or Heart Failure.
Tele-medicine & Monitoring	No	Eligible members have access to Registered Nurses 24/7 that help monitor blood pressure, pulse, and other vitals from home via devices	Eligible members have access to Registered Nurses 24/7 that connect members to doctor or healthcare provider using a camera.

Additional MississippiCAN and Mississippi Medicaid benefits that do not require prior authorization include:

- Chiropractic services (\$700 maximum per year)
- Ambulatory surgery services
- Dialysis

- Family planning services
- Lab and radiology services
- Nursing facility care (58 days per year)
- Intermediate care facility (90 days per year)
- Preventative services
- Physical, occupational, and speech therapy (12 visits per year)
- Urgent care (United Healthcare, 2012)

MississippiCAN and Mississippi Medicaid benefits that do require prior authorization include:

- Any services provided beyond set limits
- Inpatient hospital care
- Reconstructive surgery
- Non-diagnostic laboratory testing and nuclear medicine
- Hospice care
- Surgical services
- Orthotics and prosthetics (over \$1000)
- Behavioral health (Magnolia Health, 2013)

Mississippi Medicaid programs exclude cosmetic surgery, infertility treatment, obesity treatment, and treatments that are considered experimental. The next section provides a summary of Chapter II.

C. SUMMARY

This chapter included a literature review establishing the benefits, covered services, and operating rules for TRICARE, Medicare, and Medicaid. Another important part of this chapter was the establishment of rate shares, coinsurance, and premiums particular to each program. These provider payment rate guidelines further define the total costs borne by the federal budget in relation to the insurance programs themselves.

Chapter III discusses the methods used to perform the literature review. The chapter also discusses the methodology used to compare the provider payment rate of similar medical procedures across programs. Finally, the next chapter outlines how the research study developed commentary on the financial sustainability of each program.

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III. METHODOLOGY

A. INTRODUCTION

This chapter describes the methodology used to analyze the financial sustainability of each federally funded medical insurance program (TRICARE, Medicare, and Medicaid) based on data obtained through the Congressional Budget Office (CBO), the Centers for Medicare & Medicaid Services (CMS), and the Department of Health & Human Services (CMS parent organization). It also describes the methodology used to analyze and compare payment rates of the targeted sample of medical procedures covered by all three insurance programs. This chapter also presents the methods used in conducting the literature review and data collection. The next section provides an overview of the literature review and data collection performed in this study.

B. LITERATURE REVIEW AND DATA COLLECTION

The first step in answering the two research questions involved conducting a literature review to ascertain what medical procedures are covered by each medical insurance program. In addition, it was necessary to determine the structure of each program to include which insurance model was utilized (HMO, PPO, etc.), the rate shares required under each program, what different coverage types were available under each program, and what enrollment and eligibility rules applied to each program. To compile health plan data on each insurance program, the researcher reviewed plan information available to members and documents used to develop each plan. This included member benefit handbooks, Medicaid state plans and amendments, information available through insurance providers and government websites, published plan guidelines and regulations, and contracts.

To be more precise the plan information compilation for TRICARE required review of the most recent member handbook for each program under TRICARE (TRICARE Prime/Remote, TRICARE Standard/Extra, TRICARE For Life, and TRICARE Overseas), and the scanning of the contracts in place with each regional insurance provider. For Medicare, a review of the most recent member handbook was

conducted. Additional information was obtained through the CMS.gov and Medicare.gov websites. Specifically, the online data included clarifying details regarding eligibility, rate shares and premiums, enrollment procedures, and coverage benefits. For Medicaid, a review of member handbooks for each applicable state medical insurance plan was conducted. Additional information was obtained through review of each state's Medicaid state plan and amendments. Clarifying details regarding eligibility, rate shares and premiums, enrollment procedures, and coverage benefits were gleaned from the Medicaid.gov, CMS.gov, and each state's individual Medicaid website. The next section provides an overview of the data analysis performed in this study.

C. DATA ANALYSIS

The initial goal of the data analysis portion of this research was to determine if provider payment rate differences exist in what each federally funded medical insurance program expended on individual medical procedures. A targeted sample of 25 medical procedures was selected using the Healthcare Common Procedure Coding System (HCPCS). This system was originally developed in 1978 by CMS to provide a uniform method for identifying various medical services and procedures. The system is based on the American Medical Association's *Current Procedural Terminology* (CPT). The Health Insurance Portability and Accountability Act of 1996 made HCPCS the mandatory coding system for the medical insurance industry. Use of HCPCS ensured selection of consistent medical procedures across programs. This study used the American Medical Association's (AMA) *Current Procedural Terminology* (CPT) 4th edition in 2012 (lists all Level I codes active for 2012 [see Chapter III Section 2. Medical Procedure Provider Payment Rate Analysis of this study for a clarifying description of the HCPCS levels]) as a primary reference to identify and select the targeted sample. Each of the medical procedures selected is covered by TRICARE, Medicare, and Medicaid with payment rate data current across programs for 2014. An effort was made to spread the selected targeted sample across the following procedure categories:

- Emergency and urgent care
- Laboratory, radiological, and diagnostic services

- Outpatient care
- Hospital inpatient care

The targeted sample of medical procedures was tested (compared) for rate variances with differences noted in both current dollars and percentages. An investigation of differences was conducted to establish whether prior approval or referral was required by any of the medical programs for the procedures. It is important to note that rate shares, premiums, co-pays, or coinsurance provided by beneficiaries were not factored into the data analysis; however these factors are considered in the Financial Sustainability section of Chapter IV. Rate variance comparisons for all three programs were broken down by state to reflect the fact that all available provider payment rate data is dependent upon the state in which care is provided in order to determine the payment amount given to the health care provider. The next section details how data collection was conducted.

1. Data Collection

Medical procedure payment rate data for each of the three programs was drawn from program databases. Each program database allows users to download data in Excel format, which facilitated appropriate comparison. TRICARE and Medicare also break rate data down by state. Medicaid rate data is necessarily state specific due to the nature of the program.

TRICARE medical procedure rate data was acquired from the Defense Health Agency's CHAMPUS National Pricing System (CMAC) database (DHA, 2014). The database lists procedures by short description with rate data further divided by state. Rate data for Connecticut and Mississippi is consistent across the entire state. TRICARE rate data for California is separated by region. Because of this separation and to maintain continuity, the rate data selected from California for this research focused on the largest coverage areas of Los Angeles and San Francisco, and a grouping of California communities that fall outside those coverage areas (designated as Rest of California).

Medicare medical procedure payment rate data was attained from the Centers for Medicare and Medicaid Services (CMS) Medicare Physician Fee Schedule (MPFS) database (CMS, 2014a). The MPFS database lists medical procedures by short

description and medical billing code (HCPCS). Medicare rate data is state specific with Connecticut and Mississippi data consistent throughout each state. Similar to TRICARE, California Medicare data is separated by region. Again, rate data selected for this research focuses on the largest coverage areas of Los Angeles and San Francisco, and a grouping of California communities that fall outside those coverage areas (designated as Rest of California).

Medicaid medical procedure rate data was taken from the applicable state Medicaid provider payment rate database. California Medicaid (Medi-Cal) rate data came from the State of California Department of Health Care Services Medi-Cal rate database (DHCS, 2014). Connecticut Medicaid (Husky Health) rate data came from the State of Connecticut DSS provider fee schedule database (DSS, 2014). Mississippi Medicaid rate data came from the State of Mississippi Division of Medicaid (DOM) interactive fee schedule database (DOM, 2014). The next section discusses how the data analysis was performed.

2. Medical Procedure Provider Payment Rate Analysis

Sample medical procedures were selected based on the HCPCS medical procedure code to ensure consistency across programs. The targeted sample includes medical procedures found in the American Medical Association's (2011) *Current Procedural Terminology Fourth Edition* (CPT-4) also known as HCPCS Level I (of three levels). Level I codes incorporate all medical procedures and services with exception of services such as ambulances and durable medical equipment such as prosthetics. Level I codes are further divided in Categories I, II, and III. This study focuses on Category I codes. Category I includes the common medical procedures that form the core of CPT-4 whereas Category II includes performance measures (procedure modifiers) not pertinent to this study and Category III includes uncommon medical procedures that are classified as experimental, non-Food and Drug Administration (FDA) approved, etc. (AMA, 2011).

Payment rate data for each medical procedure (based on the state) across the three medical insurance programs was compared for differences and displayed graphically. Medicaid payment rate data for California is set by DHCS and was

consistent throughout the entire state. In order to normalize comparison of California TRICARE and Medicare rate data against California Medicaid data, the researcher averaged regional TRICARE and Medicare data for California. The mean of the regional TRICARE and Medicare data for each medical procedure was then used for the comparison sample. Differences were annotated in dollars as well as percentages and observations were made on observable differences. The next section gives an overview of the financial sustainability portion of the study.

D. FINANCIAL SUSTAINABILITY

In order to develop a working knowledge of the issues impacting each medical insurance program's solvency, the researcher conducted an examination of CBO cost projections from May 2013 for Medicare and Medicaid. A CBO (2012) presentation to the Organization for Economic Cooperation and Development Expert Workshop on Medicare cost projections was employed to uncover additional information related to financial pressures being exerted on Medicare by federal law and policies presently and in the coming decades. A CBO (2014) report titled *Approaches to Reducing Federal Spending on Military Healthcare* was also used to obtain background information and additional TRICARE cost data. The report also helped to establish a baseline for measures aimed at preserving the continued financial viability of military health care. A summary paper on the overall federal budget published by the Center on Budget and Policy Priorities (CBPP) (2013) listed aggregated federal funding levels for Medicaid and Medicare along with a macro-level view of where funding is derived. Information on the portion of the total federal budget that these programs accounted for was included. The following sections provide an overview of the data collected and analyzed in this study.

1. U.S. Healthcare Expenditures

Centers for Medicare and Medicaid Services (CMS) data on national health expenditure trends from 1960–2012 (CMS, 2013b) and more detailed information on national health expenditure projections (CMS, 2011) created a baseline for health care cost growth. The baseline guided the study in evaluating whether cost growth in any of the federal programs outpaced national cost growth tendencies. The congruence or lack

of congruence between federal program health spending and national spending assisted with directing more in depth efforts on any of the three programs that demonstrated abnormal cost growth.

2. Medicaid Expenditures

Because Medicaid requires matching state funds, data available from the Kaiser Family Foundation (KFF) on state Medicaid expenditures (KFF, 2012) was used to create a more comprehensive picture of total Medicaid costs. CBO (2013b) Medicaid cost projections, Kaiser Family Foundation analysis of the CBO projections (KFF, 2013), and the HHS (2013) Medicaid actuarial report formed the basis for research study commentary on the financial sustainability of Medicaid.

3. Medicare Expenditures

CBO (2013a) Medicare cost projections, an article published by the CBPP (Van de Water, 2013) on the solvency of Medicare, and CBO (2012) and CBPP (2013) published data on Medicare federal spending formed the basis for study commentary on the financial viability of the Medicare program.

4. TRICARE Expenditures

The CBO (2014) report *Approaches to Reducing Spending on Military Health Care* provided data on TRICARE spending and proposed measures to achieve significant savings in military health care accounts. The Defense Industry Daily devoted two articles to the discussion on developments in the TRICARE program in the last decade. One article touches on long-term funding issues facing TRICARE since 2000 (Defense Industry Daily, 2006) and the second covers the contracts in place with TRICARE regional contractors and the costs of those contracts (Defense Industry Daily, 2012). The next section provides a summary of Chapter III.

E. SUMMARY

This chapter presented the methodology used to analyze the financial sustainability of each medical insurance program. It presented the methods used in

conducting the literature review and data collection and conducting the data analysis. Chapter IV presents the results of the provider payment rate comparison and financial sustainability analysis.

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IV. DATA ANALYSIS AND FINANCIAL SUSTAINABILITY

A. INTRODUCTION

A main goal of this research study is to uncover or partially uncover whether TRICARE rates paid for medical services are observably higher or lower when compared to Medicare and Medicaid. Making this determination helps answer one of the main research questions and meet the objectives of the study. This chapter lays out the results of the payment rate comparison analysis and the financial sustainability analysis. Specifically, it shows how Medicare and Medicaid rates paid for medical procedures compare to TRICARE. Rate comparisons are shown both graphically and by dollar value and percentage differences.

The financial sustainability portion of this chapter describes spending and growth statistics published by CMS for national health expenditures as well as expenditures for TRICARE published in a report by CBO. Expenditures and cost growth for Medicare and Medicaid are also used. Comparison of these expenditures and growth rates provides an idea of how similar TRICARE numbers match up. Comparison of cost growth and expenditures helps show whether TRICARE spending is reasonable and efficient. The following section details the payment rate comparison conducted in this study.

B. MEDICAL PROCEDURE PROVIDER PAYMENT RATE ANALYSIS

In order to conduct the medical procedure rate analysis, the researcher selected a targeted sample of 25 medical procedures. The sample selection focused on four categories, 1) emergency and urgent care; 2) laboratory, radiological, and diagnostic procedures; 3) outpatient care; and 4) hospital inpatient care. Each procedure of the targeted sample was chosen using the HCPCS CPT-4 procedure coding system. This system, developed by CMS and based on the Fourth Edition of Current Procedural Terminology (CPT) of the American Medical Association (AMA, 2011), is the current standard for medical billing and coding in the United States. Consequently, it provides

the best method to select a sample and maintain the consistency of the procedures across the federal medical insurance programs covered in this study. Table 14 details the 25 procedures selected for the targeted sample.

Table 14. List of HCPCS CPT-4 Codes (Sample)

Sample ID	HCPCS CPT-4 Code	Procedure Description
1	80061	Lipid Panel
2	81005	Urinalysis
3	82950	Glucose Test
4	83951	Oncoprotein DCP
5	85041	Red Blood Cell (RBC) Count
6	19300	Mastectomy
7	20200	Muscle Biopsy
8	20520	Removal of Foreign Body
9	20615	Treatment of Bone Cyst
10	20808	Replant Hand Complete
11	20982	Ablate Bone Tumor
12	88304	Tissue Exam (Pathologist)
13	88348	Diagnostic Electron Microscope
14	88358	Tumor Analysis
15	90672	Flu Vaccine (Nasal)
16	90703	Tetanus Vaccine
17	70355	Panoramic X-ray of Jaws
18	70450	CT Scan w/ Contrast (Head or Brain)
19	70540	MRI (EG Proton)
20	71010	Chest X-ray (Frontal)
21	99205	Office Visit (Outpatient) New
22	22325	Treat Spine Fracture
23	99285	Emergency Department Visit

Sample ID	HCPCS CPT-4 Code	Procedure Description
24	99291	Critical Care (First Hour)
25	99466	Pediatric Critical Care Transport

The researcher selected the targeted sample of 25 medical procedures using the American Medical Association’s (AMA) *Current Procedural Terminology (CPT)* 4th edition, 2012 (AMA, 2011). This reference text lists all of the Category I HCPCS codes active for 2012 and is divided into six sections, 1) evaluation and management; 2) anesthesia; 3) surgery; 4) radiology; 5) pathology and laboratory; and 6) medicine (AMA, 2011, p. ix). More specifically, Category I codes must have the following key characteristics as defined by the AMA’s CPT Editorial Panel:

- All devices and drugs necessary for performance of the procedure of service have received FDA clearance or approval when such is required for performance of the procedure or service.
- The procedure or service is performed by many physicians or other qualified health care professionals across the United States.
- The procedure or service is performed with frequency consistent with the intended clinical use (i.e., a service for a common condition should have high volume).
- The procedure or service is consistent with current medical practice.
- The clinical efficacy of the procedure or service is properly documented (AMA, n.d.).

The targeted sample of codes listed in Table 14 was chosen from five of the six sections. Section Two, Anesthesia (AMA, 2011, pp. 46–52), was not used due to its small footprint within the reference text (seven pages within approximately 500 pages of Category I codes) and the ancillary nature of the procedures it contains. Each code was selected based on its existence in the reference text within one of the noted sections, its status as a medical procedure covered by Medicare, Medicaid, and TRICARE, and its classification in one of the following categories, 1) emergency and urgent care; 2) laboratory, radiological, and diagnostic procedures; 3) outpatient care; and 4) hospital inpatient care. The 25 procedure sample represents roughly 0.5 percent of the approximately 5000 Category I CPT codes contained in the reference text. This sample

should not be taken as being an all-inclusive list of medical procedures that meet the required criteria of this research study. They are simply the first 25 medical procedures identified by the study to satisfy those criteria.

The payment rate data pertaining to the medical procedure code sample varies depending on the state in which the particular procedure is performed. Medical costs tend to vary between states so standard procedure for insurance providers is to vary payment rates accordingly. To account for this, the researcher collected medical procedure rate data for each program from each of three states, California, Connecticut, and Mississippi. These states were chosen in order to provide a partial cross-section of the United States without expanding the scope of the project beyond manageable limits. California was chosen as it is the most populous state in the United States. Connecticut was chosen for its small population and high per capita income. Mississippi was chosen for its low per capita income. The goal was also to spread the state selection over the regions of the U.S.

Medical procedure rate data for Connecticut and Mississippi is consistent throughout these states and varies based only on which federal medical insurance program (Medicaid, Medicare or TRICARE) pays for the procedure. Medical procedure rate data for Medi-Cal, the State of California's Medicaid program, presents a single set of rates for the entire state. This diverges from TRICARE and Medicare, which have fluctuating payment rates for different regions of California. To normalize the rate data for California, the researcher averaged TRICARE and Medicare regional data (Los Angeles, San Francisco, and Rest of California) for each procedure in the selected sample. The means of the regional rate data for each procedure formed the test data used for the California payment rate comparison analysis. It is important to note that the California regional rate data for TRICARE and Medicare follows an unwavering pattern. San Francisco was found to consistently have the highest rates of the three regions selected while Rest of California consistently had the lowest. This pattern further justified the averaging method used to normalize California's rate data.

Due to the number of procedures in the targeted sample and the wide variance of payment rates, the medical procedures listed in Table 14 were broken down into three sets for state based on similar rate values. Each set was then displayed graphically on a

chart in order to ease viewing. The charts detailing this data list the actual payment rate per procedure for the medical procedures in 2014 (current) dollars on the y-axis and the Sample ID, as they correspond to the procedures listed in Table 14, on the x-axis. The next section discusses the rate comparison results for California.

1. California Provider Payment Rate Comparison Results

Analysis of medical procedure rates for California (DHCS, 2014) showed identical provider payment rates for Medicare and TRICARE for the vast majority of procedures. Only laboratory procedures presented any significant difference between TRICARE and Medicare. Procedures one through five in Table 14 (Sample IDs 1–5) are defined as laboratory procedures. Medicare rates for lab procedures (Sample IDs 1–5) average 13.42 percent lower than TRICARE with the smallest difference being 13.38 percent lower and the largest difference being 13.47 percent lower. Figure 1 shows California medical procedure rate data.

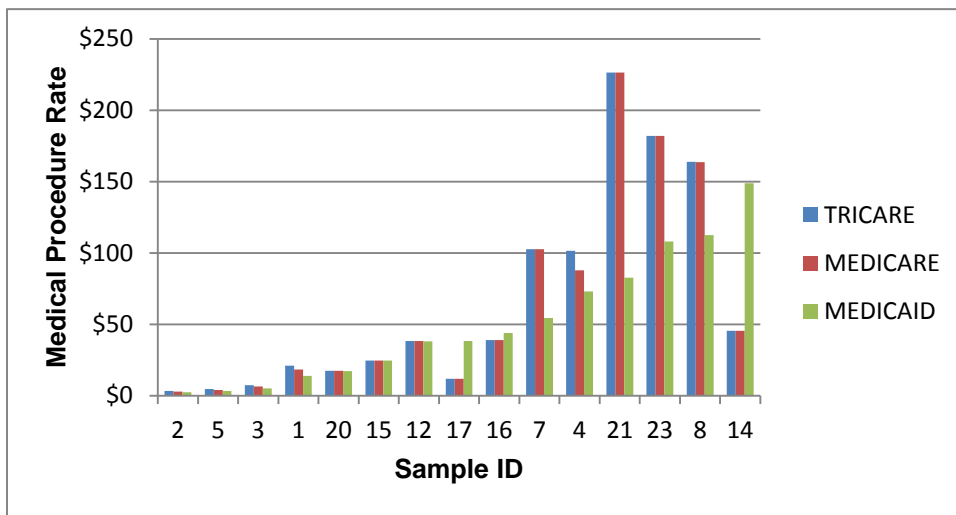


Figure 1. California Medical Procedure Rate Comparison (Set One)

California Medicaid (Medi-Cal) procedure rates are an average of 33.64 percent higher than TRICARE rates. This statistic may not be as telling as it seems as the majority of Medi-Cal rates are lower than those of TRICARE while five procedures were found to have higher rates than TRICARE. The Medi-Cal rate for procedure ablate bone

tumor (Sample ID 11) is 786.59 percent higher than TRICARE. Furthermore, the Medi-Cal rates for tumor analysis (Sample ID 14), panoramic x-ray of jaws (Sample ID 17), CT scan with contrast head or brain (Sample ID 18), and MRI (Sample ID 19) are 226.38, 221.55, 99.51, and 43.54 percent higher than TRICARE respectively. Without these five procedures factored in, the remaining 20 Medi-Cal procedures are 26.8 percent lower than TRICARE.

The rate difference for the procedure, ablate bone tumor, stems from Medi-Cal designating this procedure as an inpatient hospital surgery (overnight hospital care) whereas TRICARE and Medicare designate it as an outpatient hospital procedure. The other four procedures are defined as diagnostic. The rate difference for diagnostic procedures comes from Medi-Cal requiring specific short-notice availability of those services to patients. To ensure short notice availability of these services to recipients, Medi-Cal builds a premium into its rate structure. Figures 2 and 3 detail rate comparisons for the balance of sample data not displayed in Figure 1.

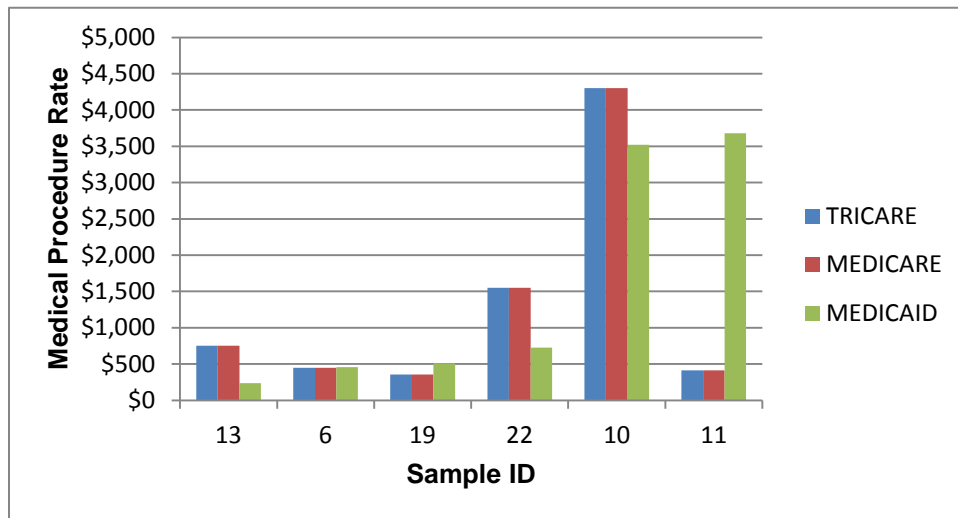


Figure 2. California Medical Procedure Rate Comparison (Set Two)

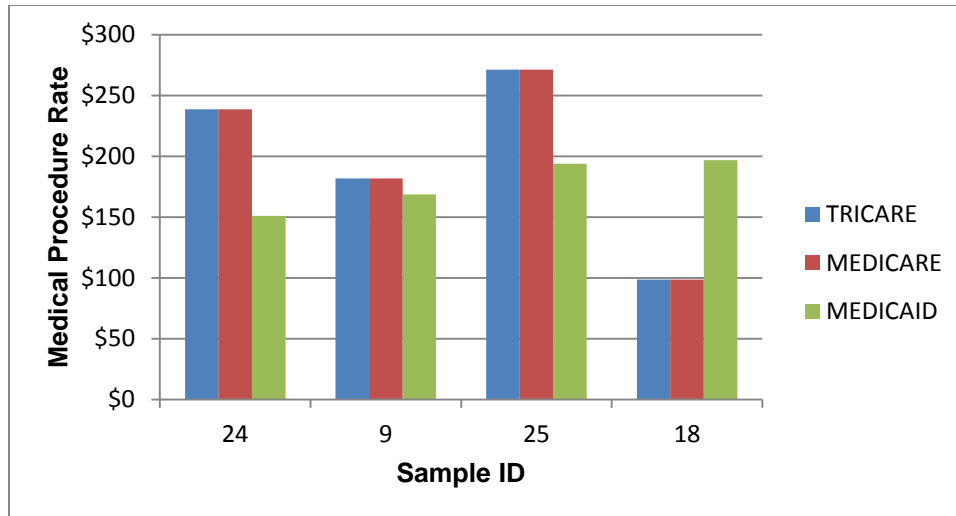


Figure 3. California Medical Procedure Rate Comparison (Set Three)

Full medical procedure rate differences between TRICARE, Medicare and Medicaid are outlined in Table 15. Differences (deltas) for both Medicare and Medicaid are shown in both current (2014) dollars and percentages. Medical procedure rates for TRICARE, Medicare, and Medicaid are also included in Table 15.

Table 15. California Sample Medical Procedure Rates and Differences

Sample ID	Procedure Description	TRICARE Rate	Medicare Rate	Medicaid Rate	Medicare Delta	Medicaid Delta	Medicare Delta %	Medicaid Delta %
1	Lipid Panel	21.09	18.27	13.88	-2.82	-7.21	-13.38%	-34.20%
2	Urinalysis	3.42	2.96	2.40	-0.46	-1.02	-13.45%	-29.82%
3	Glucose Test	7.48	6.48	5.06	-1.00	-2.42	-13.41%	-32.38%
4	Oncoprotein DCP	101.45	87.88	72.98	-13.57	-28.47	-13.38%	-28.07%
5	Red Blood Cell (RBC) Count	4.75	4.11	3.33	-0.64	-1.42	-13.47%	-29.89%
6	Mastectomy	450.09	450.09	457.55	0.00	7.46	0.00%	1.66%
7	Muscle Biopsy	102.53	102.53	54.36	0.00	-48.17	0.00%	-46.98%
8	Removal of Foreign Body	163.71	163.71	112.43	0.00	-51.28	0.00%	-31.33%
9	Treatment of Bone Cyst	181.80	181.80	168.65	0.00	-13.15	0.00%	-7.23%
10	Replant Hand Complete	4301.31	4301.31	3521.96	0.00	-779.35	0.00%	-18.12%
11	Ablate Bone Tumor	414.86	414.86	3678.13	0.00	3263.27	0.00%	786.59%

Sample ID	Procedure Description	TRICARE Rate	Medicare Rate	Medicaid Rate	Medicare Delta	Medicaid Delta	Medicare Delta %	Medicaid Delta %
12	Tissue Exam (Pathologist)	38.22	38.22	38.00	0.00	-0.22	0.00%	-0.58%
13	Diagnostic Electron Microscope	752.66	752.66	237.71	0.00	-514.95	0.00%	-68.42%
14	Tumor Analysis	45.57	45.57	148.72	0.00	103.15	0.00%	226.38%
15	Flu Vaccine (Nasal)	24.60	24.60	24.60	0.00	0.00	0.00%	0.00%
16	Tetanus Vaccine	39.03	39.03	43.83	0.00	4.80	0.00%	12.30%
17	Panoramic X-ray of Jaws	11.88	11.88	38.20	0.00	26.32	0.00%	221.55%
18	CT Scan w/ Contrast (Head or	98.66	98.66	196.84	0.00	98.18	0.00%	99.51%
19	MRI (EG Proton)	355.15	356.88	509.78	1.73	154.63	0.49%	43.54%
20	Chest X-ray (Frontal)	17.50	17.50	17.30	0.00	-0.20	0.00%	-1.12%
21	Office Visit (Outpatient) New	226.28	226.28	82.70	0.00	-143.58	0.00%	-63.45%
22	Treat Spine Fracture	1552.35	1552.35	725.61	0.00	-826.74	0.00%	-53.26%
23	Emergency Department Visit	181.93	181.93	108.08	0.00	-73.85	0.00%	-40.59%
24	Critical Care (First Hour)	238.47	238.47	151.03	0.00	-87.44	0.00%	-36.67%
25	Pediatric Critical Care Transport	271.17	271.17	193.96	0.00	-77.21	0.00%	-28.47%

The discount exhibited in the balance of the medical procedure rates under Medi-Cal stems primarily from the downward driving force exerted on provider payments native to the directive rate setting framework found in Medicaid regulations. In other words, Medicaid rates are consistently driven downward by legislation that lowers rates paid to health care providers. Additionally, since principal Medicaid administration falls to the respective state agencies, rates tend to fluctuate due to decentralized management structures. Follow-on data presented in Sections 2. Connecticut Rate Comparison Results and 3. Mississippi Rate Comparison Results demonstrate a pattern analogous to that of Medi-Cal where a handful of medical procedures exhibit much higher rates than Medicare or TRICARE and the rest exhibit a discount. This Medicaid rate discount is expected to erode as states implement provisions of the Affordable Care Act, which

require increases in payments paid to health care providers in line with Medicare rates. The next section discusses the rate comparison results for Connecticut.

2. Connecticut Provider Payment Rate Comparison Results

As with California, analysis of medical procedure rates for Connecticut TRICARE and Medicare were almost all identical with differences manifesting solely in medical procedure Sample IDs 1–5 listed in Table 14. Medicare rates for these five laboratory procedures averaged 18.88 percent lower than TRICARE with limited variance (see Table 16). Figures 4, 5, and 6 provide a graphic representation of sample medical procedure rate comparisons for Connecticut.

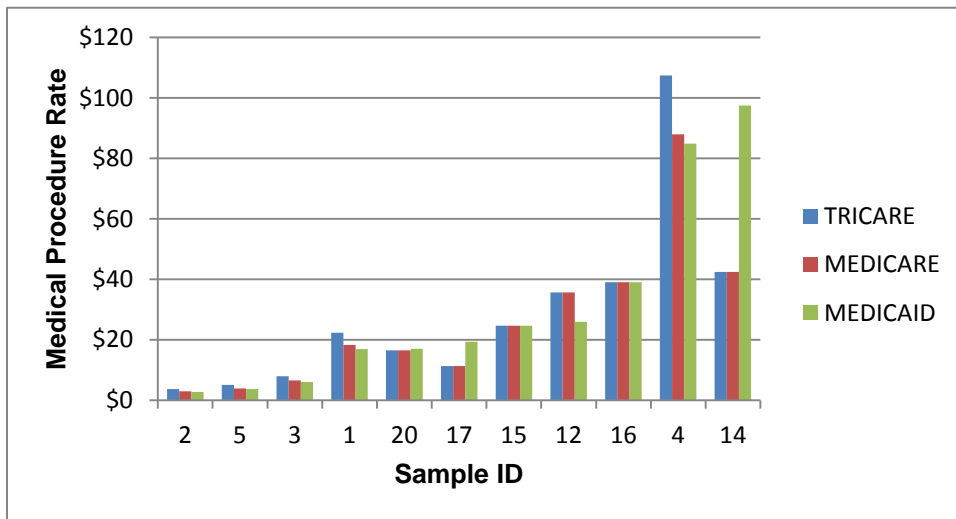


Figure 4. Connecticut Medical Procedure Rate Comparison (Set One)

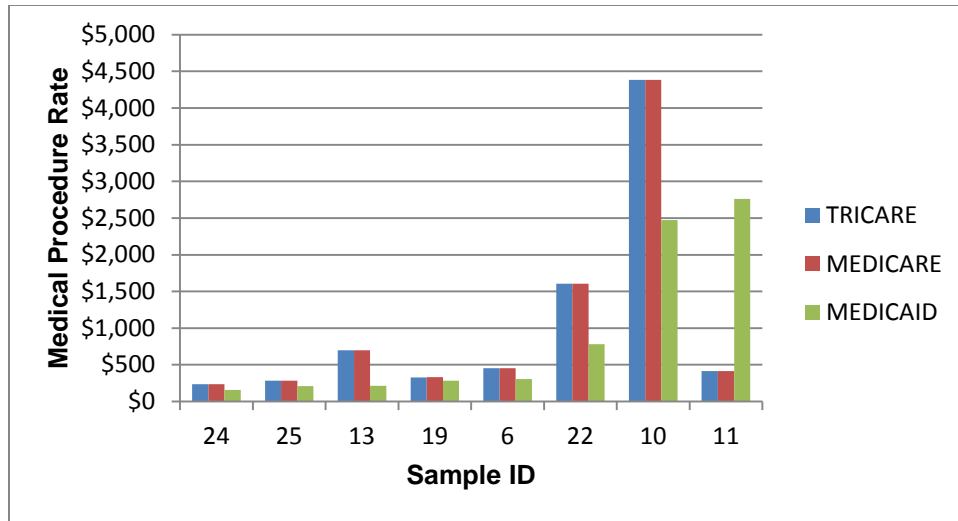


Figure 5. Connecticut Medical Procedure Rate Comparison (Set Two)

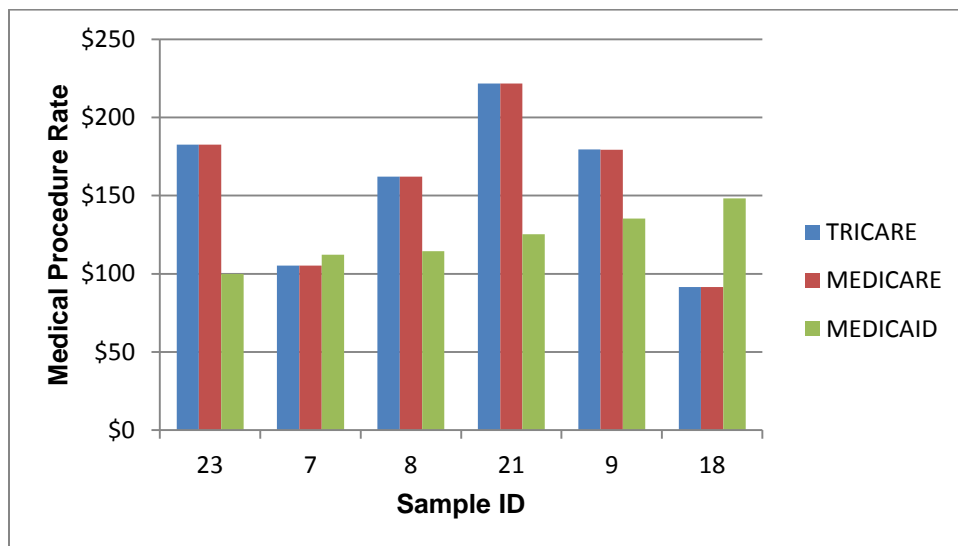


Figure 6. Connecticut Medical Procedure Rate Comparison (Set Three)

Table 16 shows full provider payment rate and difference data for Connecticut. Medicare and Medicaid differences are shown in both 2014 (current) dollars and percentages. As stated in the previous paragraph, Medicare’s limited variance in percentage differences for Sample IDs 1–5 is illustrated. Similar to Medicare, Medicaid percentage differences also showed limited variance among the five medical procedure codes (Sample IDs 1–5). Similar to the results detailed in section 1. California Rate

Comparison Results, Connecticut Medicaid presented higher rates for four procedures. The majority of the 21 procedures remaining presented rate discounts.

Table 16. Connecticut Sample Medical Procedure Rates and Differences

Sample ID	Procedure Description	TRICARE Rate	Medicare Rate	Medicaid Rate	Medicare Delta	Medicaid Delta	Medicare Delta %	Medicaid Delta %
1	Lipid Panel	22.32	18.27	16.89	-4.05	-5.43	-18.15%	-24.33%
2	Urinalysis	3.62	2.96	2.74	-0.66	-0.88	-18.23%	-24.31%
3	Glucose Test	7.92	6.48	5.99	-1.44	-1.93	-18.18%	-24.37%
4	Oncoprotein DCP	107.34	87.88	84.87	-19.46	-22.47	-18.13%	-20.93%
5	Red Blood Cell (RBC) Count	5.02	3.93	3.63	-1.09	-1.39	-21.71%	-27.69%
6	Mastectomy	452.41	452.41	306.64	0.00	-145.77	0.00%	-32.22%
7	Muscle Biopsy	105.28	105.28	112.22	0.00	6.94	0.00%	6.59%
8	Removal of Foreign Body	162.07	162.07	114.33	0.00	-47.74	0.00%	-29.46%
9	Treatment of Bone Cyst	179.40	179.40	135.22	0.00	-44.18	0.00%	-24.63%
10	Replant Hand Complete	4384.26	4384.26	2472.33	0.00	-1911.93	0.00%	-43.61%
11	Ablate Bone Tumor	416.25	416.25	2760.12	0.00	2343.87	0.00%	563.09%
12	Tissue Exam (Pathologist)	35.62	35.62	25.86	0.00	-9.76	0.00%	-27.40%
13	Diagnostic Electron Microscope	698.76	698.76	216.39	0.00	-482.37	0.00%	-69.03%
14	Tumor Analysis	42.42	42.42	97.41	0.00	54.99	0.00%	129.63%
15	Flu Vaccine (Nasal)	24.60	24.60	24.60	0.00	0.00	0.00%	0.00%
16	Tetanus Vaccine	39.03	39.03	39.03	0.00	0.00	0.00%	0.00%
17	Panoramic X-ray of Jaws	11.24	11.24	19.34	0.00	8.10	0.00%	72.06%
18	CT Scan w/ Contrast (Head or Brain)	91.59	91.59	148.19	0.00	56.60	0.00%	61.80%
19	MRI (EG Proton)	329.06	330.66	285.05	1.60	-44.01	0.49%	-13.37%
20	Chest X-ray (Frontal)	16.44	16.44	16.97	0.00	0.53	0.00%	3.22%
21	Office Visit (Outpatient) New	221.73	221.73	125.34	0.00	-96.39	0.00%	-43.47%
22	Treat Spine Fracture	1603.81	1603.81	782.65	0.00	-821.16	0.00%	-51.20%
23	Emergency Department Visit	182.60	182.60	99.99	0.00	-82.61	0.00%	-45.24%

Sample ID	Procedure Description	TRICARE Rate	Medicare Rate	Medicaid Rate	Medicare Delta	Medicaid Delta	Medicare Delta %	Medicaid Delta %
24	Critical Care (First Hour)	237.23	237.23	159.51	0.00	-77.72	0.00%	-32.76%
25	Pediatric Critical Care Transport	283.40	283.40	210.49	0.00	-72.91	0.00%	-25.73%

Connecticut Medicaid (Husky Health) medical procedure rates averaged 11.07 percent higher than those of TRICARE. These higher rates, as shown in Table 16, stem primarily from drastically higher rates for several diagnostic procedures and for Sample ID 11 ablate bone tumor. As with Medi-Cal, Husky Health treats the medical procedure ablate bone tumor as a more involved inpatient surgery rather than an outpatient procedure, which accounts for the higher rate (563.09 percent higher than TRICARE). Husky Health also includes a premium for diagnostic procedures tumor analysis (129.63 percent higher than TRICARE), panoramic x-ray of jaws (72.06 percent higher than TRICARE), and CT scan with contrast of head or brain (61.8 percent higher than TRICARE). Similar to Medi-Cal, Husky Health uses this rate premium to ensure short notice availability of these diagnostic procedures to patients.

The rate discounts presented by Husky Health emulate those found in Medi-Cal and derive from the same cause. The directive nature of Connecticut Medicaid rate setting exerts downward pressure on provider payments from legislation passed to reduce rates and ease pressure on government budgets. Akin to Medi-Cal, Husky Health discounts should erode as provisions of the Affordable Care Act requiring Medicaid rate increases come into effect. The next section discusses the rate comparison results for Mississippi.

3. Mississippi Provider Payment Rate Comparison Results

Rate comparison results for Mississippi show a provider payment pattern slightly dissimilar from those of California and Connecticut. Specifically, the Medicare rate for Sample IDs 1–5 was an average of 1.6 percent higher than TRICARE although, like the patterns present in Connecticut and California data, the percentages showed limited variation. Further, Mississippi Medicaid rates were on average 3.8 percent lower than

TRICARE differing from the Medicaid programs of California and Connecticut whose programs had higher payment rates. Rate premiums and discounts were also less pronounced with the maximum premium paid being for Sample ID 18 CT scan with contrast of head or brain (39.1 percent higher than TRICARE) and the maximum discount for Sample ID 10 replant hand complete (18.3 percent lower than TRICARE). The provider payment congruence pattern between TRICARE and Medicare present in the California and Connecticut data manifested in the Mississippi data as well.

Figures 7, 8, and 9 show medical procedure rates for Mississippi graphically. Following the same procedure used for California and Connecticut data, the rate data from Mississippi was separated into three sets. This was done to facilitate generating the graphs and make them more readable.

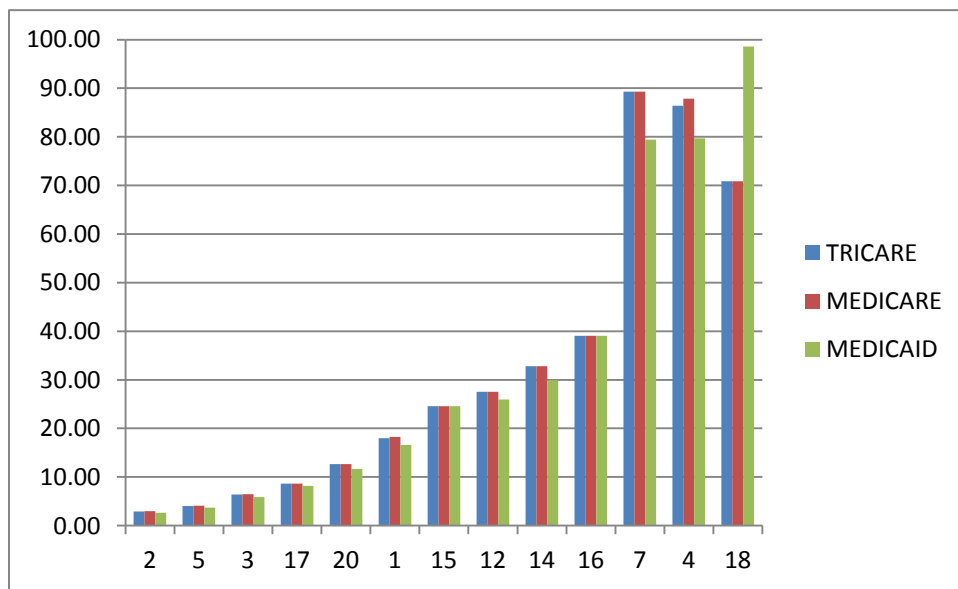


Figure 7. Mississippi Medical Procedure Rate Comparison (Set One)

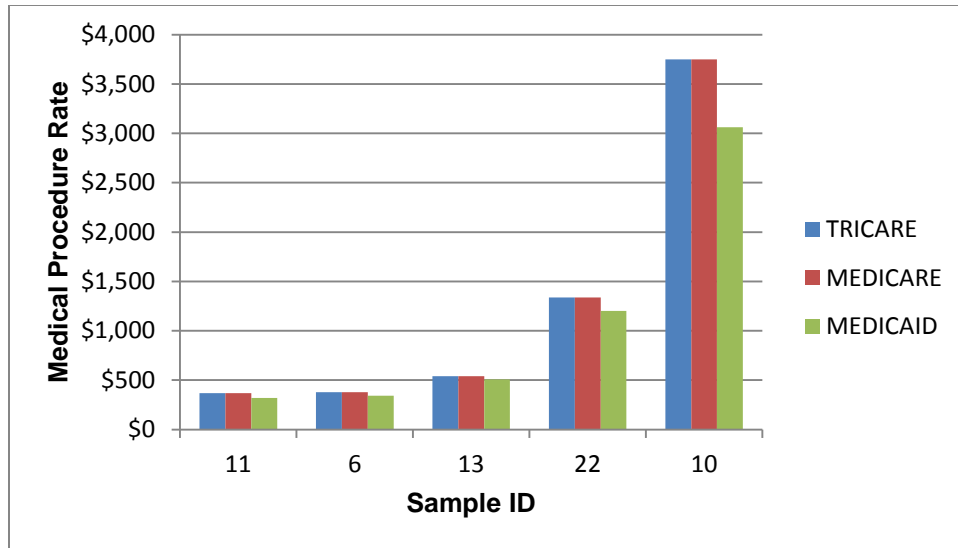


Figure 8. Mississippi Medical Procedure Rate Comparison (Set Two)

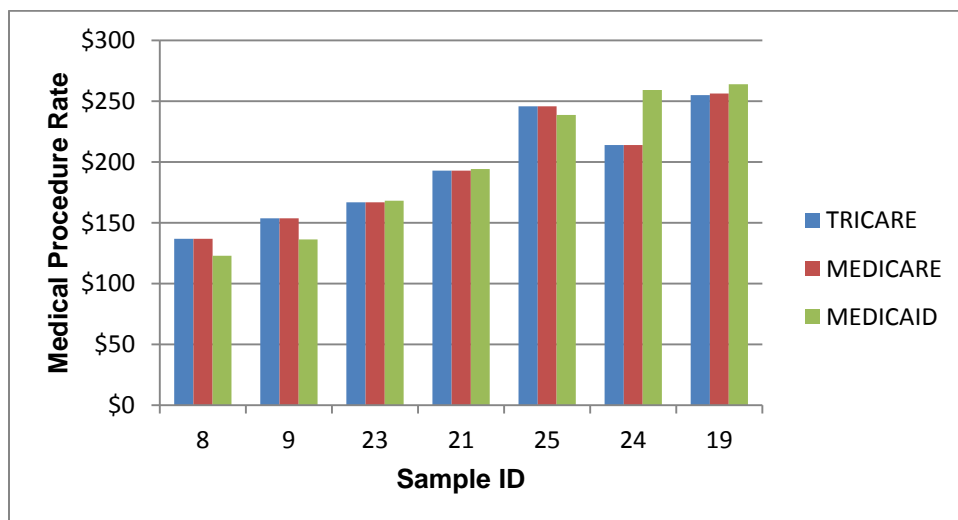


Figure 9. Mississippi Medical Procedure Rate Comparison (Set Three)

It is important to note that Mississippi was the only state in this study found to have a lower average payment rate for Medicaid. As covered earlier in this section, Mississippi Medicaid’s average rate was 3.8 percent lower than TRICARE. Mississippi Medicaid did however exhibit many of the other provider payment patterns found in California’s and Connecticut’s Medicaid programs. These pattern consistencies included discounts for the majority of the procedures used in the targeted sample and consistent discounts as a percentage for Sample IDs 1–5. The average lower payment rate for

Mississippi Medicaid is the result of the absence of the steep premiums paid for certain medical procedures found in Medi-Cal and Husky Health. The reason for this could not be definitively ascertained through the work conducted in this study. It does appear, however, that since California and Connecticut receive the minimum amount of federal Medicaid assistance on the FMAP scale (covered in Section 3. Medicaid in Chapter II); while Mississippi receives a much higher percentage (indicating a lower per capita income); that California and Connecticut have or are perceived to have greater resources, which motivates their legislative bodies to offer higher Medicaid payments to health care providers. Essentially, Mississippi appears to possess a smaller resource pool from which to draw and consequently requires lower rates to ensure affordability. Full medical procedure rate and comparison data for Mississippi is included in Table 17.

Table 17. Mississippi Sample Medical Procedure Rates and Differences

Sample ID	Procedure Description	TRICARE Rate	Medicare Rate	Medicaid Rate	Medicare Delta	Medicaid Delta	Medicare Delta %	Medicaid Delta %
1	Lipid Panel	17.97	18.27	16.58	0.30	-1.39	1.7%	-7.7%
2	Urinalysis	2.91	2.96	2.68	0.05	-0.23	1.7%	-7.9%
3	Glucose Test	6.38	6.48	5.88	0.10	-0.50	1.6%	-7.8%
4	Oncoprotein DCP	86.43	87.88	79.69	1.45	-6.74	1.7%	-7.8%
5	Red Blood Cell (RBC) Count	4.05	4.11	3.73	0.06	-0.32	1.5%	-7.9%
6	Mastectomy	379.48	379.48	343.26	0.00	-36.22	0.0%	-9.5%
7	Muscle Biopsy	89.31	89.31	79.44	0.00	-9.87	0.0%	-11.1%
8	Removal of Foreign Body	136.86	136.86	122.72	0.00	-14.14	0.0%	-10.3%
9	Treatment of Bone Cyst	153.57	153.57	136.18	0.00	-17.39	0.0%	-11.3%
10	Replant Hand Complete	3749.69	3749.69	3061.85	0.00	-687.84	0.0%	-18.3%
11	Ablate Bone Tumor	368.93	368.93	318.95	0.00	-49.98	0.0%	-13.5%
12	Tissue Exam (Pathologist)	27.52	27.52	25.96	0.00	-1.56	0.0%	-5.7%
13	Diagnostic Electron Microscope	540.83	540.83	507.29	0.00	-33.54	0.0%	-6.2%
14	Tumor Analysis	32.79	32.79	29.93	0.00	-2.86	0.0%	-8.7%
15	Flu Vaccine (Nasal)	24.60	24.60	24.60	0.00	0.00	0.0%	0.0%
16	Tetanus Vaccine	39.03	39.03	39.03	0.00	0.00	0.0%	0.0%
17	Panoramic X-ray of Jaws	8.62	8.62	8.19	0.00	-0.43	0.0%	-5.0%

Sample ID	Procedure Description	TRICARE Rate	Medicare Rate	Medicaid Rate	Medicare Delta	Medicaid Delta	Medicare Delta %	Medicaid Delta %
18	CT Scan w/ Contrast (Head or Brain)	70.89	70.89	98.61	0.00	27.72	0.0%	39.1%
19	MRI (EG Proton)	254.96	256.20	263.82	1.24	8.86	0.5%	3.5%
20	Chest X-ray (Frontal)	12.64	12.64	11.64	0.00	-1.00	0.0%	-7.9%
21	Office Visit (Outpatient) New	192.78	192.78	194.09	0.00	1.31	0.0%	0.7%
22	Treat Spine Fracture	1337.44	1337.44	1200.04	0.00	-137.40	0.0%	-10.3%
23	Emergency Department Visit	166.81	166.81	167.95	0.00	1.14	0.0%	0.7%
24	Critical Care (First Hour)	213.95	213.95	259.08	0.00	45.13	0.0%	21.1%
25	Pediatric Critical Care Transport	245.60	245.60	238.51	0.00	-7.09	0.0%	-2.9%

In summary, TRICARE and Medicare exhibited almost identical provider payment rates across all three of the states compared in this study. The only differences found between Medicare and TRICARE occurred in Sample IDs 1–5. For California, Medicare rates for these five procedures averaged 13.42 percent lower than TRICARE. On the other hand, California Medicaid averaged 33.64 percent higher than TRICARE with five specific procedures claiming responsibility for the higher rates. For Connecticut, Medicare rates for Sample IDs 1–5 averaged 18.88 percent lower than TRICARE while Medicaid rates were an average of 11.07 percent higher than TRICARE. Like California, Connecticut’s higher Medicaid rates are attributable to a handful of sample procedures. Finally, for Mississippi, Medicare rates for Sample IDs 1–5 averaged 1.6 percent higher than TRICARE, the only state exhibiting that pattern. Medicaid rates in Mississippi, contrastingly, were an average of 3.8 percent lower than TRICARE; also the only state to exhibit such a pattern. Figure 10 displays the average deltas across states and programs graphically. Note that average deltas for Medicare apply only to Sample IDs 1–5 while Medicaid average deltas are program-wide.

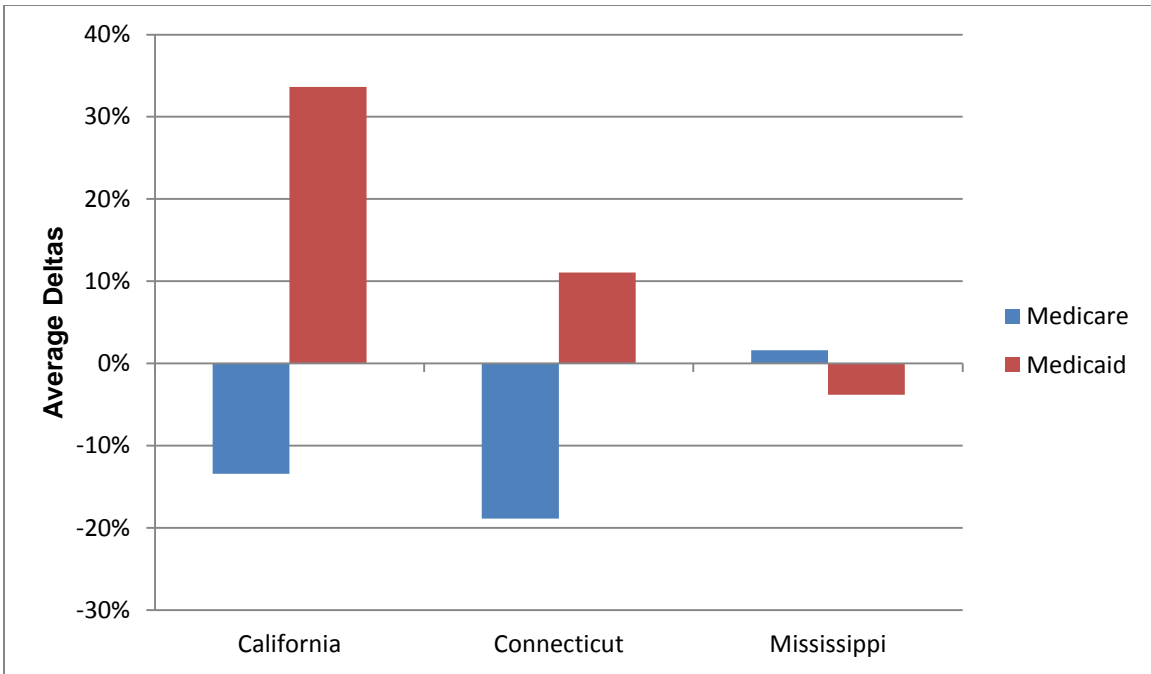


Figure 10. Medicare and Medicaid Procedure Payment Average Percentage Differences (Deltas) Compared to TRICARE

Figure 11 displays the median deltas across states and programs graphically in order to illustrate how outliers are influencing the mean. Note that median deltas for Medicare apply only to Sample IDs 1–5 while Medicaid median deltas are program-wide.

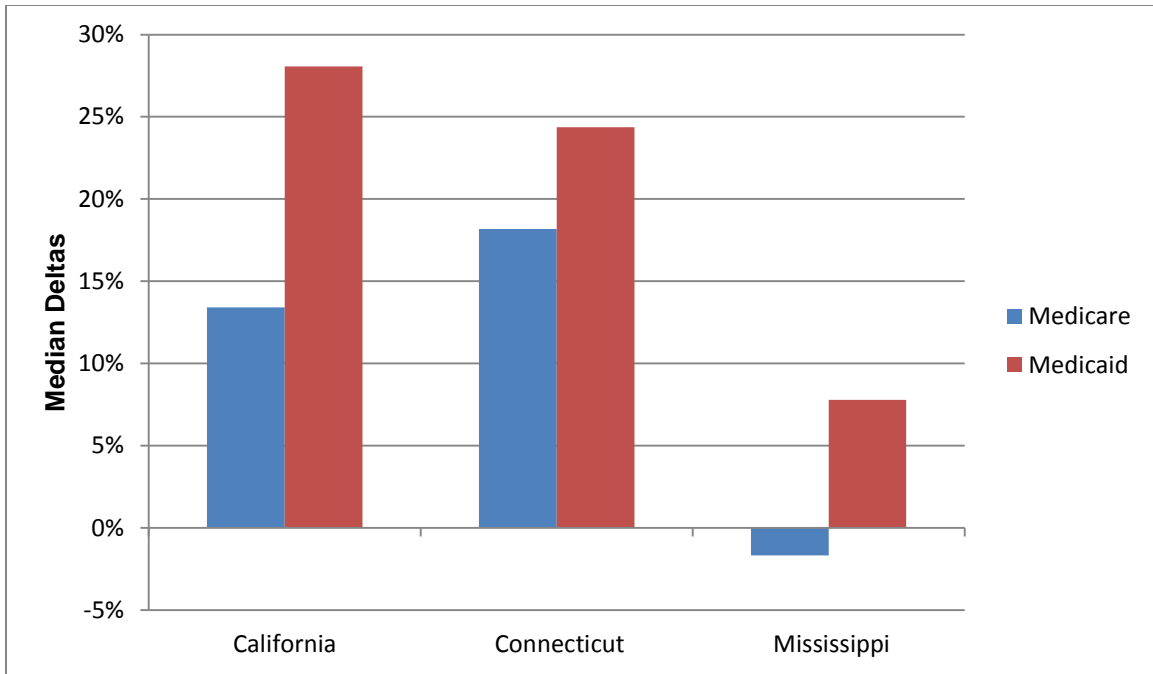


Figure 11. Medicare and Medicaid Procedure Payment Median Percentage Differences (Deltas) Compared to TRICARE

Table 18 summarizes the mean and median payment rates across all procedures for each program by state. Mean and median program payment rate deltas across all procedures by state are also provided.

Table 18. Rate and Difference (Deltas) Means and Medians by State and Program

State	TRICARE Rate Mean	TRICARE Rate Median	Medicare Rate Mean	Medicare Rate Median	Medicaid Rate Mean	Medicaid Rate Median	Medicare Rate Delta Mean	Medicare Rate Delta Median	Medicaid Rate Delta Mean	Medicaid Rate Delta Median
CA	384.24	102.53	383.57	102.53	424.28	108.08	0.67	0.00	-40.04	2.42
CT	386.54	107.34	385.53	105.28	330.63	112.22	1.00	0.00	55.91	9.77
MS	326.56	89.31	326.69	89.31	289.59	98.61	-0.13	0.00	36.97	1.39
ALL	365.78	105.28	365.26	102.53	348.17	108.08	0.52	0.00	17.61	2.42

The next section discusses the financial sustainability analysis to include presentation of cost growth factors and cost projections made by CMS and CBO. Furthermore, each program is compared in regard to overall cost growth and potential impact on the federal budget. Program per capita spending is also examined.

C. FINANCIAL SUSTAINABILITY ANALYSIS

As covered in Chapter I, each of the federal health care programs in this research study exhibits substantial growth rates. May 2013 CBO Medicaid cost projections show an average annual growth rate of eight percent from 2012–2023. CBO Medicare cost projections published concurrently with the Medicaid projections show an average annual growth rate of 5.41 percent over the same time period (CBO, 2013a). The CBO further projected in its June 2011 study titled *Long-Term Implications of the 2012 Future Years Defense Program* that costs for military health care would increase an average of 3.2 percent annually from 2016–2030 (CBO, 2011, p. 17).

These annual growth rates have each been cited by CBO as exceeding gross domestic product annual growth rates. This circumstance indicates that spending for these programs is growing faster than the economic resources needed to pay for them. Without increases in federal revenue or borrowing, Medicare indeed faces insolvency and Medicaid and TRICARE threaten to consume a disproportionate share of federal dollars. How dire is this problem? The following section explores this question.

1. Per Capita Program Spending

In the report titled *Approaches to Reducing Federal Spending on Military Healthcare*, CBO (2014) estimates place TRICARE enrollment in 2012 at just over eight million beneficiaries with an additional two million being eligible for care but receiving care from other sources. The CBO (2014) further presents total military healthcare spending as \$52 billion for the same year. This yields a per capita spending figure of \$6,500 for the eight million TRICARE enrollees.

Based on CBO May 2013 cost projections, Medicare per capita spending was \$9,833 per enrollee for 2012. This number included net Medicare outlays of \$472 billion

and enrollment of approximately 48 million people (CBO, 2013a). These numbers concur with CBPP figures. CBO May 2013 cost projections also put total federal 2012 outlays for Medicaid at \$251 billion. This information concurs with 2012 Medicaid spending data published by HHS in its *2013 Actuarial Report*. The *2013 Actuarial Report* (HHS) also places state Medicaid spending at \$181 billion and total Medicaid spending at \$432 billion. A slight divergence is present between CBO and HHS enrollment numbers. CBO (2013b) numbers place 2012 Medicaid enrollment at 57 million while HHS (2013) lists enrollment at almost 59 million for 2012 (58.6 million). This research study used an approximation of 58 million Medicaid enrollees to generate 2012 per capita Medicaid costs. These numbers yield a per capita figure of \$4,328 for the federal portion of Medicaid and a per capita figure of \$3,121 for the state portion. Together, the federal and state Medicaid per capita figures equal \$7,449. The *2013 Actuarial Report* (HHS) does put Medicaid per capita spending at \$6641; however, this number does not include mandatory Medicaid administration costs. It should be noted that this research study focuses on each program's total cost to ensure equitable comparison.

Taken together these figures paint an interesting picture. Per capita, both Medicare and Medicaid are more expensive than TRICARE and the military health system. Per capita spending for TRICARE and the military health system is also lower than national per capita spending, which the CMS (2013b) holds at \$8,915 in 2012. A portion of this difference in cost can be explained by the fact that both Medicare and Medicaid serve vulnerable segments of the U.S. population, specifically the elderly and disabled whom require a disproportionate percentage of resources for health care. For example, CBO numbers place the federal per capita cost of treating an elderly or disabled patient under Medicaid in 2012 at \$10,850 and \$9,870 respectively (CBO, 2013b). CBO (2013b) estimates further show that average spending for a disabled enrollee is seven times as great as that for a non-disabled enrollee. These figures indicate that as the enrollment of aged and disabled increases, so too do program costs.

TRICARE and the military health system, however, also treat elderly military retirees and disabled service members and dependents, though TRICARE For Life functions effectively as a Medicare supplement plan (thus, not bearing the majority of

costs). Further, disabled service members generally transition to other health care programs not funded by DOD such as those provided by VA. As such, it can be argued that TRICARE and the military health system maintain a smaller proportion of elderly and disabled enrollees than Medicare or Medicaid. Per CBO, DOD health expenditures do include infrastructure costs such as construction and maintenance, which are for building and maintaining military health facilities (\$1.7 billion in 2012) (CBO, 2014). The 2012 DOD health care budget also included \$1.3 billion for research and development (CBO, 2014). These are costs that Medicare and Medicaid do not incur. The next section discusses program cost growth and the factors influencing that growth.

2. Program Cost Growth and Factors

From 2012–2022, CMS statistics project that national health expenditures to include Medicare and Medicaid will increase annually by 5.76 percent on average while the cost of private health insurance on average will increase 6.54 percent (CMS, 2011). Average annual growth rates for Medicare, Medicaid, and TRICARE over roughly the same time period were presented in the first paragraph of this section (C. Financial Sustainability Analysis). Both Medicare (5.41 percent) and TRICARE (3.2 percent) show projected average annual growth that falls below these aggregate national numbers. As to Medicaid (8 percent), CBO attributes its larger average annual growth rate projection to provisions of the Affordable Care Act that expand Medicaid eligibility and increase the federal government’s share of medical costs (KFF, 2013). The next section provides cost growth data and analysis for Medicaid.

a. Medicaid

The CMS provides historical Medicaid data which shows that from 2001–2012 the average annual growth rate for the federal portion of Medicaid expenses was a much more modest 6.38 percent (CMS, 2013b). This data helps to provide clearer insight into the impactful role that the Medicaid enrollment expansion and increase in the federal share of expenses, affected by the Affordable Care Act, have had in skewing Medicaid cost growth projections when compared to Medicare and TRICARE. Even at the lower historical growth figure, Medicaid’s average annual cost growth rate is still higher than

Medicare or TRICARE. HHS (2013), KFF (2013), and CBO (2012) do point out that Medicaid's higher cost growth can be attributed to the fact that both total enrollment and the percentage of disabled and critically ill patients covered by Medicaid, are expected to increase over the next decade. This increase derives from two main factors. First, provisions of the Affordable Care Act relax Medicaid eligibility standards that are projected to expand total enrollment, specifically enrollment of disabled and critically ill beneficiaries (KFF, 2013). Second, the aging of the U.S. population is projected to increase the percentage of elderly beneficiaries (who typically require more care) (HHS, 2013, p. 29). All three agencies also bring attention to the fact that Medicaid, at almost 60 million in 2012, has the highest number of enrollees of any major federal health care program.

The Henry J. Kaiser Family Foundation (KFF) listed key findings in its August 2013 issue brief on the May 2013 CBO Medicaid baseline. These findings include an expected enrollment expansion to 91 million enrollees and an increase in the federal portion of Medicaid to \$554 billion, both by 2023 (KFF, 2013). These are considerable increases over the 2012 numbers of just under 60 million enrollees and \$251 billion in federal Medicaid expenses (CBO, 2013b). Medicaid's 2013 actuarial report states that the program cannot go bankrupt since it does not rely on a trust fund or dedicated revenue source for funding (HHS, 2013, p. 3). Despite this, the report does state that under the president's fiscal year 2015 budget, federal outlays for Medicaid are projected to account for nine percent of the total federal budget by 2022 (HHS, 2013, p. 53). This is an increase over the 7.7 percent of the federal budget claimed by Medicaid in 2013 (HHS, 2013). The report further shows that Medicaid is projected to represent roughly 3.3 percent of gross domestic product by 2021 up from 2.7 percent in 2012 (HHS, 2013, p. 54).

The projections of CBO and CMS do show a clear pattern of ever increasing Medicaid costs for both the federal and state governments. It cannot be clearly determined whether these increases will definitively lead to a federal budget meltdown. It

is clear however, that Medicaid expenditures will exert serious pressure on federal fiscal budgets over the next 10 years. The next section provides cost growth data and analysis for Medicare.

b. Medicare

Unlike Medicaid, Medicare does rely on a trust fund for funding. A 2013 report filed by Medicare's trustees and cited by the CBPP in the article titled *Medicare Is Not Bankrupt* (Van de Water, 2013) projects that Medicare Part A will become insolvent in 2026 when payroll taxes and trust fund revenues will cover only 87 percent of obligations. By 2047, the Part A trust fund is expected to decline, covering only 71 percent of obligations (Van de Water, 2013). Part B of Medicare derives funding from enrollee premiums and federal coffers based on a 25/75 split (Van de Water, 2013). The premiums are set annually and must equal 25 percent of expenditures (Van de Water, 2013). Consequently, the trust fund into which the premiums are deposited always has funds available while the federal budget portion can consistently be covered through tax increases or borrowing. As such, Part B cannot go bankrupt.

The CBPP article referenced in the previous paragraph points to interesting an fact, which is that since 1970, Medicare trustees have projected insolvency for the program as soon as two years into the future and as many as 28 years into the future (Van de Water, 2013). Over that four decade period, the government has taken steps to ensure that insolvency does not occur. CBPP expects this trend to continue and holds up the historic stability of the federal government as the keystone of their summation (Van de Water, 2013). As long as the government remains able to borrow and interest payments on the national debt (six percent of the federal budget or \$220 billion in 2012) (CBPP, 2013, p. 3) do not crowd out funding for Medicare, CBPP's assessment remains true.

The CBO's May 2013 Medicare projections show federal outlays of \$905 billion in 2023 for the program. Comparing the 2023 figure to the \$472 billion cost in 2012 (CBO, 2013a) elicits the average annual growth of 5.41 percent projected during that period. Projection narratives indicate that some of the growth can be attributed to provisions in the Affordable Care Act that expand enrollment and increase health care

provider payments, albeit at rates far below those of Medicaid. The majority of the growth is attributed to the ever increasing number of Americans reaching the age of Medicare eligibility. In particular, the benefits claimed by the “baby boom” generation (Americans born between 1946 and 1964) are predicted to put extensive pressure on the finances of Medicare. The next section discusses cost growth and analysis for TRICARE.

c. TRICARE and the Military Health System

Of the three programs looked at in this study, TRICARE and the military health system show the slowest projected growth in cost along with growth below both the growth of national health expenditure and private health insurance. These CBO (2014) statistics indicate that the cost growth of TRICARE and the military health system place the smallest burden on federal budgets. Despite this, the growth of TRICARE and the military health system as a whole and as a percentage of the DOD base budget is sobering. In 1990, CBO (2014) states military health care made up four percent of the total DOD budget. By 2012, that number had climbed to 10 percent and CBO (2014) estimates that the figure will continue to increase to 11 percent by 2028. Specifically, DOD spending on TRICARE and the military health system increased by 14 percent from 1990–2000 but increased 130 percent from 2000–2012 (CBO, 2014, p. 8). Furthermore, TRICARE and military health system spending as a portion of the total DOD budget held steady at six percent from 1994 to 2000, after which it increased sharply (CBO, 2014, p. 8).

The CBO (2014) attributes growth in DOD health care spending to three main factors. The first is the implementation of new programs enacted by Congress to expand the number of people eligible for TRICARE. The two largest new programs are TRICARE For Life, which is TRICARE’s Medicare supplement program, and TRICARE Reserve/Reserve Select. TRICARE Reserve/Reserve Select was implemented to provide low cost medical insurance to military reservists who are not currently on active duty. The second factor is the financial incentive of beneficiaries to use TRICARE. This stems from TRICARE’s lower than average out-of-pocket expenses when compared to private insurance plans. The third factor consists of the costs imposed on TRICARE and the

military health system for the care of wounded service members. This last factor is cited by CBO (2014) as having the least influence on DOD health care budgets. This is due to the small number of wounded service members (when compared to the number of all other beneficiaries covered under TRICARE) and the fact that these service members frequently transition to alternate sources of health care such as VA. The next section summarizes Chapter IV.

D. SUMMARY

This chapter presented an analysis of medical procedure provider payment rates consisting of primarily a comparison of actual payment rates for a targeted sample of 25 medical procedures across three states, California, Connecticut, and Mississippi and the three subject federal health care programs, Medicare, Medicaid, and TRICARE. The comparison revealed that TRICARE and Medicare exhibited almost identical payment rates across all three of the states compared in this study. The only payment rate differences between Medicare and TRICARE were found in Sample IDs 1–5. Medicare average payment rates for these Sample IDs were 13.42 percent lower than TRICARE in California, 18.88 percent lower in Connecticut, and 1.6 percent higher in Mississippi. Medicaid average payment rates were found to be 33.64 percent higher than TRICARE in California, 11.07 percent higher in Connecticut, and 3.8 percent lower in Mississippi.

Further, this chapter discussed the financial sustainability of each health care program to include per capita spending, historical and projected growth rates for each program, and the factors responsible for driving that growth. This analysis showed that TRICARE had the lowest per capita spending (\$6,500) when compared to Medicare (\$9,833), Medicaid (\$7,449), and CMS's national per capita spending figure (\$8,915). The analysis also showed that over roughly the next decade, TRICARE has the lowest projected spending growth (3.2 percent) when compared to Medicare (5.41 percent), Medicaid (eight percent), and CMS's projected national growth (5.76 percent). The next chapter, Chapter V, provides a summary and recommendations, presents the conclusion, and discusses areas for further research.

V. SUMMARY, RECOMMENDATIONS, CONCLUSION, AND AREAS FOR FURTHER RESEARCH

A. INTRODUCTION

This chapter summarizes what was discussed in each of the chapters of this research study. This chapter also provides recommendations to aid DOD in maintaining the financial integrity of TRICARE and a conclusion addressing how the two research questions were answered in this research project. Furthermore, this chapter discusses areas for further TRICARE research. The following section is a summary of this research project.

B. SUMMARY

In the current fiscal environment, budget concerns are an everyday reality. Because the DOD budget is composed primarily of discretionary funds, the recent sequestration measures have been particularly straining. With the real threat of government shutdowns, downsizing, furloughs, and possible changes in military retirement, it is critical that DOD maintain its finances in the most efficient way possible.

Chapter I of this research study included the research purpose, the background, problem, research questions, objectives, and benefits and limitations of the study. Chapter II provided an in-depth review of program literature for Medicare, Medicaid, and TRICARE, summarized the operations of each program, and listed the covered services and benefits of each program. Chapter III described the methodology used to conduct the medical procedure cost comparison to include data collection and actual analysis. The chapter also presented the methods used to analyze the financial sustainability of each medical insurance program. Chapter IV presented the results of the medical procedure cost analysis to include cost differences based on the state of residence of the beneficiary and the program providing medical coverage. The chapter also provided the results of the financial sustainability analysis to include per capita spending figures, program cost growth, and growth factors. The following section discusses the recommendations of this study.

C. RECOMMENDATIONS

The CBO report titled *Approaches to Reducing Federal Spending on Military Healthcare* (2014) has been referenced several times in this research study and for good reason. The CBO provides multiple critical pieces of information in its report. Further, the report is primarily focused on fiscal year 2012, which, per CBO's own admission, is the first year for which complete military health system data is available. So what are the critical pieces of information?

The CBO's three biggest culprits responsible for the sharp increases in military health care as a percentage of the overall budget are presented in Chapter IV, Section C. TRICARE and the Military Health System. These three factors, 1) new and expanded TRICARE benefits, 2) increased utilization fostered by financial incentives to use TRICARE, and 3) medical costs of recent wars, are discussed in the cited section of this research study. These factors and CBO's recommendation listed in the report cited in the previous paragraph lead directly to recommendations presented in this research study. The next section discusses the CBO's recommendations for reducing the cost of TRICARE and the military health system.

1. CBO Recommendations

The CBO lists three primary recommendations. These recommendations are:

- Improve patient health by better managing chronic diseases
- Administer the military health system more effectively
- Increase cost sharing for retirees who use TRICARE

CBO contends that the third recommendation is the only one that holds the promise of reducing DOD health spending significantly and lists three options to increase cost sharing (CBO, 2014, p. 3). The first option would increase enrollment fees, copayments, and deductibles paid by working-age retirees starting in 2015. CBO estimates place DOD cost savings over a 10-year span (2014–2023) at \$23 billion for this first option (CBO, 2014, p. 25). The second option would deny working-age retirees the opportunity of enrolling themselves and their families in TRICARE Prime (the most costly TRICARE option for DOD) but would allow enrollment in Standard or Extra for a

new annual enrollment fee starting in 2015. This option is estimated to save DOD \$85 billion over the same 10-year period (2014–2023) (CBO, 2014, p. 25). The third option would require Medicare-eligible retirees to pay the all health care costs not covered by Medicare up to a cap of \$3,025 in the first year of implementation (2015). Once this cap is reached, TRICARE For Life would take over to cover 100 percent of eligible health care costs not paid by Medicare. CBO estimates that savings from this option would be \$31 billion over the aforementioned 10-year span (CBO, 2014, p. 25). The CBO states that these options are not additive, as several of the provisions counteract one another (CBO, 2014, p.25). These recommendations show considerable cost savings but leave out active duty service members and their families, in the interest of maintaining readiness. This view is understandable, but from the view of active duty service members, access, stability, and quality of care are the key concerns. The recommendations presented in this research study include active duty dependent family members in order to reduce costs by the maximum amount possible without affecting the medical readiness of active duty military members. The recommendations also remain inside the confines of existing TRICARE and the military health system without creating any new programs or channels to provide medical care. The next section discusses the recommendations of this study.

2. Research Study Recommendations

The recommendations provided in this section can be implemented individually or as a package without cancelling out each other's effects. The recommendations are:

- Require payment of small monthly premiums for beneficiaries (excluding active duty members) enrolled in TRICARE while reducing referral requirements for alternate treatment options such as urgent care centers and retail medical clinics
- Change TRICARE For Life from a strictly Medicare supplement insurance plan to a full-spectrum supplemental insurance plan and mandate that TRICARE For Life is the only TRICARE plan available to retirees and their families
- Eliminate TRICARE Prime for all beneficiaries excluding active duty members

Cost savings for each of these plans are difficult to estimate without more specific data; however rough estimates are presented in the next section.

a. Cost Savings Estimate for Recommendation One

In 2012, of the 8.1 million beneficiaries enrolled in TRICARE, 6.3 million were not active duty service members. Based on these numbers, instituting even a modest average monthly premium of \$25 per beneficiary would yield savings of just under \$1.9 billion annually. The CBO specifies that in 2012, annual premiums for an HMO-type private insurance plan typically equal \$5,080 per family (CBO, 2014, p. 13). The CBO also specifies that annual premiums for a private PPO-type plan typically equal \$4,270 per family (CBO, 2014, p. 15). These figures provide a frame of reference when determining the impact of this measure on military families.

The implementation of this recommendation would also include expansion of medical services not requiring referral. Specifically, it would include eliminating referral requirements for visits to urgent care facilities and retail medical clinics. The idea would be to increase convenience and access to care for beneficiaries while steering them away from costly emergency room visits. Research conducted by RAND Corporation (Mehrotra et al., 2009) showed that when compared to emergency room services, urgent care and retail clinic visits were far cheaper on average (\$110 and \$156 for retail clinics and urgent care respectively vs. \$570 for ER visits). The Centers for Disease Control posted survey data indicating that the rate for emergency room visits in the U.S. was 42.8 per 100 people and the number of non-emergency visits averaged 17 percent (CDC, 2010, p. 3). This could mean that TRICARE incurs as many as 600,000 non-emergency ER visits per year. If the average savings (\$437) from seeking care at an urgent care facility or retail clinic versus the ER is applied to the 600,000 figure, then annual savings of over \$250 million could be realized.

b. Cost Savings Estimate for Recommendation Two

The DOD (2013, p. 16) placed 2012 enrollment for TRICARE For Life at 1.6 million enrollees. CBO (2014, p. 11) also put 2012 TRICARE payments made on behalf of TRICARE For Life beneficiaries at \$8.2 billion. These numbers yield a rough per capita spending figure of \$5,125 for TRICARE For Life. CBO (2014, p. 30) figures put TRICARE Prime enrollment for working-age military retirees at 1.6 million. CBO (2014,

p. 8) estimates put the 2012 per capita spending figure for a TRICARE Prime beneficiary at \$4,800. CBO (2014, p. 12) estimates further put TRICARE Prime usage for working-age retirees at roughly 1.5 times the average rate. This would indicate a per capita spending figure of approximately \$7,200 for working-age retirees enrolled in TRICARE Prime. When compared to the TRICARE For Life per capita figure (without any consideration for the fact that Medicare-eligible retirees use TRICARE services at a rate roughly 3.5 times the average [CBO, 2014, p. 12]), switching all working-age retirees from TRICARE Prime to TRICARE For Life would save \$2,075 per enrollee annually. Once expanded to the 1.6 million working-age retirees on TRICARE Prime, annual savings could reach over \$3.3 billion.

c. Cost Savings Estimate for Recommendation Three

Of the 5.5 million TRICARE Prime enrollees in 2012, 3.8 million were not active duty service members. CBO (2014, p. 8) estimates per capita spending for TRICARE Standard/Extra beneficiaries at \$3,900. The comparison of this to the \$4,800 per capita spending for TRICARE Prime produces a difference of \$900. When multiplied by the 3.8 million TRICARE Prime enrollees switched to TRICARE Standard/Extra, this difference yields annual cost savings of almost \$3.5 billion. The next section discusses considerations that must be taken into account when implementing the recommendations of this study.

3. Research Study Recommendation Considerations

One of the key concerns of military leaders and lawmakers is the impact that tinkering with military compensation and benefits will have on recruitment, retention, and readiness. That being said, these recommendations are for reductions in benefits for active duty military members. The reductions do, however, keep the cost of TRICARE to military members well below costs experienced by comparable civilian employees. Because of the unique nature of military service and the hardships imposed on families, financial and otherwise, it seems only fair that these costs to them are lower than those experienced by civilians. It is also important that TRICARE provide stable and reliable coverage from year to year without forcing active duty service members and their

families to adjust to iterative changes. If the result of not achieving the DOD's cost cutting goal for TRICARE and the military health system are disruptive iterative changes in military benefits and compensation, then all options must be considered to avoid that disruption.

The premiums supported in Recommendation One are simply suggestions and actual premiums must be based on greater analysis and set schedules, much like Medicare Part B premium schedules. The typical annual premium for comparable civilian coverage should serve as an additional benchmark when determining those premiums. Further, the expansion of non-referral services to urgent care and retail medical clinics is designed to encourage TRICARE beneficiaries to avoid emergency room visits for all but the direst circumstances.

Mandating TRICARE For Life as the only option available to working-age retirees forces them to seek private coverage through their employer once they leave active service. CBO (2014) confirms communal military knowledge that the vast majority of military retirees obtain private sector jobs upon leaving the military as they are still of working-age. Consequently, these retirees have access to private insurance through their own or their spouses' employers. Recommendation Two places pressure on working-age retirees to seek the majority of their care through these private plans while still providing a level of the low cost subsidized 100 percent coverage they originally expected.

Elimination of TRICARE Prime for all but active duty service members is an extreme measure. Unsurprisingly, it also results in the greatest cost savings of any of the three recommendations. Of the three recommendations, it is also the one that can be expected to noticeably hurt retention. Because TRICARE Prime possesses the largest enrollment of any TRICARE program, its popularity among beneficiaries is inferred. Therefore, if the program eligibility were limited only to active duty military members, the negative sentiment among former beneficiaries could be considerable. For that reason, this recommendation should be chosen only in order to avoid substantially changing or eliminating other military compensation and benefits such as pensions or basic allowance for housing. The next section discusses conclusions pertaining to the results of this study, in particular the two research questions.

D. CONCLUSIONS

This research study addressed and answered two research questions, which are discussed next.

1. How Does TRICARE Compare to the Other Major Federal Medical Insurance Programs (Medicare and Medicaid) in Regard to Covered Services and Costs?

Answering this research question required conducting an extensive review of program documentation, cost comparison, and cost analysis. This work generated per capita spending data for each program as well as information on overall cost growth, both historical and projected. A look at this data shows that per Chapter IV, Section 2. Program Cost Growth and Factors, TRICARE exhibits the lowest cost growth percentage of any of the three federal programs (at 3.2 percent) as well as the lowest per capita spending at \$6,500 as shown in Chapter IV, Section 1. Per Capita Program Spending. TRICARE's growth is also well below growth of national health expenditures (5.76 percent) and private insurance cost (6.54 percent).

As to actual cost for medical procedures, TRICARE and Medicare are almost identical. Medicaid served as the outlier, exhibiting higher sample costs than TRICARE in Connecticut and California (11.07 percent and 33.64 percent) respectively. Mississippi Medicaid actual sample costs were 3.8 percent lower than TRICARE but because per capita spending for Medicaid is higher than TRICARE, it is logical to assume that Mississippi's lower costs are the exception rather than the rule.

Of the three programs, TRICARE is the only program that does not cover chiropractic services. Medicaid differs more than the other three programs. This results from the decentralized nature of Medicaid coverage decisions where individual states have considerable say over what their respective programs will and will not cover. Medicaid is also the only program of the three that offers cash incentives for seeking certain types of services such as pre- and post-natal care. Medi-Cal and Husky Health also cover urgent care services without referral, which dovetails with CMS's initiative to encourage Medicaid recipients to avoid ER visits for routine injuries and illnesses.

2. What Similarities and Differences Exist between TRICARE, Medicare, and Medicaid?

With the exception of the similarities and differences discussed in the previous section, TRICARE, Medicare, and Medicaid differ in how they are funded and how payment rates for services are determined. Specifically, TRICARE is funded through the Defense Health Program, which is built into the annual Defense Authorization Act. Medicare is funded through payroll taxes, premiums, and direct federal outlays deposited into appropriate trust funds based on predetermined rates. Medicaid is funded through state outlays and federal matching funds based on the FMAP system as explained in Chapter III, Section 3. Medicaid.

As to payment rate determination, Medicare and TRICARE rely on rates contracted with specific providers whereas Medicaid determines rates legislatively and directs or gives providers the option of whether or not to accept those rates. Medicaid's payment rate determination method is currently undergoing change due to provisions of the Affordable Care Act, which require Medicaid payment rates to fall in line with those of Medicare. The expected outcome of this measure is that all three federal programs (to include Medicaid) will maintain medical procedure costs that exhibit very little variation, much like costs for TRICARE and Medicare. The next section will provide areas for further research.

E. AREAS FOR FURTHER RESEARCH

There are several areas for further research that are beyond the scope of this research study. These areas fall into two main categories: 1) more detailed testing of a larger sample of medical procedure payment rates over several years; and 2) comparison of per capita program spending based on beneficiary demographics. Additional research in these two areas can be expected to lead to additional insight. This insight could be applied to refining the projected cost savings data and developing appropriate premium schedules as part of the three recommendations presented by this study. By better knowing the costs encapsulated in these programs and the cost savings generated by

implementing the recommendations, more comprehensive measures can be taken to reduce pressure on DOD budgets. The next section provides an overall summary of this chapter

F. OVERALL SUMMARY

This chapter summarized the five chapters of this research study, discussed recommendations for reducing DOD health budgets, provided a conclusion to the two research questions, and discussed areas for further TRICARE research.

This research study set out with the primary goal of determining how TRICARE compares to Medicare and Medicaid in regard to covered services, costs, and provider payment rates. The results of this research study, particularly those related to cost growth, medical procedure payment rates, and per capita program spending indicate that TRICARE's numbers are lower while providing similar coverage.

The question then becomes, if TRICARE and military health system spending are growing much more slowly and per capita spending is lower than each of the major federal health care programs and national per capita spending, then why are TRICARE costs drawing so much DOD attention? Specifically, DOD concerns are based on the growing percentage of the total defense budget that health care consumes. The answer most likely lies in shrinking DOD budgets and the growing cost of health care as a national trend. Sequestration and the discretionary nature of the DOD budget are causing the DOD budget to contract and make it a ripe target for lawmakers to institute additional cuts. Unfortunately, despite the appearance that TRICARE is growing more slowly and costs less than comparable programs, it is still subject to the overwhelming cost growth trend of health care in the U.S. As the cost of TRICARE and the military health system continues to grow, albeit comparatively slowly, inside a dwindling DOD budget, alarms sound off. These alarms are compounded because reigning in medical costs is consistently difficult because of the economic forces influencing them. In reality, it seems that either difficult changes must be made to TRICARE to counteract trending growth or DOD and the federal government will need to account for that growth and accept that it occurs due to forces present within the medical economy.

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