TRICARE For Life alternative: Employer Group Waiver Plan

Commissioned by Humana Government Business

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For members of the uniformed services, military retirees, and their eligible dependents, the TRICARE program offers a managed and coordinated healthcare benefit experience. At age 65, however, beneficiaries are disenrolled from TRICARE managed care support and may elect health benefits coverage through Traditional Medicare with a wraparound plan called TRICARE For Life. This white paper explores an alternative approach to providing retiree medical benefits for TRICARE beneficiaries based on the Employer Group Waiver Plan model.

EXECUTIVE SUMMARY

TRICARE provides healthcare benefits for approximately 9.6 million service members, military retirees, and their dependents. Once TRICARE beneficiaries enrolled in the TRICARE managed care support program turn age 65, they are disenrolled. If they sign up for Medicare Part A and Part B, they are eligible for TRICARE For Life (TFL), which provides wraparound coverage for Traditional Medicare, similar to a Medicare supplement plan. This arrangement offers important benefits including generous pharmacy benefits, overseas coverage, and very low or zero out-of-pocket costs.

At the time of its authorization in 2001, TFL represented a significant benefit enhancement for older military retirees receiving health benefits through Medicare. Surveys show that satisfaction is very high among TFL beneficiaries. However, there are certain critiques of the program that arise from time to time:

- **Abrupt transition from coordinated care to self-management.** Most TRICARE beneficiaries under age 65 are enrolled in TRICARE Prime, which operates like a health maintenance organization (HMO). The program is highly managed and offers high-touch services that help beneficiaries navigate the complex military health system. Upon turning age 65, these beneficiaries are rapidly transitioned from this managed healthcare system to an unmanaged one. Some beneficiaries are required to change physicians, and many can no longer access healthcare services at military treatment facilities (MTFs). The transition to TFL can be abrupt and disruptive, especially for those with chronic conditions or higher disease burdens.
- **Increased richness of alternatives to Traditional Medicare.** When TFL was introduced, it offered a significant benefit enhancement for older military retirees. It was considered a rich offering compared to the relatively new Medicare+Choice program. In the 20 years since TFL was introduced, the managed care option for Medicare beneficiaries—Medicare Advantage—has expanded in terms of enrollment and scope of benefits. Today Medicare Advantage (MA) plans offer a vast array of supplemental benefits not covered by Traditional Medicare. The Congressional Budget Office (CBO) projects that, by 2030, more than half of Medicare eligibles will be enrolled in an MA plan.
- **Budget pressure.** Funding for TFL benefits not otherwise covered by Traditional Medicare is provided through the U.S. Department of Defense (DoD) Medicare-Eligible Retiree Health Care Fund (MERHCF). As of 2020, the actuarial value of all future liabilities for military retirement medical benefits for Medicare-eligible beneficiaries was approximately $577.1 billion, of which approximately $313.2 billion represents unfunded liabilities and a growing budgetary item for the DoD. The CBO conservatively projects that MERHCF expenditures for TFL will grow at 5% per year, exceeding $17 billion by 2031 for a 10-year price tag of $139 billion in addition to the costs borne by the Centers for Medicare and Medicaid Services (CMS) to provide Traditional Medicare benefits for TFL beneficiaries.
- **Forgone managed care efficiencies.** Traditional Medicare with TFL is an unmanaged health benefits program. This is in comparison to TRICARE Prime and Medicare Advantage, which are both managed care programs that use administrative processes to optimize utilization, manage unit costs, and improve clinical quality. While these activities can reduce beneficiary

choice, it is well established that managed care strategies can reduce the overall costs of healthcare benefit programs compared to unmanaged programs.

Recognizing these concerns about TFL, the Senate version of the fiscal year (FY) 2018 National Defense Authorization Act (NDAA) and the House version of the FY2019 NDAA each included proposals that would have required DoD to develop a demonstration program to enable eligible TFL beneficiaries to enroll in MA plans. Although these proposals did not move forward in the final bills, the concept of a group retiree medical benefit that leverages the MA construct already exists in the civilian market, called an Employer Group Waiver Plan (EGWP). Humana Government Business engaged Milliman to explore this concept with a focus on key considerations for a TRICARE EGWP offered as an alternative to TRICARE For Life.

Under an EGWP, an employer, union, or affinity group works with an insurer to offer an MA plan tailored to the retiree group. Often these benefits are offered to the specific group of retirees at no cost while any additional benefit expense is covered by the employer or affinity group. The existing EGWP model could provide a framework for how DoD could pilot or introduce a new program for TRICARE beneficiaries over age 65 that resolves some of the noted critiques of TFL. A TRICARE EGWP could have several key features, including:

- Plan designs similar to TRICARE Prime, an HMO-like design, and to TRICARE Select, a preferred provider organization (PPO)-like design
- Benefits that align with the health burden(s) of military retirees and supplemental benefits that complement those available to TRICARE beneficiaries under TFL or other sources of coverage
- Access to a broad network of contracted healthcare providers accustomed to serving TRICARE beneficiaries
- High-touch customer service that is consistent with the TRICARE beneficiary experience under managed care support
- A transition program that facilitates the beneficiary's move from managed care support to the retiree medical program
- Care management programs that help coordinate beneficiary care and management of chronic conditions

A TRICARE EGWP would also introduce an opportunity for potential managed care efficiencies not available to CMS and DoD under Traditional Medicare with TFL. A recent Milliman study estimated that MA plans deliver the Medicare Part A and Part B benefits for 8% to 16% less than Traditional Medicare. Similarly, the 2022 Report to Congress by the Medicare Payment Advisory Commission (MedPAC) shows that MA plan bid amounts for Part A and Part B services range from 8% to 24% less than per capita spending on Traditional Medicare for the same benefits.

Although there are important nuances when using these reports to estimate managed care efficiencies for a TRICARE EGWP, as described in the body of this white paper, the reports suggest that managed care plans can deliver the Part A and Part B benefits for lower per capita cost than an unmanaged program like Traditional Medicare with TFL. While a TRICARE EGWP would be unlikely to fully capture these managed care efficiencies due to design variables like broader provider networks, geographic differences, less restrictive managed care strategies, higher administrative costs, and known population differences, it is likely that implementing a managed care element to TFL would generate meaningful savings that could be leveraged to provide increased benefits or offset rising program costs borne by DoD and CMS.

A TRICARE EGWP could offer several benefits, but there are key factors to consider in evaluating the merits of such a program.

- **Funding.** Under the current funding arrangement for TFL, CMS pays for Part A and Part B expenses and DoD funds the excess. An EGWP could operate under a similar arrangement, with CMS funding the EGWP for Medicare benefits and the employer, in this case, DoD, covering the cost of extra or supplemental benefits. It would be important to consider how MTFs are compensated for services they provide, what efficiencies may be generated through managed care activities, the potential impact on MA benchmarks, and how costs and/or savings would be split between CMS and DoD. Additional actuarial modeling is needed to understand these important considerations.
- **Operations.** A TRICARE EGWP would need to accommodate several complex operational factors. In the existing TFL and TRICARE structures, for example, there are system integrations and operational requirements not found in traditional EGWPs. A new operating model could build on the traditional EGWP structure but would need to be customized for TRICARE.

A TRICARE EGWP has the potential to offer an improved beneficiary experience, enhanced benefits, and lower costs, but comes with challenges around operational complexity, potentially more limited provider choice for beneficiaries, consideration for how to transition existing TFL beneficiaries to a new program, and risk of unintended/unexpected downstream effects. An appropriate next step to evaluate the feasibility of such an offering may be to authorize a pilot program. Such an undertaking could provide valuable insight into the possible benefits, beneficiary appeal, and challenges hypothesized in more detail in this white paper.

Overview of the TRICARE program

TRICARE is the healthcare benefits program for approximately 9.6 million uniformed and retired service members and their eligible dependents.[1] Beneficiaries can access various TRICARE plan options based on their eligibility and location. For the 6.9 million TRICARE beneficiaries under the age of 65, TRICARE offers two primary options for comprehensive health benefit coverage:

- **TRICARE Prime.** TRICARE Prime operates like a health maintenance organization (HMO). Each beneficiary is assigned a military or civilian primary care manager (PCM) who coordinates their access to healthcare services. Approximately 4.8 million beneficiaries are enrolled in TRICARE Prime.
- **TRICARE Select.** Like a preferred provider organization (PPO) plan, TRICARE Select offers access to a network of contracted providers who have agreed to certain participation provisions. Beneficiaries select their own providers and manage their own care. Approximately 2.3 million beneficiaries participate in TRICARE Select.

While there are other TRICARE plan options for beneficiaries (e.g., Uniform Services Family Health Plan, TRICARE Young Adult-Prime, Direct-Care Only, TRICARE Plus, TRICARE Retired Reserve), these plans have much lower enrollment and are typically offered with specific limitations for eligibility either by age, retired status, or geography.

TRICARE beneficiaries receive care from a combination of direct care providers (military treatment facilities or MTFs) and purchased care providers (contracted civilian providers including physicians and hospitals). The managed care support contractors (MCSC), which administer the TRICARE managed care support contracts, provide administrative services to help TRICARE beneficiaries navigate the healthcare system, including help finding healthcare providers, coordinating care, and answering beneficiary questions about the program. For the population under age 65, TRICARE's comprehensive healthcare programs offer robust beneficiary support and care management, population health, and care navigation.

Upon turning age 65, TRICARE beneficiaries are automatically disenrolled from TRICARE managed care support. If they sign up for Medicare Part A and Part B, they are automatically eligible for TRICARE For Life (TFL), which provides wraparound coverage much like a Medicare supplement plan. Under TFL, most beneficiaries have zero out-of-pocket costs as amounts not paid for by Medicare are covered by TFL. Beneficiaries in Traditional Medicare with TFL select their own providers and manage their own care. They can access customer service through CMS, including online and telephone support.

Benefits and critiques of TFL

TRICARE For Life was authorized by Congress as part of the FY2001 National Defense Authorization Act (NDAA) to ease the financial burden of out-of-pocket expenses for older military retirees receiving health coverage through Medicare.[2]

Major selling points of the program for beneficiaries are its simple enrollment, comprehensive medical benefit, and financial appeal:

- Enrollment is automatic for eligible beneficiaries who sign up for Medicare Part A and Part B.
- The program offers rich benefit coverage (combining Medicare and TRICARE benefits), including a low-cost pharmacy benefit, and covers services outside the United States and from providers who do not accept Medicare.
- Most beneficiaries with TFL have no out-of-pocket costs beyond their Medicare Part B premiums.

Notwithstanding these significant benefits, there are some critiques of TFL, which are summarized below.

TRANSITION FROM COORDINATED CARE TO SELF-MANAGEMENT

Nearly 70% of TRICARE beneficiaries under age 65 are enrolled in TRICARE Prime, which is a highly managed healthcare benefits program. Each beneficiary is assigned a primary care manager who coordinates their access to healthcare services and helps them navigate the complex military health system. Another 2.3 million beneficiaries participate in TRICARE Select, a self-managed benefit through which they can access healthcare services from contracted civilian network providers who are trained on TRICARE and can help them navigate the healthcare delivery system. In addition, TRICARE beneficiaries have access to high-touch multi-modal beneficiary support through the MCSCs and MTFs.[3]

Upon turning age 65, however, beneficiaries are automatically disenrolled from TRICARE managed care support and become eligible for Traditional Medicare. If they are eligible for TRICARE and have Medicare Part A and Part B, they are automatically eligible for TFL. For most beneficiaries, this disenrollment involves a rapid transition from a highly managed healthcare

[1] Military Health System (2021). Patients by TRICARE Plan. Retrieved August 10, 2022, from https://www.health.mil/I-Am-A/Media/Media-Center/Patient-Population-Statistics/Patients-by-TRICARE-Plan.

[2] Congress.gov (October 30, 2000). Public Law 106-398: National Defense Authorization Act Fiscal Year 2001. Retrieved August 10, 2022, from https://www.congress.gov/106/plaws/publ398/PLAW-106publ398.pdf.

[3] Military Health System, Patients by TRICARE Plan, op cit.

system to an unmanaged one with time-limited access to the high-touch service model available through the TRICARE managed care support program.

In addition to changing benefit programs, beneficiaries assigned to a military PCM are often required to change physicians and many can no longer access healthcare services at the MTFs. The transition can be jarring for beneficiaries, many of whom have been enrolled in TRICARE for decades by the time they reach this transition point. The loss of these patients also limits opportunities for MTFs to fill extra capacity and for MTF clinicians to maintain their knowledge, skills, and abilities (KSA).

INCREASED RICHNESS OF MEDICARE ALTERNATIVES

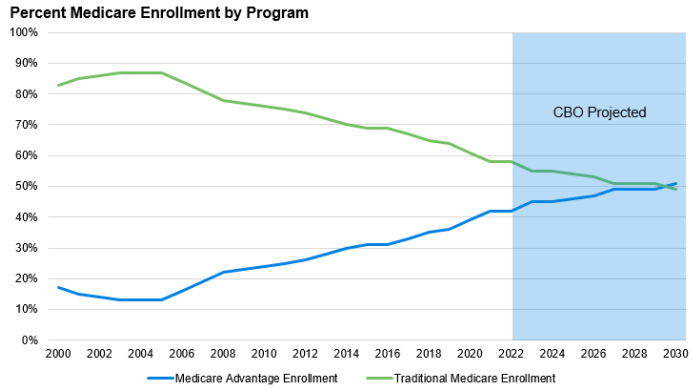
At the time TFL was introduced, Medicare Part C (Medicare Advantage or MA) was in its infancy, having been formally launched only five years earlier in 1997 (then called Medicare+Choice). TRICARE For Life offered a significant benefit expansion and cost reduction for older military retirees. It also corrected what some viewed as a "broken promise" of "free medical care for life" which had been a component of the U.S. military's recruiting strategy for decades.[4] At the time of its launch, the executive director of TRICARE Management Activity called TFL the "golden supplemental" referring to the richness of value for beneficiaries compared to other options.[5]

In the 20 years since TFL was introduced, however, the Medicare Advantage program has significantly expanded. In 2021, 42% of Medicare beneficiaries (26 million) were enrolled in Medicare Advantage, and, as illustrated in Figure 1, the Congressional Budget Office (CBO) projects more than half (51%) of Medicare beneficiaries will be enrolled in Medicare Advantage by 2030.[6]

The popularity of Medicare Advantage has been driven, at least in part, by the availability of attractive benefits for low out-of-pocket cost to the beneficiary. Nearly two-thirds of Medicare Advantage enrollees select a plan with no additional premium.

Since 2006, Medicare Advantage plans have been allowed to offer supplemental benefits not covered by Traditional Medicare. The definition of supplemental benefits an MA plan can offer to enrollees was expanded for 2019 and again for 2021.

FIGURE 1: MEDICARE ENROLLMENT BY PROGRAM (2000-2030)



Today, MA plans can offer a wide range of supplemental benefits such as dental, vision, fitness memberships, transportation, and meal delivery. Some plans also subsidize Medicare Part B premiums as a benefit, which can be a material direct financial savings for the beneficiary and a strong incentive to enroll in a Medicare Advantage plan. In 2021, the majority of MA enrollees were enrolled in plans that offer eye exams or glasses (99%), hearing exams and/or aids (97%), dental care (94%), and a fitness benefit (93%), and a growing number of plans are offering other benefits.[7] Unless they have access through another program such as the Federal Employees Dental and Vision Insurance Program (FEDVIP), or enroll in an MA plan, TFL beneficiaries do not have access to these additional benefits.

FORGONE MANAGED CARE EFFICIENCIES

Traditional Medicare is an unmanaged healthcare program. To be covered under the program, the services must be delivered by an authorized provider who has agreed to accept reimbursement from CMS. The program manages unit costs through reimbursement policies that set the amount providers will be paid for the services.

This is in comparison to TRICARE Prime and Medicare Advantage, which are both managed care programs that use key administrative processes to optimize utilization, manage unit costs, and improve clinical quality. Examples of common managed care strategies are shown in Figure 2.

[4] Philpott, T. (April 1, 2001). Here Comes Tricare For Life. Air Force Magazine. Retrieved August 10, 2022, from https://www.airforcemag.com/article/0401tricare/.

[5] Philpott, T. (December 1, 2000). Tricare for Life. Air Force Magazine. Retrieved August 10, 2022, from https://www.airforcemag.com/article/1200tricare/#:~:text=Tricare%20for%20Life%20was%20approved%20as%20part%20of,a%20fundamental%20and%20irreversible%20change%20has%20taken%20place.

[6] Kaiser Family Foundation (June 21, 2021). Medicare Advantage in 2021: Enrollment Update and Key Trends, Figure 1. Retrieved August 10, 2022, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/#Figure1.

[7] Kaiser Family Foundation (June 21, 2021). Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits, and Supplemental Benefits. Retrieved August 10, 2022, from https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-premiums-cost-sharing-out-of-pocket-limits-and-supplemental-benefits/.

FIGURE 2: COMMON MANAGED CARE STRATEGIES

Provider Networks

- Contracting with providers with a demonstrated record of delivering high-quality and cost-effective care.
- Leveraging value-based contracting to reward providers for delivering high-quality and cost-effective care, and giving providers financial incentives to achieve particular objectives.

Utilization Management

- Limiting benefit coverage for certain clinical services to cases with documented medical necessity.
- Validating proposed treatments against evidence-based guidelines prior to authorizing benefit coverage.
- Concurrent review to ensure continued hospitalization is appropriate.
- Retrospective review to ensure services delivered are documented in clinical records and were appropriate.

Case Management

- Coordinating and managing complex cases involving multiple providers.
- Coordinating cases involving transitions between different levels of care (e.g., inpatient to skilled nursing to rehabilitation to discharge).

Population Health

- Applying risk scoring and predictive modeling techniques to proactively identify beneficiaries likely to experience an acute or potentially avoidable event.
- Applying risk stratification methods to segment beneficiaries and then deploying segment-specific interventions to prevent adverse events.
- Deploying population health programs targeting diseases or chronic conditions with a goal of forestalling disease progression and helping beneficiaries self-manage their condition.
- Member engagement programs such as care coordination, health coaching, and concierge-like navigation support.

Plan Design Incentives

- Utilizing member cost-sharing differentials to encourage the use of lower-cost sites of care.
- Implementing value-based insurance design concepts to encourage appropriate care and discourage waste.

Each of these managed care activities is intended to have the effect of improving the patient experience, improving clinical quality, and/or ensuring appropriate use of clinical resources. It is well established that managed care strategies can reduce the overall costs of healthcare benefit programs compared to unmanaged programs.[8] As an unmanaged healthcare program, Traditional Medicare, with or without TFL, forgoes these managed care efficiencies.

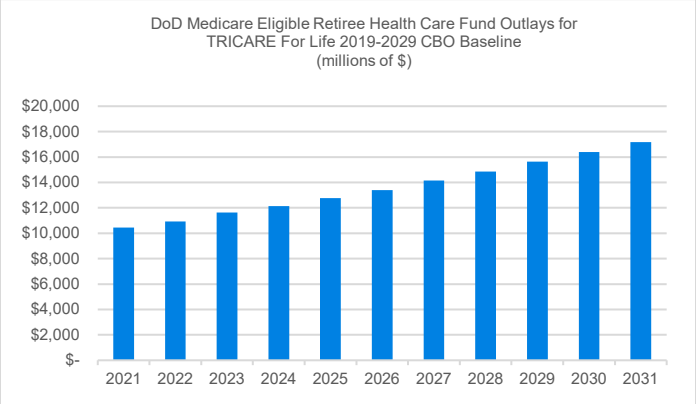
BUDGET PRESSURE

When TFL was authorized by the FY2001 NDAA, the new program reclassified the benefit expenses for TFL beneficiaries as entitlements, making their funding mandatory rather than discretionary, and established the Department of Defense Medicare-Eligible Retiree Health Care Fund (MERHCF) to fund the cost of the benefits.

The outlays for these benefits are shared between CMS, which funds the Traditional Medicare portion, and the Department of Defense (DoD), which funds the TFL portion through the MERHCF. The MERHCF also provides for the Uniform Services Family Health Plan (USFHP) expenditures. Similar to TRICARE Prime, USFHP is a managed care option that is available to TRICARE beneficiaries through integrated delivery systems in six regional locations. Covering 112,000 beneficiaries, USFHP has much smaller enrollment than other TRICARE programs.[9]

In 2020, the MERHCF's annual expenditures for TFL were approximately $10.0 billion. As shown in Figure 3, the Congressional Budget Office conservatively projects the MERHCF contribution to TFL will grow by approximately 5% per year, exceeding $17 billion by 2031.[10]

FIGURE 3: PROJECTED MERHC FUND OUTLAYS FOR TFL (2021-2031)



As of 2020, the actuarial value of all future MEHRCF liabilities for military retirement medical benefits for Medicare-eligible beneficiaries was approximately $577.1 billion, of which approximately $313.2 billion is not covered by current budgetary resources.[11] These amounts do not include the outlays by CMS

[8] Langwell, K. & Staines, V.S. The impact of managed care on costs and health spending. Managed Care Quarterly. 1993 Autumn;1(4):41-5.

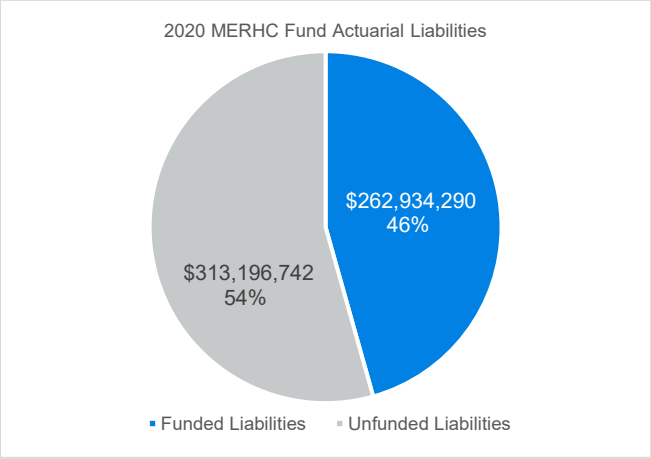
[9] Military Health System, Patients by TRICARE Plan, op cit.

[10] Congressional Budget Office (July 2021). Department of Defense Medicare-Eligible Retiree Health Care Fund. Retrieved August 10, 2022, from https://www.cbo.gov/system/files/2021-07/54946-2021-07-dodmedicare.pdf.

[11] U.S. Department of Defense (November 9, 2020). Fiscal Year 2020: Medicare-Eligible Retiree Health Care Fund Audited Financial Report. Retrieved August 10, 2022, from https://comptroller.defense.gov/Portals/45/Documents/afr/fy2020/DoD_Components/2020_AFR_MERHCF.pdf.

for the TFL beneficiaries' Traditional Medicare benefits. This shortfall of over 54% is illustrated in Figure 4.

FIGURE 4: MERHC FUND ACTUARIAL LIABILITIES (2020)



As mandatory outlays, the growing costs of unmanaged TFL care continue to put pressure on the U.S. defense budget, potentially crowding out other important investments. Implementation of a managed care program for TFL could help relieve this budget pressure.

TRICARE For Life alternatives

Although TFL is very popular among TRICARE beneficiaries, Congress has considered alternatives that could resolve some of the challenges of the current program.[12]

The Senate version of the FY2018 NDAA and the House version of the FY2019 NDAA each described proposals that would have required DoD to develop a demonstration program to enable eligible TFL beneficiaries to enroll in Medicare Advantage plans. The demonstration program was proposed to modernize and improve the benefits available to military retirees.[13,14]

Although these proposals did not end up in the respective final versions of the NDAA, the concept of a group medical benefit for retirees that leverages MA already exists in the civilian market as what is called an Employer Group Waiver Plan (EGWP).[15]

Like DoD, large employers, some state and local governments, and unions often use the promise of enhanced post-retirement healthcare benefits as an employee recruiting and retention tool. Approximately 19% or 4.9 million Medicare beneficiaries are enrolled in a retiree medical program offered by their employer or a union. Although this percentage has remained stable since 2014, the number of enrolled beneficiaries has more than doubled during that time.[16]

The EGWP is one approach these employers can use to offer this coverage while leveraging funding and infrastructure for retiree medical coverage from CMS. An employer offers this program by contracting with an insurer that offers EGWPs. More than half of large firms (those with 5,000+ workers) offering retiree health benefits to Medicare-age retirees contract with a Medicare Advantage plan to offer these benefits for at least some of their retirees.[17] Benefits covered by Traditional Medicare are typically funded by CMS, and the employer funds reduced member cost sharing as well as any additional or supplemental benefits the plan provides. CMS has endorsed such arrangements, including the use of passive PPO agreements that allow MA plans to offer products outside of their typical service areas as long as network adequacy requirements can be met.[18]

Employer Group Waiver Plan benefits are usually tailored to the specific needs and characteristics of the population. For example, a large employer or labor union may choose to offer a plan at little or no cost to retired employees that covers benefits they previously had while under full employment but that would not be available under Traditional Medicare. These additional benefits commonly include dental coverage, wellness services, foot care, eye exams, and others.

The existing EGWP model could provide a framework for how DoD could pilot or introduce a new program for TRICARE

[12] Military Officers Association of America (March 1, 2019). As TRICARE Costs Rise, Beneficiary Satisfaction Falls. Retrieved August 10, 2022, from https://www.moaa.org/Content/Publications-and-Media/News-Articles/2019-News-Articles/Advocacy/MOAA-Survey--Beneficiary-Satisfaction-with-TRICARE-Costs-Keeps-Falling.

[13] Congress.gov (November 9, 2017). H.R. 2810 – 115th Congress (2017-2019): National Defense Authorization Act for Fiscal Year 2018: Conference Report. Retrieved August 10, 2022, from https://www.congress.gov/115/crpt/hrpt404/CRPT-115hrpt404.pdf.

[14] Congress.gov (July 25, 2018). H.R. 5515 – 115th Congress (2017-2019): John S. McCain National Defense Authorization Act for Fiscal Year 2019: Conference Report. Retrieved August 10, 2022, from https://www.govinfo.gov/content/pkg/CRPT-115hrpt874/pdf/CRPT-115hrpt874.pdf.

[15] CMS.gov (December 1, 2021). Employer Group Waiver Plans. Retrieved August 10, 2022, from https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/PartD-EGWP.

[16] Kaiser Family Foundation, Medicare Advantage in 2021: Enrollment Update and Key Trends, op cit.

[17] Kaiser Family Foundation (October 8, 2020). 2020 Employer Health Benefits Survey. Retrieved August 10, 2022, from https://www.kff.org/report-section/ehbs-2020-section-11-retiree-health-benefits/.

[18] CMS.gov (May 5, 2013). Medicare Managed Care Manual: Chapter 9, Section 40.3: Employer/Union Sponsored Group Health Plans. Retrieved August 10, 2022, from https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c09.pdf.

beneficiaries over the age of 65 that resolves some of the noted critiques of TFL.

Humana Government Business engaged Milliman to explore this concept with a focus on key considerations for a TRICARE EGWP offered as an alternative to TRICARE For Life.

Considerations for a TRICARE EGWP

Employer Group Waiver Plans often replicate the pre-retirement health benefits offered by the employer and may offer reduced member out-of-pocket costs, but in terms of plan designs, network composition, managed care strategies, service model, and administrative infrastructure, EGWPs resemble other Medicare Advantage plans. To be viable as an alternative for TFL, a TRICARE EGWP may need other and more extensive customizations than a typical EGWP, including:

- **Benefits and supplemental benefits** that align with the health burden(s) of military retirees and complement those available to TRICARE beneficiaries, including a rich prescription drug benefit.
- **A broad network of contracted providers** who are trained and accustomed to serving the TRICARE population.
- **High-touch customer service** that is consistent with TRICARE beneficiary experiences under managed care support.
- **A transition program** that facilitates the beneficiary's move from TRICARE managed care support to the retiree medical program.

Getting these customizations right, plus ensuring no change in plan benefits and beneficiary out-of-pocket costs, are key considerations for any programmatic change intended to replace or be an alternative to the existing TFL program. Program design is further complicated by the complex operational systems that underlie TFL and the division of responsibilities and funding between CMS and DoD.

PLAN DESIGN STRUCTURES

TRICARE Prime and TRICARE Select are the two key benefit structures available to TRICARE beneficiaries under the age of 65. These two plan designs—a health maintenance organization (HMO) and a preferred provider organization (PPO)—are ubiquitous among Medicare Advantage plans. Nearly two-thirds of all MA beneficiaries are enrolled in HMO plans and most of the remainder are enrolled in PPO plans.[19] Among group retiree plans, the opposite is true, with approximately 34% of beneficiaries enrolled in HMO plans and 66% enrolled in PPO plans.[20] Similar plans could be offered under a TRICARE EGWP.

PLAN BENEFITS

TRICARE For Life provides a rich set of plan benefits that combines Traditional Medicare and TRICARE covered benefits. While Medicare Advantage plans are required to offer benefits at least equal to Traditional Medicare, there are some benefits covered by TRICARE but not by Medicare Advantage plans such as coverage for services received while traveling outside of the United States.

In addition, TFL enrollees have access to high-value pharmacy benefits under the TRICARE Pharmacy program (TPHARM). This program offers an extensive formulary, low copayments/coinsurance, access to a large network of retail pharmacies, a convenient mail order option, and concierge-level customer service. TRICARE Pharmacy program coverage also meets the standard for creditable coverage, which allows beneficiaries to forgo enrollment in Medicare Part D without incurring a late enrollment penalty.

The option to offer enhanced benefits to enrollees beyond Traditional Medicare is a key component of the EGWP model and thus designing a plan that meets the benefits available to TFL enrollees should be feasible.

SUPPLEMENTAL BENEFITS

Most Medicare Advantage plans offer supplemental benefits that exceed those offered under Traditional Medicare. The list of such benefits is extensive and includes:

- **Hearing exams and hearing aids:** Most MA plans offer supplemental coverage for hearing exams and hearing aids. TFL does not currently cover hearing exams or hearing aids.[21]
- **Vision exams and glasses:** Most MA plans offer vision exams and coverage for glasses. While some vision benefits are provided under TRICARE Prime and TRICARE Select, under TFL coverage for routine eye exams is limited. TFL enrollees are eligible to enroll in the vision programs of FEDVIP for an additional fee.[22]

[19] Kaiser Family Foundation (June 6, 2019). Medicare Advantage. Retrieved August 10, 2022, from https://www.kff.org/medicare/fact-sheet/medicare-advantage/.

[20] Better Medicare Alliance (March 15, 2016). Medicare Advantage Retiree Coverage: Understanding "EGWPs." Retrieved August 10, 2022, from https://www.bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_EGWP_Issue_Brief_Mar2016_sm.pdf.

[21] TRICARE (October 27, 2020). Protect Your Hearing with TRICARE. Retrieved August 10, 2022, from https://www.tricare.mil/CoveredServices/BenefitUpdates/Archives/10_27_2020_Protect_Your_Hearing_with_TRICARE.

[22] TRICARE (March 8, 2022). Vision. Retrieved August 10, 2022, from https://www.tricare.mil/CoveredServices/Vision.

- **Dental:** Most MA plans offer routine and preventive dental coverage. TFL enrollees are eligible to enroll in the dental programs of FEDVIP for an additional fee.[23]
- **Wellness:** Most MA plans cover popular wellness programs and products such as gym memberships, online classes, weight management programs, and nutritional guidance. These programs are generally not covered under TFL.
- **Transportation:** Some MA plans cover medical transportation for doctor's visits, physical therapy, etc. TFL does not cover transportation services except in the case of emergencies.
- **Over-the-counter medications:** Some MA plans cover over-the-counter medications. While TFL does cover pharmaceuticals, it does not provide a benefit for common over-the-counter medications.

Other supplemental benefits such as home meal delivery, therapeutic massage, and home modifications are growing in prevalence. None of these services are available to TFL beneficiaries through their Medicare or TRICARE benefits.

Access to supplemental benefits is believed to be one of the key drivers of Medicare Advantage plan popularity. A TRICARE EGWP could offer customized supplemental benefits that appeal to the TRICARE beneficiary population and that are not duplicative of benefits otherwise available to these beneficiaries for low or no cost such as dental and vision coverage through FEDVIP.

BENEFICIARY OUT-OF-POCKET COSTS

Most TFL enrollees pay little or no cost beyond their Medicare Part B premiums because TFL pays any remaining out-of-pocket amounts after Medicare benefits are applied. Beneficiaries enrolled in Medicare Advantage plans are typically subject to out-of-pocket costs including premiums, cost sharing, and deductibles. Although 65% of Medicare Advantage enrollees were in plans with no premium, the average premium in 2021 was $21 per month.[24]

In addition to premiums, Medicare Advantage enrollees are subject to deductibles and cost sharing. Although maximum out-of-pocket amounts have been capped since 2011, beneficiaries can have significant out-of-pocket cost exposure depending on which plan they choose. The weighted average out-of-pocket limit in 2021 exceeded $5,000 for in-network services and $9,000 for in-network and out-of-network services combined. These amounts are substantially greater than the very limited, if any, amounts paid by TFL beneficiaries.[25]

However, as with benefit design, the option to subsidize beneficiary out-of-pocket costs is one of the key features and differentiators of the EGWP model. A TRICARE EGWP could offer enrollees financial value comparable to what they receive under TFL through out-of-pocket cost subsidies.

PROVIDER NETWORKS

Medicare Advantage plans establish contracted provider networks. The plans are required to meet network access and adequacy standards for medical specialties, hospitals, and other types of providers. One of the biggest differences between Traditional Medicare and MA is reduced provider choice for beneficiaries, especially among HMO plans, where provider networks are narrower and tightly managed by design. On average, Medicare Advantage plans contract with about half of the hospitals and about 46% of the physicians in a given county. Just over one-third of MA beneficiaries were enrolled in a plan with a narrow physician network (defined as a county where less than 30% of all physicians were in-network with the plan).[26] While provider networks tend to be broader for PPO plans, which are more common than HMOs among group retiree programs, provider network access will be an important consideration in design of a TRICARE EGWP.

TRICARE For Life beneficiaries currently have access to any provider that accepts Medicare, which represents the vast majority of all providers nationwide. They also have access to providers who do not accept Medicare reimbursement and services provided outside the United States. A TRICARE EGWP will need to balance beneficiary choice against unit cost and utilization management mechanisms that come with provider networks. Historically, TRICARE beneficiaries, even those enrolled in TRICARE Prime, have had access to broad networks with few constraints on provider choice. A TRICARE EGWP may need to offer greater access than a traditional EGWP to minimize beneficiary disruption and meet beneficiary expectations for access. CMS policy supports passive PPO arrangements, which enable a broader network outside of the typical service area. This

[23] TRICARE (March 30, 2020). Dental Care. Retrieved August 10, 2022, from https://www.tricare.mil/CoveredServices/Dental.

[24] Kaiser Family Foundation, Medicare Advantage in 2021: Premiums, Cost Sharing, Out-of-Pocket Limits and Supplemental Benefits, op cit.

[25] Ibid.

[26] Kaiser Family Foundation (October 5, 2017). Medicare Advantage: How Robust Are Plans' Physician Networks? Retrieved August 10, 2022, from https://www.kff.org/medicare/report/medicare-advantage-how-robust-are-plans-physician-networks/. [27] CMS.gov, Medicare Managed Care Manual Chapter 9, Section 40.3: Employer/Union Sponsored Group Health Plans, op cit.

flexibility may limit some disruption or constraint for current TFL beneficiaries.[27]

CUSTOMER SERVICE

TRICARE beneficiaries are accustomed to a high-touch customer service model through the MCSCs that offers multiple modalities including online, self-service, and highly responsive telephone support. Beneficiaries also often access customer support in the MTFs. Similarly, Medicare Advantage beneficiaries expect and receive high-touch customer service, sometimes including walk-in service. Some employers sponsoring EGWP plans offer high-touch, dedicated customer service infrastructure including online, telephonic, and walk-in service center capabilities. A TRICARE EGWP would be expected to deliver customer service options and service levels at least on par with what is available to TRICARE managed care support beneficiaries.

MANAGED CARE EFFICIENCIES

Use of managed care strategies such as those shown in Figure 2 above to support improved quality outcomes and manage use of resources is another major difference between Traditional Medicare and Medicare Advantage. Conventional wisdom suggests that managed care plans can deliver the same health benefits more efficiently than unmanaged programs. Consistent with this hypothesis, there is strong evidence that MA plans, which proactively manage utilization and use other cost management levers, can offer Medicare Part A and Part B benefits for a lower per capita cost than Traditional Medicare. For example, the 2022 Report to Congress from MedPAC shows that Medicare Advantage plan bid amounts for Part A and Part B services range from 8% to 24% lower than per capita spending on these services through Traditional Medicare. In other words, MA plans bid to provide Part A and Part B services for less than those benefits cost under Traditional Medicare.[28] Although there is variability between bid amounts and actual costs, this plan behavior is supportive of the hypothesis.

A recent Milliman study compared the per capita healthcare costs to the federal government under Medicare Part A and Part B versus the costs for those benefits under Medicare Advantage. The results of this study are summarized in Figure 5.[29]

FIGURE 5: COMPARISON OF PER CAPITA COSTS UNDER MEDICARE PART A AND PART B VS. MEDICARE ADVANTAGE

	TRADITIONAL MEDICARE (PART A AND PART B)	MEDICARE ADVANTAGE
Benefit Cost	$936 to $949	$710 to $796
Administrative Cost	$14	$86
Total	$950 to $963	$796 to $882

The cost of Part A and Part B benefits under Traditional Medicare ranges from $936 to $949 per member per month (PMPM) plus administrative costs of $14 PMPM for a total of $950 to $963 PMPM. For the same period, and also for a typical Medicare beneficiary, the report estimates the cost of Part A and Part B benefits under MA is $710 to $796 PMPM plus administrative costs of $86 PMPM for a total of $796 to $882 PMPM. The conclusion from the study is that Medicare Advantage plans deliver Part A and Part B benefits for 8% to 16% less than the same benefits under Traditional Medicare. Again, there are important nuances to consider when relying on this study for projections, but it also supports the hypothesis that managed Medicare generates efficiencies not available in an unmanaged program like Traditional Medicare with TFL.

This estimated impact from an average individual MA plan on the per capita cost of covering Part A and Part B services may be useful when considering the potential financial impact of a TRICARE EGWP compared to Traditional Medicare with TFL. Assuming the enrollment of all eligible retirees, if similar experience was realized in a TRICARE EGWP, it could result in a range of outcomes from an increased program cost of $672 million to a program cost reduction of $1.6 billion depending on the cost of supplemental benefits and the level of managed care efficiencies achieved. See Figure 6 for the assumptions underlying these financial impact scenarios.

[27] CMS.gov, Medicare Managed Care Manual Chapter 9, Section 40.3: Employer/Union Sponsored Group Health Plans, op cit.

[28] MedPAC (March 2022). Report to the Congress: Medicare Payment Policy. Retrieved August 10, 2022, from https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_SEC.pdf.

[29] Gervenak, C. & Mike, D. (October 2021). Value to the Federal Government of Medicare Advantage. Milliman Report. Retrieved August 10, 2022, from https://www.milliman.com/en/insight/Value-to-the-federal-government-of-medicare-advantage.

FIGURE 6: FINANCIAL IMPACT SCENARIO ASSUMPTIONS

High Supplemental Benefit Costs/ Lower Managed Care Efficiencies	This scenario generates a **$672M increase** in program cost to DoD. Assumptions • TRICARE EGWP achieves 5.3% savings on baseline Medicare FFS spend of $950 PMPM ($51 PMPM) • TRICARE EGWP spends $50 PMPM on supplemental benefits • CMS accrues ≈3% savings Calculation: ($51 - $50 - $29) X 12 X 2M
Low Supplemental Benefit Costs/ Higher Managed Care Efficiencies	This scenario generates **a $1.6B decrease** in program cost to DoD. Assumptions • TRICARE EGWP achieves 10.7% savings on baseline Medicare FFS spend of $950 PMPM ($102 PMPM) • TRICARE EGWP spends $25 PMPM on supplemental benefits • CMS accrues ≈1% savings Calculation: ($102 - $25 - $10) X 12 X 2M

Additional actuarial modeling is necessary to estimate an appropriate range of managed care efficiencies a TRICARE EGWP might generate compared to Traditional Medicare with TFL. Although there are many similarities between a comparison of Medicare Advantage versus Traditional Medicare and a TRICARE EGWP versus Traditional Medicare with TFL, there are important differences that must be considered when evaluating the potential financial impact of the TRICARE EGWP, which are described below.

Individual versus group MA plans

The estimates from the aforementioned Milliman study reflect the impact of an average individual MA plan on costs. These plans, whose financial viability is dependent upon managing costs, may be more aggressive than a TRICARE EGWP would be in managing care. Although TRICARE Prime is a managed care product, it does not operate in the same highly competitive environment as Medicare Advantage plans targeting individual beneficiaries for enrollment and thus we expect there are material differences in the level of clinical management implemented under these different programs.

Population differences

TRICARE For Life beneficiaries may have a different baseline level of cost and utilization pattern than a typical Medicare beneficiary. This difference may mean that the savings opportunity for a TRICARE EGWP may vary—potentially materially—from the estimated savings from an average individual MA plan.

Beneficiary cost sharing

Individual MA plans utilize cost sharing to encourage efficient use of healthcare resources among members as well as to encourage the use of lower-cost sites of care. Because a TRICARE EGWP is not expected to have significant beneficiary cost sharing, this cost management strategy may be unavailable.

Geographic variation

Individual MA plans annually submit bids to the federal government with their projected cost—including administration costs—of covering Part A and Part B services for a typical Medicare beneficiary. There is wide geographic variation of Medicare Advantage program costs and savings versus Traditional Medicare. The previously mentioned MedPAC report to Congress shows that the bid-to-actual rate for Part A and Part B benefits varies from 8% in regions with the lowest level of per capita Traditional Medicare spending to 24% in regions with the highest level of per capita Traditional Medicare spending.[30] We would expect to see similar wide variation in TRICARE EGWP efficiencies by region due to the same factors as well as unique local differences like MTF utilization.

Notwithstanding these caveats and differences, there is much evidence that a managed care program modeled after Medicare Advantage delivers the same benefits of Part A and Part B for lower cost than Traditional Medicare. While a TRICARE EGWP is not likely to fully capture these efficiencies due to program design differences like broader provider networks to maintain beneficiary choice, differing costs of care by geography, or less restrictive managed care strategies, in addition to the known programmatic differences described above, this comparison suggests it is realistic to expect some level of financial efficiencies.

Funding and other considerations

A TRICARE EGWP could be funded in several different ways. The simplest approach may be for CMS to make payments to a TRICARE EGWP as it would to any other MA plan. DoD could then provide payment for any EGWP-style benefits offered to beneficiaries that are over and above the typical MA benefit (much like an employer funds these differences for an EGWP). Regardless of the funding mechanism implemented, there will be several important considerations.

OFFSETTING EXPENSES

Despite the potential for savings from managed care noted above, there will be offsetting costs that may erode the level of achievable savings. Those considerations include the cost of providing pharmaceutical services that are at least equivalent to those currently available to TFL beneficiaries, the cost of

[30] MedPAC (March 2022), op cit.

providing any supplemental benefits, and the increased cost of administration that typically accompanies MA plan operations (and may be higher due to additional complexities of operating as part of the Military Health System). The scale of these additional expenses is not known but could be significant.

ACCRUAL OF BENEFITS TO STAKEHOLDERS

Any savings from implementation of a TRICARE EGWP would be realized primarily by DoD, or the EGWP itself. CMS ties capitation rates for EGWPs to the average cost of a beneficiary under Traditional Medicare and thus it is not likely that there would be a significant cost savings to CMS under this model unless a special financial arrangement between CMS and DoD was developed for this program. The accrual of benefits among stakeholders is an important consideration when implementing programs that change the status quo.

IMPACT ON MEDICARE ADVANTAGE BENCHMARK RATES

Medicare Advantage benchmarks are set at a county level and generally reflect Traditional Medicare spending. Moving the TFL population into a TRICARE EGWP would remove the costs associated with these beneficiaries from the Traditional Medicare risk pool and thus could affect MA benchmarks. The impact would vary by county depending on the prevalence of TFL and the variation in cost under Medicare fee-for-service (FFS) between TFL/non-TFL beneficiaries. Changes in MA benchmarks affect CMS' costs under the MA program, and thus should be considered when evaluating the feasibility and total fiscal impact of a TRICARE EGWP.

COMPENSATING THE MTFS FOR SERVICES

How MTF services will be valued and compensated will be important if TRICARE EGWP beneficiaries receive care from MTFs. Services provided by MTFs do not currently generate a bill or claim, although the encounter data is collected. CMS and the future TRICARE EGWP will need to determine how to value these services to prevent CMS from providing capitated compensation for services for which the TRICARE EGWP may not be billed. A final benefit design would be key to developing an estimate for any assumption of savings by CMS and DoD.

Operational considerations

Some unique operational considerations for a TRICARE EGWP are discussed below.

TECHNOLOGY AND ADMINISTRATIVE INTEGRATIONS

In the current TFL structure, there are complex interactions among the MCSCs, the Defense Enrollment Eligibility Reporting System (DEERS), MHS Genesis (the electronic medical record system for the Military Health System), and many other systems that support program management and delivery of care to beneficiaries. A TRICARE EGWP may need to interact with contractors and systems in ways that are new and unexplored by existing EGWPs. These additional requirements will likely increase the administrative costs of the TRICARE EGWP compared to other EGWPs and will complicate the program design work and performance risk.

MTF READINESS

Currently, under TRICARE Prime and Select, MTFs work with MCSCs to engage with the right of first refusal (ROFR) process to maintain appropriate KSAs and mobilization readiness and fill excess MTF capacity. Under TFL, this process is no longer observed because these beneficiaries are disenrolled from TRICARE managed care support.

While there is access to MTFs for TFL beneficiaries, that access is not facilitated or prioritized by the MCSCs and thus the ability of MTFs to manage their operational readiness through providing care to TFL beneficiaries is degraded. Under an EGWP model that replicates the existing TRICARE plan designs, there is potential for the ROFR process to be maintained to the benefit of MTFs and TRICARE beneficiaries who may prefer to receive care at the MTFs. As noted above, these direct care services must be appropriately valued and accounted for to avoid cost duplication and ensure appropriate distribution of financial benefits among stakeholders.

TRANSITION APPROACH

For a new program of this magnitude and complexity, a pilot program is likely the preferred approach to design and testing. There are many operational variables and policy decisions that will need to be made before a program like what is described in this white paper could be implemented nationally. Different pilot program models will yield different results. For example, a pilot could be offered on a regional basis (or in multiple regions such as those with high and low MTF penetration). A pilot could be offered to existing TFL beneficiaries or to beneficiaries as they age into TFL. A pilot could be limited to MCSCs that offer EGWPs to manage the performance risk around systems and agency integrations or opened to any organization offering EGWPs today (or new entrants). Pilot design will be key to ensuring the myriad operational considerations described in this white paper, as well as the many unknowns and potential unintended consequences can be fully explored as inputs to the design of a national program that might be offered alongside TFL or as a replacement to TFL.

Conclusion

For more than 20 years, TFL has supported the promise of "free medical care for life" that once underpinned the U.S. military's recruiting strategy. TRICARE For Life offers simple enrollment, rich benefits, and low costs for TRICARE retirees, and they report high levels of satisfaction with the program. At the same

time, the plethora of retiree medical options available to civilian retirees under MA has grown significantly and the growth of this unmanaged healthcare program continues to put stress on the DoD budget. Alternatives to TFL could do more to manage and coordinate the healthcare experience, expand supplemental benefits for military retirees consistent with options available to civilian retirees, and expand MTF opportunities to maintain KSAs and mission-readiness. There is also evidence that such a program may be able reduce the government's overall program cost, with cost efficiencies that could be redeployed in the form of additional benefits or cost offsets.

A new or pilot program based on the existing EGWP model for offering retiree medical benefits through a partnership between the employer (in this case DoD) and CMS could alleviate some of these challenges. Notwithstanding the potential stakeholder benefits, designing such a program would be a complex undertaking and require a rethinking of a well-established program with generally satisfied beneficiaries. A pilot program, such as was considered in the FY2018 and FY2019 NDAAs, may be an appropriate next step that could be implemented under the next generation of TRICARE contracts scheduled to begin in 2024. Such an approach could help to determine whether the concept can decrease cost, increase beneficiary satisfaction, and offer a viable path to modernizing the health benefit offerings for Medicare-eligible military retirees.

Caveats and Limitations

This white paper summarizes considerations related to the theoretical establishment of an alternative or supplement to the TRICARE For Life program based on the Employer Group Waiver Plan concept. This information may not be appropriate and may not be used for other purposes. Milliman does not intend to benefit, and assumes no duty to or liability to, third parties that receive this work product. Any third-party recipient of this work product should not rely upon Milliman's work product but should engage qualified professionals for advice appropriate to its own specific needs. Any releases of this report to a third party should be in its entirety. Milliman does not endorse any public policy or advocacy position on matters discussed in this report.

The results presented herein are estimates based on actuarial judgment, experience, and research. This report provides objective examination and consideration of theoretical program design and results and is not advocating for any viewpoint.

In developing this paper, we relied on several publicly available resources for background, estimates, and other benefit design details. We have not audited or verified any data or information used, but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the findings in this paper may likewise by inaccurate or incomplete.

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