THE ASSISTANT SECRETARY OF DEFENSE

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WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUN 17 2004

The Honorable John W. Warner
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

The enclosed report responds to the House Armed Services Committee Report (108-106) requesting the Secretary of Defense to submit a report on a study of the cost and feasibility of providing TRICARE benefits to adult family members or adopted adult family members who become incapacitated after they are no longer eligible for TRICARE benefits. I regret the report could not be completed by the originally requested date of March 31, 2004

This report includes the Department's assessment regarding the cost of options for providing such benefits. The report also outlines the methodology used to arrive at the increased numbers of beneficiaries and cost estimates for coverage of certain currently ineligible individuals, based on their incapacitation.

Thank you for your continued interest in the Military Health System.

Sincerely,

William Winkenwerder, Jr., MD

Enclosure:
As stated

cc.
Senator Carl Levin

REPORT TO CONGRESS ON COST AND FEASIBILITY OF TRICARE ELIGIBILITY FOR ADULT DISABLED FAMILY MEMBERS

INTRODUCTION

House Report 108-106, of the Committee on Armed Services, House of Representatives, on H.R. 1588, page 337, requests the Secretary of Defense to conduct a study of the cost and feasibility of extending TRICARE eligibility to adult children of active-duty and retired military personnel who become disabled after losing their TRICARE eligibility.

The cost impact of adopted adult family members would depend on the eligibility rules adopted in conjunction with such a benefit. The issues that would arise include whether such persons would be eligible for the benefit at all, whether they would only have MTF-based space-available benefits, as is currently the case, and whether any such individual adopted after a disability occurred would be eligible for such a benefit. There is clearly a potential for increased costs related to this class of beneficiaries, but we have not tried to estimate the magnitude of such costs at this time.

Potential Eligibility

The Department reviewed potential eligibility as applying to any adult family member, or adopted family member, of an active-duty or retired service member who had at one time been eligible for TRICARE benefits, but who is no longer eligible. The reason for loss of eligibility would be turning age 21, if not a full-time student, or turning

age 23, if a full-time student. Eligibility for TRICARE benefits currently may extend beyond these ages if the child is incapable of self-support because of a mental or physical incapacity and condition that existed prior to age 21, or if the condition occurred between the ages of 21 and 23 while the child was a full-time student. Thus, this new type of eligibility would provide adult children who become incapacitated after losing their TRICARE eligibility due to age the same benefits as those who became incapacitated before losing their eligibility.

Based on the report language and current eligibility requirements, we assumed that the potential pool of eligible beneficiaries for this study (those who might become eligible if they were to become incapacitated) consists of all adult children of active duty and retired personnel, regardless of age or marital status, who were not disabled when they became ineligible by virtue of their age. Therefore, we have assumed that virtually all 20-year-old TRICARE eligibles who are children of active-duty or retired personnel when they turn age 21 or 23, depending on their student status, would be eligible, if they were to become disabled at anytime after their loss of eligibility by reason of age. We exclude from this group adult children who lost their TRICARE eligibility as a result of their sponsor's separation from the Service before becoming eligible for retirement benefits. Furthermore, we included in this study not only those currently aging out of eligibility, but also all those who have similarly aged out in the past, since the CHAMPUS program was instituted in 1966. Although the language of the report is couched in terms of "military personnel," we included in the study adult children of all active-duty or retired uniformed services personnel, including the Coast Guard, National

Oceanic and Atmospheric Administration (NOAA), and the commissioned corps of the Public Health Service. Therefore, a member of the potential-eligibles pool is someone who:

1. Is the child, or adopted child, of an active-duty or retired sponsor.
2. Was at one time eligible for TRICARE benefits (or CHAMPUS benefits, as they were defined in past years)
3. Has lost TRICARE eligibility due to age, rather than due to an active-duty sponsor's separating from the service before qualifying for retirement benefits.
4. Is married or unmarried.
5. Is still alive, regardless of age.

The above parameters describe the characteristics of the potential-eligibles pool. Whether or not members of this pool actually regain their TRICARE eligibility will depend on whether they become incapacitated.

Definition of Incapacitation

The report language addressed individuals who become "incapacitated." The TRICARE eligibility requirements relating to continuing eligibility due to incapacitation before the ages of 21, or 23 in the case of a full-time student, are couched in terms of inability for self-support. For purposes of estimating the potential costs, as requested by the Committee, we have assumed that the incapacity determinations would be similar to those used by the Social Security Administration's Disability Insurance (DI) program. In other words, if the potentially eligible beneficiary were to exhibit the same disability

characteristics that would qualify a DI-eligible person for disability benefits, we assume that the person would be eligible under TRICARE. Here is the essence of the definition of disability used by the Social Security Administration:

> *"For purposes of entitlement to DI benefits, disability is defined as the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment. The impairment must be expected to result in death or to last for a continuous period of at least 12 months. In addition, the disability must prevent the claimant from performing previous work, or engaging in any other kind of work in which a significant number of jobs exist. It is immaterial whether such work exists in the claimant's immediate area, or whether a specific job vacancy exists, or whether the claimant would be hired if he or she applied for work."*

ESTIMATION OF COSTS

We have estimated the potential cost of such a benefit, as defined by the Committee, for fiscal years 2005 through 2011, based on assumptions about disability rates, death rates, and termination of disability rates by age. We discuss the most important factors below.

Numbers of Eligibles

We assume that the number of former eligibles who would potentially become eligible each year is roughly equivalent to the number of 20-year olds who are eligible for TRICARE benefits, and who therefore lose their eligibility over the next two years, as they become ineligible for CHAMPUS benefits by virtue of their age. While some of these 20-year-old beneficiaries may drop out of the eligibility pool by virtue of their active-duty sponsor's being separated from active duty before becoming retirement eligible, we assume that in the vast majority of cases the active-duty sponsors of 20-year-old children either already are retirement eligible or will become so. Therefore, we have not made a downward adjustment in the number of eligibles entering the pool after age 20. This may slightly overstate the number of potential eligibles.

We did reduce the potential number of potential eligibles to reflect the impact of the start-up year for CHAMPUS benefits in 1966. Benefits were extended to retirees and their family members beginning in 1967, only 37 years ago. Therefore, the adult children of former active-duty and retired personnel who were age 21 and older then, and who are therefore 58 and older now, would not now be former eligibles, and therefore would presumably not be potentially eligible for such a benefit. Nonetheless, in each successive year that a benefit such as this would be offered, another year of age will be added to the benefit. Therefore, we assume that for calendar year 2004, there would be no potential eligibles over age 57. In 2005, this eligibility cut-off date would rise to 58, and so on, until all age groups would be covered. We have accounted for these circumstances in our

cost estimates by excluding costs for potential eligibles over age 58 in fiscal year 2005 (the earliest assumed implementation year), and excluding one fewer year of costs in each subsequent year. Nonetheless, even in fiscal year 2005, before those older than 58 years are even considered, we estimate that the potential-eligibles pool, including all age groups from 21 through 58, consists of over 4.0 million people, and this number could exceed 5.5 million potential eligibles by fiscal year 2025.

A rapid increase in disability rates in the later years of life, combined with an anticipated continuation of health care cost inflation, results in a rapid escalation of the potential costs of this benefit from FY05 onward into the foreseeable future, with the 60-and-older age group continuing to grow in each subsequent year, as more and more formerly eligible adult children reach that age group. Table 1 provides a summary of the estimated numbers of incapacitated formerly eligible adult children who would receive TRICARE services as a result of this new benefit in FY05 and in FY11.

Table 1
Estimated Numbers of Incapacitated Formerly Eligible Adult Children By Age Group for FY05 and FY11

Age Group	Number of Incapacitated in FY005	Number of Incapacitated in FY11
Ages 21- 29	4,000	4,000
Ages 30-39	19,000	19,000
Ages 40-49	47,000	47,000
Ages 50-59	83,000	95,000
Ages 60 and Older	0	72,000
Total	153,000	237,000

The 60-and-over age group would continue to grow in future years, as the oldest eligible children age. We estimate that the number of actual (incapacitated) eligibles could easily expand to over 350,000 by FY 2025.

Sites of Care

We assumed that continuing declines in the availability of health care services for CHAMPUS-eligible beneficiaries in military treatment facilities (MTFs) would lead to all of such benefits being provided in the civilian community. However, the costs we have estimated were derived from both MTF and civilian-care sources and therefore would still be applicable if some of the care provided to this new class of beneficiary were to be provided at MTFs.

Health care Cost Inflation

Based on continuing health care cost inflation in the purchased-care component of the TRICARE program and in civilian health care costs in general in recent years, we have estimated future health care cost inflation related to the program to be 10 percent per year.

Per-Person Health care Cost Estimates

The individuals who would potentially be eligible for such a benefit are significantly more expensive than the average TRICARE beneficiary. Our estimates of the per-person costs of such a benefit, for each disabled adult child, come from data for the purchased-care and MTF costs of beneficiaries who currently qualify for the Program for Persons with Disabilities under TRICARE. These average per-person costs range from approximately $5,500 - $6,600 per year, depending on age. This compares favorably with Medicare health care costs for DI beneficiaries of about $6,200 per year.[1]

Alternate Sources of Payment

Many individuals who would potentially be eligible for such a benefit would also be eligible for Medicare. After being in the DI program for two years, disabled persons become eligible for Medicare health care benefits, at which point we assume they would become Medicare-TRICARE dual eligible and that Medicare would pick up about 80 percent of their health care costs. Therefore, we assumed that each disabled beneficiary who remains disabled for more than two years would have 100 percent of his or her allowable costs (minus any applicable deductibles or cost shares) paid by TRICARE for the first two years of his or her eligibility, after which time, TRICARE would pick up only about 20 percent of such costs. We have not considered other alternative sources of payment, such as private other health insurance (OHI) or Medicaid. In the former case,

we think it is likely that OHI coverage would rarely be as good as TRICARE coverage and that it would probably be dropped in favor of TRICARE. In the latter circumstance, TRICARE is first payer to Medicaid, in which case little or no offsetting payment would occur.

HEALTH CARE COST ESTIMATE

Based on the assumptions made above, we have estimated the costs of this benefit for fiscal years 2005 through 2011 that are displayed in Table 2 below. The rapid acceleration of costs from FY05 forward, as explained above, is due to adding an additional cohort of older potential eligibles in each subsequent year (with higher disability rates) and to the impact of health care cost inflation, compounded over time. As indicated above, these cost estimates assume that TRICARE would be responsible for 100 percent of health care costs for the first two years of disability, after which Medicare would become primary payer and TRICARE's portion of costs, as second payer, would approximate twenty percent of annual health care costs.

Based on the USPCC for disabled Medicare beneficiaries in 2004.

Table 2
Projected Health care Costs for Adult Disabled Children's Benefit

Fiscal Year 2005	$371 million
Fiscal Year 2006	$442 million
Fiscal Year 2007	$526 million
Fiscal Year 2008	$625 million
Fiscal Year 2009	$740 million
Fiscal Year 2010	$875 million
Fiscal Year 2011	$1,033 million

Assuming a moderate rate of health care inflation after FY11 (5 percent) and that the number of incapacitated persons over age 60 will continue to grow as the maximum age of eligibility is extended, the cost of such a benefit for DoD, as outlined by the Committee, would be likely to increase to over $3 billion per year by FY 2025.

FEASIBILITY

We have not attempted to design the administrative and contract mechanisms that would be required to administer this program. Although it is clear this program would pose numerous technical challenges, we believe that it is technically feasible to administer based on the fact that Medicare operates similar programs and that DoD has experience with programs for beneficiaries with disabilities, including the Program for the Handicapped, which was renamed the Program for Persons with Disabilities (PFPWD). TMA is also introducing a superceding program for disabled beneficiaries, called the Extended Care Health Option (ECHO).

Administrative Costs

As indicated in Table 1 above, we estimate that a new program such as this would start out with over 150,000 incapacitated former eligible adult children in FY 2005, and that this number could rise to as many as 240,000 by FY 2011. The administration of such a program would require evaluation of potential eligibles for disabilities, monitoring of disability status, case management, claims processing, and close coordination with Medicare and perhaps with the Social Security DI program. We believe that a conservative estimate of the costs of administering such a program would amount to about $77 million starting in FY 2005. This amounts to about $500 per incapacitated beneficiary per year. Allowing for 3 percent inflation per year for administrative costs and, considering the rate of increase in the number of persons with disabilities over the next several years, these costs could rise to approximately $142 million per year by FY 2011.

OTHER CONSIDERATIONS

Potential for Double Payment from Multiple Public Sources

In addition to the Medicare payment possibilities discussed above (post two years of being disabled), we believe that Medicaid and other public and private sources currently cover part of the health care costs for some of the potential eligibles for a benefit such as this, although we have no way of determining the magnitude of such other coverage for this specific population. We believe this type of coverage is not extensive

for this specific population. Nonetheless, we are confident that the implementation of such a benefit would carry with it the potential for some double payment. Therefore, part of the program's administration would have to include monitoring of other potential sources of funding and could possibly include some offsets in payments for such funding that might already be available to such newly covered beneficiaries.

Potential for Cost Shifting from Other Public Sources

TRICARE is first payer when Medicaid coverage is available. Therefore, to the extent that some of these potential new beneficiaries are already covered by Medicaid, there would be some cost shifting from Medicaid to TRICARE under this new benefit. We are not, however, able to estimate the magnitude of this effect at this time. We also do not know to what extent various other state or local public programs are currently providing health care coverage to these potential new beneficiaries. Unless there were provisions incorporated into the program to require taking full advantage of such other programs, there would also be some cost shifting from such programs to TRICARE.

Impact of Active-Duty and Retired Military Who Reside Outside of CONUS

The adult children of these beneficiaries who reside outside of CONUS would presumably be covered by TRICARE benefits if they lived outside of CONUS, and presumably by TRICARE and Medicare benefits if they reside within CONUS. We have

not estimated this impact on the program, but we believe that these costs are subsumed within the range of the overall estimate we have provided in this report.

Potential for Adoption of Non-US Citizen Family Members

The cost impact of adopted adult family members would depend on the eligibility rules adopted in conjunction with such a benefit. The issues that would arise include whether such persons would be eligible for the benefit at all, whether they would only have MTF-based space-available benefits, as is currently the case, and whether any such individual adopted after a disability occurred would be eligible for the benefit. There is clearly a potential for increased costs related to this class of beneficiaries, but we have not tried to estimate the magnitude of such costs at this time.

SUMMARY

This report provides an estimate of the costs of allowing formerly eligible adult family members to regain their eligibility for TRICARE benefits when they become incapacitated after the loss of their eligibility. Based on the request by the House Armed Services Committee, it was necessary to make numerous assumptions about eligibility issues. The key assumptions are as follows:

1. Eligibility would be open to all children or adopted children of active-duty or retired sponsors who lost their TRICARE eligibility due to age before becoming incapacitated. These persons would be eligible whether they were married or not, regardless of age.

2. The definition of incapacity and the incidence of incapacity and death would be the same for the Social Security Administration's Disability Insurance program.

3. After being incapacitated for two years, these new TRICARE eligibles would also become eligible for Medicare.

4. TRICARE would pay 100 percent of medical-care costs in first two years of new eligibility, after which Medicare would pick up 80 percent of costs because of dual eligibility, and TRICARE would pick up the other 20 percent.

5. The average annual medical-care costs per incapacitated individual would be about $6,000 in FY05.

Based on these assumptions, the number of new eligibles and the annual costs of the program would grow as indicated in the table below. The annual cost increases not only because of inflation, but because more older beneficiaries will receive benefits over time. Because the CHAMPUS program began in 1966, in the early years of this benefit, there would be no formerly eligible adult children over age 60, but with each additional

year, that age limit would increase. There would also be some need for increased TMA staff to manage this new benefit, although these costs have not been estimated at this time.

Age Group	Number of Incapacitated in FY05	Number of Incapacitated in FY11
Ages 21- 29	4,000	4,000
Ages 30-39	19,000	19,000
Ages 40-49	47,000	47,000
Ages 50-59	83,000	95,000
Ages 60 and Older	0	72,000
Total	153,000	237,000
Total Cost of Care	$371 million	$1,033 million
Administrative Costs	$40 million	$60 million
Total Costs	$411 million	$1,093 million