



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000

APR -7 2022

The Honorable Jack Reed
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

The Department's response to House Report 116-453, page 341, accompanying H.R. 7617, the Department of Defense Appropriations Bill, 2021, is enclosed. House Report 116-453 requests a report to address the feasibility of TRICARE Prime being made available to eligible Department of Defense (DoD) beneficiaries across all States and Territories.

The DoD finds the vast majority of beneficiaries already have access to a network of TRICARE providers in their area offering fixed cost-shares. The expansion of the TRICARE Prime benefit to all locations across all States and Territories is technically achievable, but is inadvisable as the extension would ultimately result in increased costs and fail to achieve the goals of the TRICARE Prime model as a Health Maintenance Organization-style plan. Moreover, it would significantly alter the primary mission and goals of TRICARE Prime as a readiness-supporting program.

Thank you for your continued strong support for the health and well-being of our Service members, civilian workforce, and families. I am sending similar letters to the other congressional defense committees.

Sincerely,

A handwritten signature in black ink, appearing to read "Gilbert R. Cisneros, Jr.", written in a cursive style.

Gilbert R. Cisneros, Jr.

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member



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APR -7 2022

The Honorable Adam Smith
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

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cc:
The Honorable Mike D. Rogers
Ranking Member



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APR -7 2022

The Honorable Jon Tester
Chairman
Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

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cc:
The Honorable Richard C. Shelby
Vice Chairman



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UNDER SECRETARY OF DEFENSE
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WASHINGTON, D.C. 20301-4000

APR - 7 2022

The Honorable Betty McCollum
Chair
Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chair:

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Enclosure:
As stated

cc:
The Honorable Ken Calvert
Ranking Member

Report to the Congressional Defense Committees



House Report 116-453, page 341, accompanying H.R. 7617, the Department of Defense Appropriations Bill, 2021

TRICARE Prime Availability

The estimated cost of this report or study for the Department of Defense is approximately \$7,790 in Fiscal Years 2020 - 2021. This includes \$0 in expenses and \$7,790 in DoD labor.

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I. Summary

This report is in response to House Report 116-453, page 341, accompanying H.R. 7617, the Department of Defense (DoD) Appropriations Bill, 2021, requesting the Assistant Secretary of Defense for Health Affairs (ASD(HA)) to report to the congressional defense committees on the feasibility of making TRICARE Prime available across all States and U.S. territories. The Department evaluated “feasibility” in three primary avenues as outlined below.

Feasibility general considerations:

-Feasibility as cost: includes considerations of expanding networks, the TRICARE Prime travel benefit, and related items.

-Feasibility concerning available healthcare resources: includes consideration of availability of adequate network support in rural and underserved areas.

-Feasibility concerning the statutory, regulatory and policy structure of the TRICARE programs: includes consideration of the readiness mission of TRICARE Prime, the variance between the Primary Care Manager (PCM)-centric model of TRICARE Prime versus the Preferred Provider Network model of TRICARE Select.

The Department concludes that the requested evaluation of the feasibility of expanding the TRICARE Prime benefit to all locations in all States and U.S. territories calls for speculation, and therefore the Department is limited in what may be addressed. Assuming all requisite authorities were enacted, the Department can reasonably conclude that expanding the networks to support implementation of TRICARE Prime beyond currently authorized locations and purposes would involve significant cost increases, fail to achieve the goals of the TRICARE Prime model in rural and remote medically underserved communities, and significantly alter the primary mission and goals of TRICARE Prime as a readiness-supporting program.

II. Introduction

The report language from House Report 116-453, calls upon:

<p>The ASD(HA) to review the feasibility of TRICARE Prime being made available to eligible DoD beneficiaries across all states and territories and to submit a report to the congressional defense committees not later than 90 days after the enactment of this Act.</p>

Section III addresses the primary TRICARE programs and reviews applicable history and details regarding the programs for analytical context.

Section IV addresses cost considerations to the Department and beneficiaries.

Section V addresses the availability of adequate medical resources in remote and medically underserved locations and how that impacts the ability to deliver the full TRICARE Prime benefit in those locations.

Section VI explores the respective designs of the TRICARE Prime and TRICARE Select programs, with a focus on the readiness aspects of TRICARE Prime as laid out in statute and policy and includes historical perspective on the evolution of the TRICARE benefit and where it is and has been offered.

Section VII addresses the overall conclusions of the Department as to the feasibility of expanding TRICARE Prime across all geographic locations in the 50 United States and District of Columbia, Puerto Rico, and U.S. territories.

III. TRICARE Programs and Applicable History

A. General Program Overview

By law, TRICARE operates three primary entitlement programs. These are TRICARE Prime, TRICARE Select, and TRICARE for Life (TFL). Additional programs operated by TRICARE provide access, based on a beneficiary's eligibility and enrollment, to the full benefit provided by these programs.

B. TRICARE Prime

TRICARE Prime is a limited program supporting a Ready Medical Force and a Medically Ready Force in both law and practice. Readiness of the force means that Service members have health concerns addressed so they are ready to deploy to a combat zone at any time. A medically ready force means military doctors, nurses, technicians and other support staff are adequately trained and have the skills necessary to be able to deploy to support those troops in combat.

TRICARE Prime was established by law as an evolution of the Civilian Health and Medical Program of the Uniformed Services benefit in 1994, and the final rule was published in the Federal Register in October 1995. This enrollment-based program generally enrolls eligible active duty Service members (ADSMs) and certain active duty family members (ADFMs). Retirees and other eligible persons under the age of 65 may elect to enroll in TRICARE Prime when they live within a Prime Service Area (PSA), which is normally defined as within a 30-minute drive time of a military medical treatment facility (MTF). Within the catchment area (the Department's term for the radius), the MTF is able to oversee referrals for specialty care, including orthopedic, general surgery, and other specialties where cases provide critical skills maintenance for military surgical teams.

TRICARE Prime is a Health Maintenance Organization (HMO)-style plan; a PCM-centric model with oversight and management of specialty care referrals. Whether enrolled to an MTF, or to a network civilian provider in the PSA, Prime beneficiaries seek all care through their PCM, who will then refer them to specialists as appropriate.

For ADSMs, TRICARE Prime provides a significant readiness oversight. Certain elective procedures, for example, may provide a short- or longer-term impact to readiness, while otherwise legal and valid prescriptions such as opioids could, if not prescribed and taken within the applicable rules and requirements of the Services, subject the ADSM to appropriate accountability under the Uniform Code of Military Justice in addition to any adverse health effects which could impair the Service member's ability to continue in service.

Outside of PSAs, TRICARE Prime Remote (TPR) is provided to ADSMs and ADFMs to provide them a comparable level of coverage. ADFMs have no cost-shares and are provided the Prime Travel Benefit. This benefit provides for reimbursement of travel expenses when required healthcare is not available within an hour of the beneficiary's home and work locations. The

Prime Travel Benefit is not available in U.S. territories; in these locations, ADSMs and their eligible family members are funded for travel through the Service member's unit.

Because there is no readiness impact on the Ready Medical Force or a Medically Ready Force, TRICARE Prime is not normally offered outside of PSAs for retirees or other eligible family members. There have been exceptions granted due to exigent circumstances, primarily with Base Realignment and Closure (BRAC) and the resultant closure of MTFs, where beneficiaries were allowed to remain grandfathered in TRICARE Prime so long as they remained at that location. However, these were implemented and intended to be relatively short-term transitions to the non-Prime benefit, and were not planned as indefinite or permanent expansion of the locations where Prime is available. Transitional PSAs not built around MTFs or BRAC sites were terminated as of October 1, 2013, and non-ADSMs or ADFMs at these locations were transferred to TRICARE Standard, the predecessor to TRICARE Select. BRAC sites remain open as of the writing of this report and are under consideration for closure based on the original short-term intent described above.

C. TRICARE Select

TRICARE Select, formerly TRICARE Standard, is a Preferred Provider Organization-style plan, wherein a beneficiary is not required to maintain a specific primary care provider or obtain referrals for specialty care. This self-managed plan allows beneficiaries full access to mostly the same healthcare and pharmaceutical benefits as TRICARE Prime but without the additional administrative burden associated with seeking referrals for each episode of care from their PCM. As such, even within PSAs, around 58 percent of Prime-eligible beneficiaries actively choose to enroll in TRICARE Select.

While TRICARE Select enrollees may seek care from any TRICARE-authorized provider (a healthcare provider who accepts TRICARE payment, but who has not agreed to join the TRICARE network), they may obtain care from TRICARE network providers in many circumstances. TRICARE contractors covering the 50 United States and the District of Columbia (are required to ensure 85 percent of TRICARE Select beneficiaries have access to network providers within the statutory 1-hour/50-mile drive time and radius of their location, based on zip code, thus providing similar access to the same providers as TRICARE Prime enrollees. For TRICARE purposes, the continental United States (CONUS) is defined for the private sector regional contractors as all of the 50 United States and the District of Columbia, because TRICARE contracts are assigned in two specifically defined U.S. regions (East and West).

Outside of the continental United States (OCONUS) and the District of Columbia as defined for TRICARE contractors, such as in the U.S. territories, the TRICARE Overseas Program contractor is required to set up networks in locations, which are designated by the Defense Health Agency (DHA). Normally these are in locations with MTFs and non-MTF areas that have a significant troop presence or a permanent mission, for example, locations with U.S. Embassies or Consulates.

Of note, a TRICARE Prime and a TRICARE Select beneficiary may see the same TRICARE network provider with the differences being in applicable cost-shares/co-pays and referral requirements.

D. TFL

TFL is wrap-around coverage for individuals who are entitled to premium-free Medicare Part A and who have Medicare Part B coverage. When health care services are a benefit of Medicare and TRICARE, the beneficiary has no out-of-pocket (OOP) expenses. TFL exceeds “Platinum Plan” levels under the Affordable Care Act by effectively eliminating beneficiary OOP expenses in most instances (i.e., when services are covered by both Medicare and TRICARE), except when the beneficiary resides in and seeks care outside of the United States or its territories.

TRICARE beneficiaries under age 65, who are entitled to Medicare Part A and have Medicare Part B, are also eligible to enroll in TRICARE Prime, provided they live in a PSA. The Prime individual enrollment fee is waived for those who have Medicare Part B, (or in the case of family coverage, the fee is reduced by 50 percent).

IV. Feasibility as a Matter of Cost

A. Overview

With the understanding that the requested analysis calls for speculation, DoD considered the theoretical feasibility of cost increases concerning both Government and beneficiary OOP costs should TRICARE Prime implementation be expanded across all regions, illustrative of how both entities view the benefit. From the Government perspective, TRICARE Select is a lower-cost benefit with fewer requirements to administer. As outlined in Section B below, a transition to a universal “choice” TRICARE Prime benefit would cost the Government an additional ~\$80 million, with an additional ~\$10 million in one-time startup contract costs. ADFMs (who already normally have the option to enroll in TRICARE Prime/ Prime Remote) would see little change. Retirees and their eligible family members would experience more significant reductions in OOP costs.

B. Transitioning Population and Associated Costs

Because the Managed Care Support Contractors (MCSCs), except the TRICARE Overseas Contractor, must provide a full network to 85 percent of the TRICARE Select population, and only about 58 percent of TRICARE Select enrollees reside inside a PSA, many current non-PSA areas with clusters of TRICARE Select enrollees have an adequate existing TRICARE network that could support TRICARE Prime as well. Those “expansion-Prime” enrollees who are able to be assigned formal PCMs in the network need to adhere to normal Prime rules regarding reliance on the PCM before seeking specialty care. In such areas, the expansion-Prime benefit would be administered for both ADFMs and non-active duty family members (NADFMs) similar to TPR. Expansion-Prime enrollees in these areas would still be subject to most TRICARE Prime rules and managed care policies including the Prime Point-of-Service constraints on use of non-network providers. As an another example, those enrollees who are not able to have a formal network PCM due to a lack of local providers would instead contact the MCSC for specialty referral authorizations.

Enrollment data for TRICARE Prime and Select enrollees residing in PSAs as of the end of Fiscal Year (FY) 2020 indicates that 95 percent of these ADFMs and 68 percent of these retirees and their dependents (NADFMs), after excluding inactive guard/reserve) were enrolled in Prime rather than Select. In current non-PSAs, by contrast, only 60 percent of Prime and Select ADFMs and 16 percent of NADFMs were enrolled in TRICARE Prime. While there is clearly uncertainty, it is reasonable to assume that under the Prime expansion scenario, the Prime enrollment rate (Prime as a percent of Prime and Select) in the current non-PSAs would ultimately rise to the Prime enrollment rate in PSAs. Table 1 on the next page illustrates how this would adjust demand over time from TRICARE Select to TRICARE Prime.

Table 1. Steady-state Prime enrollment increase under a national expansion, assuming rates similar to current PSA Prime enrollment

	ADFM	NADFM*	ADFM+NADFM
Prime (including TPR and U.S. Family Health Plan (USFHP)) as a percent of Prime+Select in current PSAs	95%	68%	
Prime (including TPR and USFHP) as a percent of Prime+Select in current non-PSAs	60%	16%	
Enrollees shifting from Select to MCSC Prime if Prime enrollment in current non-PSAs rises to the current PSA rates	50,547	307,664	358,121

* NADFM here excludes inactive guard/reserve who are predominantly eligible through TRICARE Reserve Select and would not be eligible for Prime; a small portion are Transitional Assistance Management Program/Alert (e.g., covered beneficiaries during pre- and post-deployment when the activation qualifies them for TRICARE benefits) who only have brief eligibility and are heavily reliant on other health insurance

Table 2 below focuses on the cost of beneficiaries enrolled to the MCSC rather than including MTF Prime enrollees, given that the expansion-Prime enrollees would not be enrolling to MTFs because areas around MTFs already offer Prime. Note that retirees OCONUS are ineligible to enroll in TRICARE Prime, and only in Puerto Rico are ADFMs enrolled to civilian PCMs under Prime. The estimated net change in Government cost per enrollee shifting from Select to MCSC Prime, in current FY 2021 dollars, is a \$276 cost increase per ADFM and \$217 per NADFM. These cost differentials include health care and administrative costs offset by enrollment fee revenue, including the new \$150/\$300 enrollment fees for TRICARE Select retirees.

Table 2. Estimated differential in average net Government cost per enrollee for MCSC Prime versus Select (in current FY 2021 \$)

	ADFM	NADFM
MCSC Prime	\$3,993	\$4,364
TRICARE Select	\$3,717	\$4,147
Increased Government cost of MCSC Prime compared to Select	\$276	\$217

Considering the above factors of increased Government costs and the anticipated shift from TRICARE Select to TRICARE Prime for newly-eligible beneficiaries, the net annual increase in Government costs for health care and administrative costs, as offset by enrollment fee revenue, is estimated to be ~\$80 million (in FY 2021 dollars). In addition to the shift in cost from enrollees, there would be, as outlined in Section VI, a likely nominal shift in the TRICARE Prime Travel Benefit of ~\$600 thousand, although this estimate has significant caveats as outlined below.

More significantly, a cost of ~\$5 million per MCSC contractor, plus the TRICARE Overseas Program contractor, must be assumed. The actual implementation costs would depend on many factors including the detailed implementation requirements DHA would need to develop, each contractor’s actual approach to the network in expansion areas, the timing of the expansion, and other factors as determined by eventual implementation in statute, regulation, and policy.

C. Government vs. Beneficiary Costs

In general, the cost of TRICARE Prime is lower for the Government when consideration of MTF enrollment is a primary consideration. When adjusted for a focus on MCSC Prime enrollees as opposed to MTF enrollees (as an expansion of TRICARE Prime to all geographical locations presumes), as outlined in Table 3 below, the costs of providing the benefit are largely comparable.

Table 3. Estimated average Government costs per single/family (in FY 2021 \$)

		MCSC Prime	TRICARE Select
Per single ADFM	HC+Administrative	\$3,993	\$3,717
	Enrollment fee	\$0	\$0
	Net Govt cost	\$3,993	\$3,717
Per family of 3 ADFMs	HC+Administrative	\$11,979	\$11,151
	Enrollment fee	\$0	\$0
	Net Govt cost	\$11,979	\$11,151
Per single NADFM	HC+Administrative	\$4,576	\$4,227
	Enrollment fee	-\$303	-\$150
	Net Govt cost	\$4,273	\$4,077
Per family of 3 NADFM	HC+Administrative	\$13,726	\$12,681
	Enrollment fee	-\$606	-\$300
	Net Govt cost	\$13,122	\$12,381

Notes: Amounts for health care plus administrative costs were adjusted to control for age/gender differences in MCSC Prime versus TRICARE Select (distinctly for ADFMs and for NADFM), but not able to control for other possible health status differences beyond age/gender. For simplicity, this table assumes normal Group A enrollment fees apply in each case.

The difference in expenses, and a primary presumed driver of the Report requirement in general, is the impact on the individual Sponsor and their eligible family members. As outlined in Table 4 on the next page, ADFMs who have, for geographical reasons, elected to enroll in

TRICARE Select vice TRICARE Prime experience significant increases in projected OOP expenses. Non-ADFM experience a much smaller alteration in OOP expenses. This variance may be a result of beneficiary choice for the flexibility of TRICARE Select vice the more restrictive HMO-style administration of the TRICARE Prime since the benefit provided is the same. While this cost is demonstrably different, it is mitigated by the fact that the TRICARE benefit has significantly lower catastrophic caps than comparable Federal Employees Health Benefits (FEHB) Program or private sector plans, limiting the overall risk to the individual beneficiary.

Table 4. Estimated average OOP costs per single/family (in FY 2021 \$)

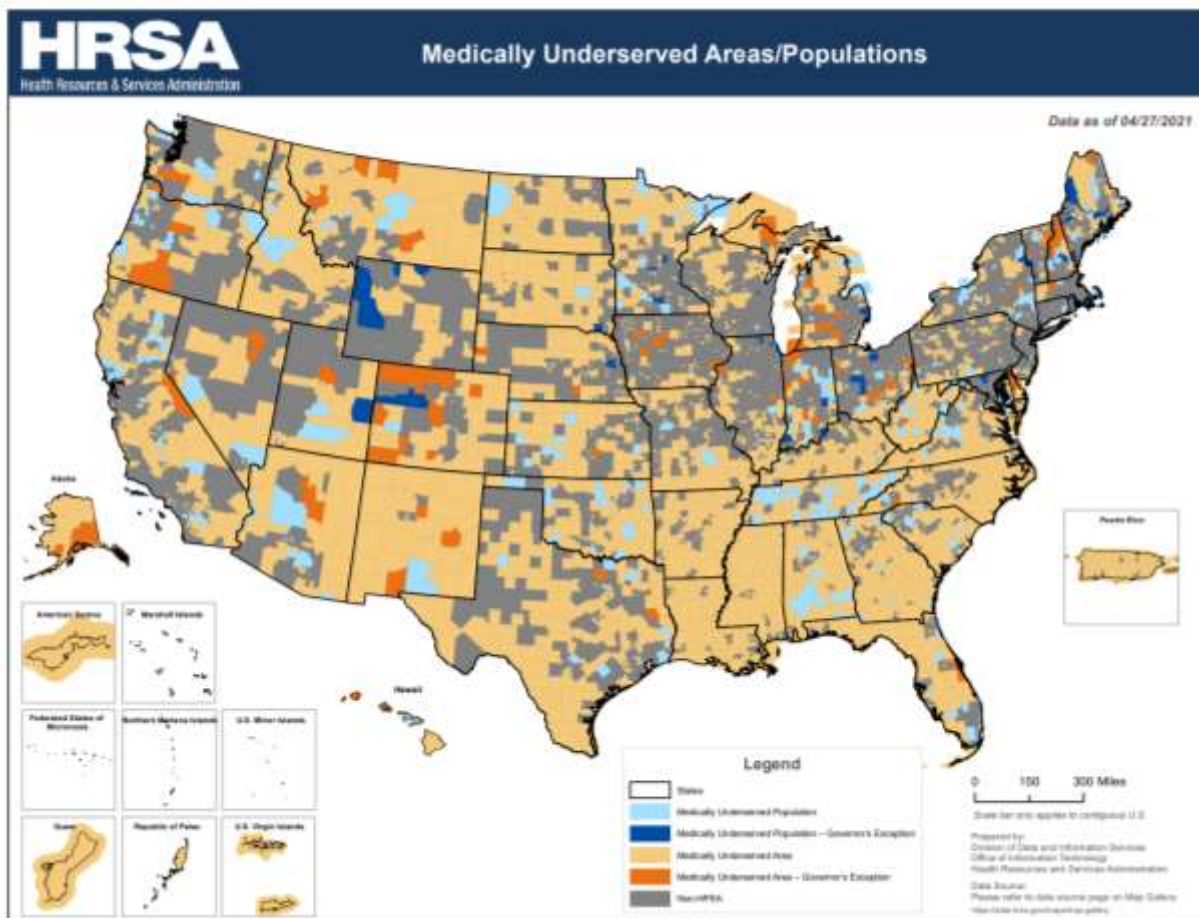
		MCSC Prime	TRICARE Select
Per single ADFM	Non-EF OOP	\$76	\$265
	Enrollment fee	\$0	\$0
	Total OOP	\$76	\$265
Per family of 3 ADFMs	Non-EF OOP	\$233	\$794
	Enrollment fee	\$0	\$0
	Total OOP	\$233	\$794
Per single NADFM	Non-EF OOP	\$344	\$530
	Enrollment fee	\$303	\$150
	Total OOP	\$647	\$680
Per family of 3 NADFM	Non-EF OOP	\$1,033	\$1,591
	Enrollment fee	\$606	\$300
	Total OOP	\$1,639	\$1,891

Notes: Non-enrollment fee OOP amounts were adjusted to control for age/gender differences in MCSC Prime versus TRICARE Select (distinctly for ADFMs and for NADFM), but not able to control for other possible health status differences beyond age/gender. For simplicity, this table assumes normal Group A enrollment fees apply in each case.

V. Feasibility as a Matter of Healthcare Availability

A. Health Resources & Services Administration

The Health Resources & Services Administration (HRSA) within the Department of Health and Human Services maintains responsibility and oversight of medically underserved areas throughout the United States and its territories. As discussed, the MCSC contractors servicing the TRICARE population in the 50 United States and District of Columbia are required to provide network coverage to 85 percent of TRICARE Select beneficiaries. Thus, expansion of coverage of TRICARE networks in general, non-specific to TRICARE Prime, is largely a discussion of expansion to the “remnant;” those beneficiaries who live and work in geographically-remote and medically-underserved areas where medical resources to support a full TRICARE Prime network experience, including adequate PCM and Specialist access may not exist.



As illustrated above, significant geographical areas within both the 50 United States, District of Columbia, Puerto Rico, and U.S. territories are considered medically underserved. Where this is extant, it can be reasonably presumed that inadequate resources are available

within those locations to deliver the full HMO-level benefit of TRICARE Prime, as outlined in Section III.

As of FY 2020, ~665,000 TRICARE beneficiaries reside in medically underserved locations. For the beneficiaries who reside outside of a PSA, extension of TRICARE Prime would therefore be more of a “choice” program, vice delivery of the full TRICARE Prime benefits. Their experience, as outlined in Section IV, therefore, would largely be altered more in the differing cost-shares applied for their healthcare, and the opportunity to access an expanded benefit with travel costs included (excepting Puerto Rico and other U.S. territories).

An additional ~208,000 beneficiaries who do not have their TRICARE benefits active, but who remain eligible for Direct Care at MTFs might also, at an undetermined cost, decide to leverage their new eligibility to access the TRICARE benefit if afforded an opportunity via statutory changes to access the TRICARE Prime benefit regardless of location.

VI. Feasibility as a Matter of Program Design

A. Readiness Impact

As noted in Section III, TRICARE Prime, by design, is focused on a Ready Medical Force and a Medically Ready Force. Readiness of the Force is supported by comprehensive healthcare services delivered to ADSMs and ADFMs through offering a full range of healthcare services delivered from MTFs and from Private Sector Care regardless of their location.

Expanding access to TRICARE Prime in PSAs with CONUS MTFs enhances a Medically Ready Force by providing an additional significant population for military medical providers and their support staffs to maintain critical skills needed when the force is called up for military operations. Specialists, such as General Surgeons and their surgical teams, require a sufficient volume of cases annually to maintain their skills and proficiency and lower the risk of errors and negative surgical outcomes for patients. By expanding the pool of beneficiaries, an MTF is able to recapture cases critical for this skills maintenance and that might otherwise not be available to them given the average younger population of ADSMs and ADFMs. This access provides active duty levels of access to Primary Care for Retirees and their eligible family members enrolled to a PCM at the MTF and Space-Available access to Specialty Care services at the MTF.

TFL beneficiaries, while no longer eligible to enroll in TRICARE Prime after they turn age 65, can maintain access to the MTF through the TRICARE Plus program. TRICARE Plus, while not a benefit in and of itself, allows eligible beneficiaries to be assigned a PCM and receive TRICARE Prime-level access to primary care and space-available access to specialty care at MTFs, further expanding the pool of potential cases for skills maintenance of military providers and support staff.

Outside of PSAs lacking MTFs, there is no similar readiness issue, which can be addressed by expanding Prime to retirees. When they live further than 30 minutes from the MTF, but still within 100 miles, retirees can elect to enroll in TRICARE Prime when located in CONUS at an MTF with a drive-time waiver, in which the beneficiary assumes responsibility for the additional travel distance and time, which is not compensable.

B. TRICARE as a “Choice” Program

As previously noted, TRICARE Prime and TRICARE Select options are not analogous to comparable FEHB Program or civilian-sector health insurance and marketplace plans, with Bronze, Silver and Gold plans providing differing levels of coverage and variable benefits. Accessing TRICARE Prime, Select, or TFL provides access to the entire TRICARE benefit. Each plan does have varying cost-shares/co-pays and applicable enrollment fees or premiums, dependent on the beneficiary’s status.

Notably, approximately 58 percent of TRICARE Select beneficiaries already reside within a PSA and may elect to enroll in TRICARE Prime if located CONUS. When considering this as a “choice” program, therefore, it is not readily apparent whether beneficiaries are

responding to the cost differential between the programs, the lower barriers to accessing specialty care without a referral and/or having expanded choice of providers.

C. TRICARE Prime Travel Benefit

Unique to the TRICARE Prime benefit is the Prime Travel Benefit, available in CONUS for TRICARE Prime and TPR beneficiaries. In U.S. territories and other overseas locations, eligible ADSMs and their command-sponsored family members are eligible for medical travel under certain circumstances as governed by the Joint Travel Regulations and administered by the Service members' units.

Where MTFs are located, even in more remote areas, there is normally a balance achieved between MTF capabilities and network capabilities, such that the predominance of care can be achieved without triggering the necessity of this additional benefit.

Expanding TRICARE Prime availability to all States and U.S. territories would expand the Prime Travel Benefit to a significant geographically-remote population in numerous medically-underserved areas with limited area resources and, unless the current Prime Travel Benefit were similarly altered, would continue to leave beneficiaries in U.S. territories without the benefit afforded to their CONUS counterparts. The addition of a travel benefit to remote and medically underserved areas for individuals who currently are enrolled in TRICARE Select can be anticipated to attract significant interest in TRICARE Prime enrollment. Overall, the current program costs of ~\$1.7 million in FY 2020 would be anticipated to increase by ~\$600,000, although factors such as induced demand (wherein the availability of a free benefit increases demand for the benefit) make prediction of actual impact unreliable.

Notably, as the expansion of TRICARE Prime to all areas of CONUS would extend the travel benefit, while residents of Puerto Rico and U.S. territories would remain excluded, an inequity between two otherwise identical groups of beneficiaries would be created, wherein a rural resident of, for example, Montana, would be eligible for extensive travel compensation for significant amounts of their specialty care, while a resident of Puerto Rico or a U.S. territory who may have to incur significant flight costs to travel for the same care would remain uncompensated.

D. PSA Reductions

Historical precedent additionally supports the limitations of PSAs to MTF locations. As part of the 2005 BRAC, multiple MTFs were closed across the United States. In order to ease the transition for affected beneficiaries in these areas, TRICARE Prime coverage was extended in these areas during a transitory period. This period ended on October 1, 2013, when remaining non-ADSM/ADFM in the location were transitioned to TRICARE Standard.

As part of this process, at the same time, non-MTF PSAs that had been established in an earlier generation of TRICARE contracts were similarly terminated. The Department reported on this previously on April 30, 2015, in response to section 723 of the Carl Levin and Howard P.

“Buck” McKeon National Defense Authorization Act (NDAA) for FY 2015 (Public Law 113-291).

E. HMO Model in Medically-Underserved Areas

As noted in Section V, many locations across the United States and, with some exceptions in Puerto Rico, the entirety of the U.S territories are considered by HRSA to be medically underserved areas. The practical impact of this for the HMO-modeled TRICARE Prime program is that it cannot fully function as designed without an adequate volume and breadth of provider specialties in the location. A beneficiary who is enrolled in TRICARE Prime, but is unable to obtain the majority of their care within their area through a PCM and specialists, would fundamentally alter the intentions of an HMO-model of healthcare provision. For example, a PCM may not be available to manage their care, leading to the beneficiary not having the actual experience of care management which is at the core of an HMO model. In essence, this would provide TRICARE Prime cost-shares for enrolled beneficiaries but without the patient management and readiness aspects inherent to TRICARE Prime.

VII. Conclusion

As noted, the Department finds that an expansion of the TRICARE Prime benefit to all locations in all States, Puerto Rico, and U.S. territories is technically achievable. However, the increase in cost for expansion of the networks, failure to achieve the goals of the TRICARE Prime model in rural and remote medically underserved communities, and ultimately significant alteration of the primary mission and goals of the TRICARE Prime as a readiness-supporting program make expansion of TRICARE Prime to all locations inadvisable. Given that TRICARE contractors in the 50 United States and District of Columbia are required already to provide a TRICARE network in locations to encompass at least 85 percent of TRICARE Select beneficiaries, the vast majority of TRICARE Select beneficiaries already have access to a network of TRICARE providers within their area who already offer the fixed cost-shares applicable to their enrolled program.

The incremental gain of expanding TRICARE Prime networks so that the remaining 15 percent of beneficiaries have access provides minimal additional benefits while incurring significant additional costs.

VIII. Glossary

A. Acronyms and Symbols

ADFM	active duty family member
ADSM	active duty service member
ASD(HA)	Assistant Secretary of Defense for Health Affairs
BRAC	Base Realignment and Closure
CONUS	continental United States
DHA	Defense Health Agency
DoD	Department of Defense
FEHB	Federal Employees Health Benefits
FY	Fiscal Year
HMO	Health Maintenance Organization
HRSA	Health Resources & Services Administration
MTF	military medical treatment facility
MCSC	Managed Care Support Contractor
NADFM	non-active duty family member
NDAA	National Defense Authorization Act
OCONUS	outside the continental United States
OOP	out-of-pocket
PCM	Primary Care Manager
PSA	Prime Service Area
SSA	Social Security Administration
TFL	TRICARE for Life
TPR	TRICARE Prime Remote
USFHP	U.S. Family Health Plan

B. Definitions

TRICARE Reserve Select. TRICARE Reserve Select is a premium-based program created with the NDAA for FY 2004 to extend TRICARE coverage under title 10 to Selected Reserve and National Guard members who otherwise do not qualify for title 10 benefits. Qualified members must enroll and pay monthly premiums in order to maintain coverage.