



INSTITUTE FOR DEFENSE ANALYSES

## **Using TRICARE Reform Pilots to Inform National Healthcare Reform Discussion**

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## Executive Summary

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The Department of Defense (DoD) provides a comprehensive health benefit (TRICARE) to military members, their families, and military retiree families. This TRICARE program is an important element of military compensation, but has challenges with cost to the government and beneficiary satisfaction. TRICARE beneficiaries use significantly more healthcare than demographically similar families with private insurance and have higher costs. TRICARE also has significantly smaller provider networks; consequently, beneficiaries have less access than federal civilians under typical health plans offered to them, leading to lower beneficiary satisfaction.

The United States (US) healthcare system struggles with similar healthcare cost and quality challenges, making healthcare reform one of the most significant issues facing policy makers. Most Americans receive health insurance coverage through large institutional payers (e.g., an employer or a large public program like Medicare or Medicaid). These payers generally use insurance carriers to manage the health benefit and interface with the delivery system. One major element of healthcare reform is identifying ways to improve the alignment of incentives across these four entities (beneficiary, institutional payer, insurance carrier, and provider) to promote improved health outcomes and control cost. A key question in this challenge is how the financial intermediary (insurance carrier) can improve healthcare value by coordinating and managing utilization, improving health outcomes, and enhancing the choices available to beneficiaries.

Private sector health insurance has evolved through a wide range of utilization management approaches, with the most notable public debate occurring in the 1990s between fee-for-service (FFS) insurers and health maintenance organizations (HMOs). FFS insurers played a smaller role in utilization management, while HMOs (as originally conceived and executed) vertically integrated the insurance function and healthcare delivery system to provide intensive utilization management. Neither of these extremes became dominant, and private healthcare today is engaged in a dynamic period exploring new ways to improve value that include greater engagement with the delivery system (e.g., capitation, bundling, and accountable care) and beneficiaries (e.g., high-deductible plans and health savings accounts). As the private sector experiments with these alternative approaches, the central policy question is about how to create the best regulatory structure to properly align incentives in this market.

Historically, the public health benefit programs (e.g., Medicare, Medicaid, and TRICARE) minimized utilization management and focused instead on procedure prices for

cost control. The approach used FFS payments according to centrally directed “take-it-or-leave-it” procedure reimbursement rates, and little or no substantive risk bearing for the insurance carrier (which merely provided pass-through claims processing). This “price control” model provides little incentive to insurers or the delivery system to coordinate and manage utilization (and can even incentivize overutilization), limiting the ability to focus on improving health outcomes and leaving the only option for cost control the reduction of reimbursement rates leading to reduction of network size and access.

These challenges highlight some of the most important questions facing policy makers on healthcare reform, including:

- What is the performance (cost control, beneficiary satisfaction, and health outcomes) of the traditional price control-based structure compared to a competitive, utilization management (i.e., insurance-based) structure for public health benefits?
- What is the relative importance of the incentives facing beneficiaries (demand-side incentives) for improvements in cost control and outcomes, and what are the most important design attributes for demand-side reform?
- What is the relative importance of the incentives facing the delivery system (supply-side incentives) for improvements in cost control and patient outcomes, and what are the most important design attributes for supply-side reform?

TRICARE operates within this broader context of US healthcare and is confronting the same questions. TRICARE’s challenges with satisfaction, the management and coordination of utilization, and cost are similar to those experienced across the healthcare sector and, in some cases, such as overutilization, worse. While TRICARE remains a procedure price control-based program, Medicare and Medicaid have moved into integrated care; approximately one third of Medicare beneficiaries are enrolled in Medicare Advantage plans and one half or more of Medicaid recipients are enrolled in Medicaid Managed Care Organizations.

In dealing with major public policy concerns like these, policy pilots are important tools for improving our understanding of the problems and choosing the best path forward. For instance, prior to the passing of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), which transformed the nation’s welfare program, there were many large-scale rigorous experimental studies of welfare-to-work programs. In the healthcare arena, the RAND health insurance experiment (HIE), which began in the early 1970s, provided significant experimental evidence on the impact of coinsurance and HMO participation. This experiment helped inform the restructuring of private insurance and managed care.

The fiscal year (FY) 2016 National Defense Authorization Act (NDAA) directed the Secretary of Defense to

commence the conduct of a pilot program ... to assess whether a reduction in the rate of increase in health care spending by the Department of Defense and an enhancement of the operation of the military health system may be achieved by developing and implementing value-based incentive programs.

The FY 2017 NDAA reinforced and expanded this direction, leaving DoD with a strong mandate and wide latitude to experiment with reforms to TRICARE. The similarity of TRICARE's challenges to broader healthcare problems, the (relatively) closed and controlled nature of the TRICARE program and beneficiary population, and the strong congressional mandate for TRICARE reform pilots provide a unique opportunity to conduct a series of experiments whose results could help to inform the national healthcare reform debate while setting a future course for TRICARE.

This paper provides examples of the types of TRICARE pilots that could be implemented, identifies the specific national healthcare reform questions that could be addressed by these pilots, and highlights key pilot design features that must be taken into account to ensure maximum value of the pilots. It also provides details on important implementation issues and key considerations for expanding pilot results to full reform implementation. In the past, policy experiments and pilot programs have provided key evidence towards answering various reform debates and have ultimately helped in shaping the reform strategy. TRICARE pilots provide a valuable and unique opportunity to provide information that not only informs TRICARE reform, but also provides information of value to national healthcare reform.





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# 1. Introduction

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Like most large employers, the Department of Defense (DoD) provides a health benefit to its (military) employees and retirees.<sup>1</sup> This TRICARE program supports over 9 million eligible beneficiaries, with DoD spending over \$50 billion per year on healthcare.<sup>2</sup> DoD produces about one-third of the care delivered to TRICARE beneficiaries in its military hospitals and purchases the rest from the private sector through contracts designed similarly to the structure of traditional Medicare.

Not surprisingly, the TRICARE program faces challenges similar to the rest of the healthcare sector. Beneficiaries value the low cost shares (premiums and copayments) offered in TRICARE, but there is widespread dissatisfaction with other benefit attributes such as the size of provider networks and access to care. From DoD's perspective, TRICARE has major challenges with cost and utilization. TRICARE beneficiaries have higher utilization rates than demographically similar civilians, and healthcare costs are now about 10 percent of the DoD's baseline budget.

In response to these satisfaction and cost challenges, the Congress has directed DoD to reform the TRICARE program and to use pilot programs to help guide development of the overall reform strategy. The fiscal year (FY) 2016 National Defense Authorization Act (NDAA) directed the Secretary of Defense to

commence the conduct of a pilot program ... to assess whether a reduction in the rate of increase in health care spending by the Department of Defense and an enhancement of the operation of the military health system may be achieved by developing and implementing value-based incentive programs.

The FY 2017 NDAA reinforced and expanded this direction, leaving DoD with a strong mandate and wide latitude to experiment with reforms to TRICARE.

The underlying causes of TRICARE's satisfaction and cost concerns are not unique to DoD; they are the same as those that confront public programs such as Medicare, Medicaid, and the developing Veterans Choice program, as well as the private sector. In dealing with major public policy challenges like healthcare reform, policy experiments and

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<sup>1</sup> Civilian DoD employees, like other federal civilians, are included in the Federal Employees Health Benefit Program (FEHBP) and not included in TRICARE. TRICARE is also separate from Department of Veterans Affairs (VA) programs. Military retirees may be eligible for both DoD and VA health benefits, while veterans who did not retire from military service may be eligible for VA health benefits.

<sup>2</sup> Dependents of employees and retirees (e.g., spouses and children) are among the eligible beneficiaries.

pilots are important tools for improving our understanding of the problems and choosing the best path forward, and have been an important element of healthcare policy reform. The similarity of TRICARE's circumstances to broader healthcare problems, the (relatively) closed and controlled nature of the TRICARE program and beneficiary population, and the strong congressional mandate for TRICARE reform pilots provide a unique opportunity to conduct a series of experiments that could generate important information to inform the national healthcare reform debate.

The purpose of this report is to highlight this unique opportunity to gain information of national significance from TRICARE pilots that are just now beginning to be developed. The first half of this report identifies the opportunity available by reviewing:

- DoD's TRICARE program and its challenges (Chapter 2),
- The similarities between the underlying causes of TRICARE's challenges and the problems in civilian (public and private) healthcare (Chapter 3), and
- The role of pilots and experiments in healthcare (Chapter 4).

The second half of this report then provides a detailed examination of:

- Specific TRICARE pilot options (Chapter 5),
- Assessment strategies for these pilots (Chapter 6), and
- Pilot implementation issues (Chapter 7).

## 2. The TRICARE Program

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As introduced in Chapter 1, DoD's TRICARE program provides a health benefit for over 9 million eligible beneficiaries, including military members, their family members, and military retirees and families. At over \$50 billion per year, DoD spends over 10 percent of its budget on healthcare. This chapter provides a brief overview of the military health system (MHS) and TRICARE program, followed by a review of some of TRICARE's challenges.

### A. Background on the MHS and TRICARE Program

TRICARE provides a comprehensive health benefit for military employees and retirees. For most beneficiaries, TRICARE offers a choice of two potential plans:<sup>3</sup>

- **TRICARE Prime.** Under this option, beneficiaries must enroll and have their care managed by a primary care manager (PCM).<sup>4</sup> The Prime option has no enrollment fee (i.e., premium) for Active Duty family members (ADFMs), a small enrollment fee for retirees (about \$600 per year in 2018), and very low cost shares (co-pays and deductible). TRICARE materials describe Prime as a managed care option due to the assignment of a PCM.
- **TRICARE Select** (formerly TRICARE Standard/Extra).<sup>5</sup> A Preferred Provider Organization (PPO)-like option available to non-Active Duty beneficiaries. This plan did not require enrollment until 2018,<sup>6</sup> has no enrollment fee for ADFMs (but has introduced one for retirees), and there is no PCM to manage utilization.

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<sup>3</sup> Other plans offered by the TRICARE program include plans supporting the Reserve Components; the Uniformed Service Family Health Plan (USFHP), through which private civilian providers offer the Prime benefit on a capitated basis in a few select markets; a plan for qualified dependents (young adults under age 26); and several supplemental plans (including TRICARE for Life for Medicare-eligible retirees).

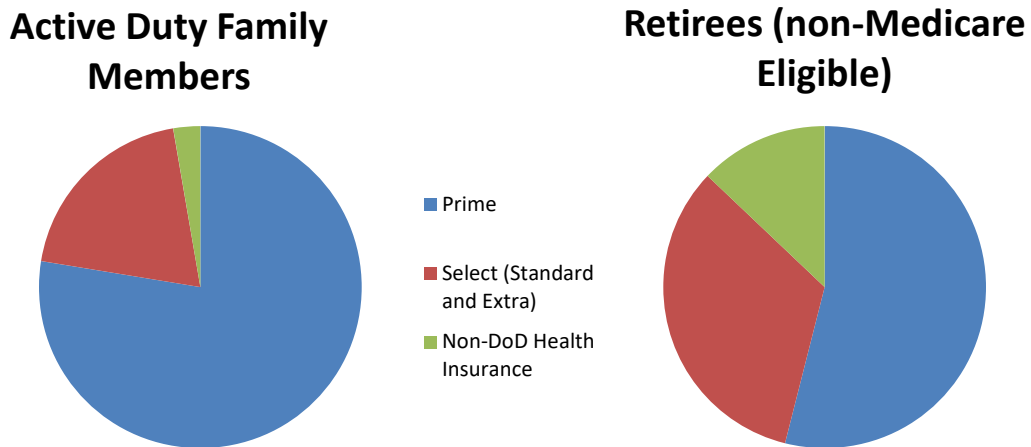
<sup>4</sup> Although often described as a Health Maintenance Organization (HMO)-like option, TRICARE Prime may be more similar to Medicaid Primary Care Case Manager programs. As will be illustrated below, utilization levels in TRICARE Prime are significantly higher than typical HMO utilization levels.

<sup>5</sup> Historically, TRICARE had two basic "plans" in addition to Prime. TRICARE Extra was a preferred provider option that gave discounts for seeing providers in a network while TRICARE Standard included all providers that met TRICARE rules (i.e., including non-network providers). TRICARE Standard and Extra were combined into a single "plan" called TRICARE Select in 2018.

<sup>6</sup> Historically there was no requirement to enroll in TRICARE Standard or Extra. A beneficiary could see a provider and file a claim without taking any prior steps to purchase or enroll in the plan.

Users of the plan may see any TRICARE-authorized provider. Cost shares are higher than in Prime and vary based on whether the beneficiary sees a network provider or a non-network provider.

Figure 1 provides a breakout of beneficiaries across these two plans for FY 2017 (which was before the combination of TRICARE Standard and Extra into TRICARE Select). About three-quarters of ADFMs and 50 percent of non-Medicare eligible retirees are in TRICARE Prime, while about three percent of ADFMs and 20 percent of non-Medicare eligible retirees maintain a non-DoD health insurance plan.



Source: "Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress," 175.

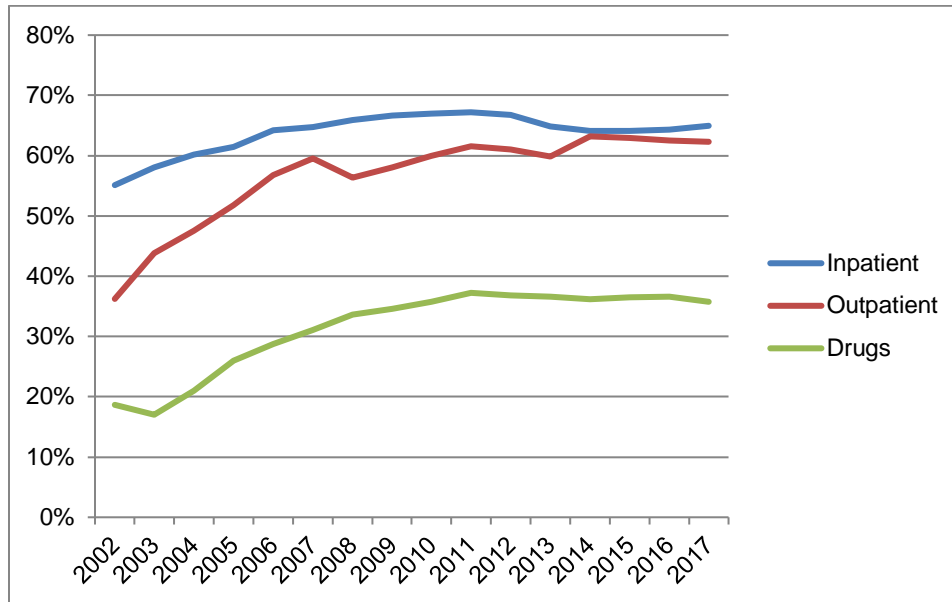
**Figure 1. Beneficiary Breakout over TRICARE Plans**

A unique aspect of the DoD benefit is that there are two distinct delivery systems through which beneficiaries may receive covered healthcare services:

- **The Direct Care System (DC).** A system of military hospitals and clinics owned and operated by the Services and staffed with uniformed military providers and DoD civilians. At present there are 37 inpatient facilities and over 300 outpatient clinics.
- **The Purchased Care System (PC).** A system of civilian-run hospitals, clinics, and/or providers that have agreed to be part of the civilian TRICARE network. This delivery system is managed through regional TRICARE contractors. These contractors are responsible for building the civilian provider networks and paying claims.

When TRICARE was first introduced in the mid-1990s, most care was delivered in the DC system, but, over time, the PC system has taken on an ever-increasing share of total care delivered, such that the PC system now delivers over 60 percent of the inpatient and outpatient healthcare services provided to TRICARE beneficiaries. Figure 2 provides the

percentage of total care delivered in PC for inpatient, outpatient, and pharmacy from 2002 to 2017. With four additional DC facility downsizings since 2017, the share of care delivered in PC will continue to increase.



**Figure 2. Purchased Care as a Percent of Total Utilization by Service Type**

DoD beneficiaries are spread across the entire globe, and TRICARE must cover this entire range. There are two regions and contracts in the United States (East and West) and a separate overseas contract.

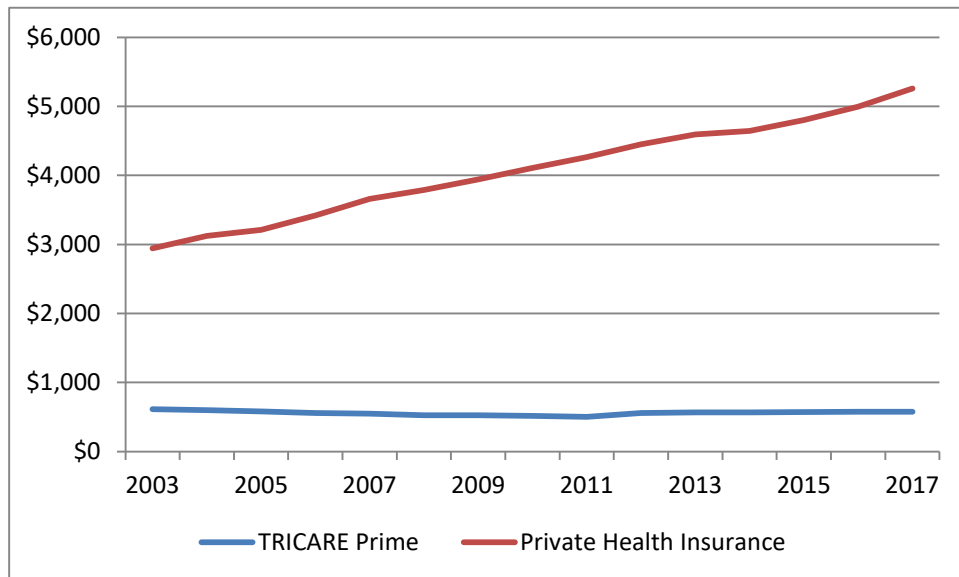
## **B. TRICARE Challenges**

The TRICARE program has many challenges. This section highlights some of the most important challenges, including cost shares, beneficiary satisfaction, utilization rates, and cost.

### **1. Low Beneficiary Cost Shares**

In the private insurance marketplace, most individuals face a clear trade-off among the common beneficiary cost-sharing and quality features: premium contribution, deductibles and copays (called out-of-pocket, or OOP, costs), network size and access, and covered services. Higher premium contributions usually mean lower co-pays and deductibles along with larger networks. Conversely, lower premium contributions often mean higher co-pays and deductibles and more limited access (e.g., beneficiaries are required to use a narrow provider network or must gain a referral from a care manager before seeing a specialist). As TRICARE currently operates, these trade-offs are essentially absent. There is a dramatic divergence between the beneficiary cost shares of TRICARE

and the costs of other insurance plans (private insurance and Medicare). As previously discussed, ADFMs do not pay enrollment fees for either benefit option while retirees pay fees well below the civilian norm. Since TRICARE’s inception until recently, the retiree premium for Prime was fixed at \$460 per year. It has recently begun to grow in accordance with inflation from that value, but without any catch-up for accumulated inflation during the intervening years through 2012. Figure 3 provides inflation adjusted (FY 2017 base year) premiums for TRICARE Prime compared to average insurance premiums for demographically similar individuals in private insurance. Retiree enrollment fees for the Select option were introduced in 2018.



Source: “Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress,” 176.

**Figure 3. Comparing Beneficiary’s Share of Premiums (family plans)**

OOP costs are also low. Table 1 provides a comparison of the total OOP costs for DoD families in Prime and Select compared to demographically similar families using private sector insurance (Prime enrollees are paired with private-sector HMO plans and Select users are paired with private-sector PPO plans). The dollar amounts are the family total for the average size family (number of adults and number of children) in each TRICARE option.



**Table 1. Deductibles and Copayments**

<b>Member Category</b>	<b>TRICARE Plan</b>	<b>TRICARE</b>	<b>Private HMO/PPO</b>
Active Duty Family Member	Prime	\$78	\$667
	Select	\$483	\$888
Retiree (non-Medicare Eligible)	Prime	\$389	\$1,094
	Select	\$1,084	\$1,466

Source: "Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress," 177, 179.

From DoD's perspective, these low cost shares are a driver of the higher utilization (discussed in more detail below). In addition to limiting DoD's ability to manage utilization, low beneficiary cost shares also limit DoD's ability to offer beneficiaries choice (e.g., some beneficiaries would prefer to pay more if it improved access).

From the perspective of the beneficiaries, these low cost shares are viewed as a positive attribute of TRICARE when the health benefit is viewed in isolation, but the disadvantages become more apparent when a broader look is taken at overall compensation design. DoD compensates the military with a range of tools including cash salary, in-kind benefits (e.g., subsidized housing, healthcare, and groceries), and deferred compensation (e.g., retired pay and healthcare). The level of this compensation is calibrated over time to meet DoD recruitment and retention needs. Providing large subsidies for healthcare increases compensation, but does so at the expense of simpler forms of compensation like cash salary. For most beneficiaries, providing higher cash salary and reducing (distorting) subsidies for in-kind benefits could increase the overall level of compensation while reducing cost to the taxpayer.

## 2. Beneficiary Satisfaction

Although beneficiaries generally appreciate the low cost shares of TRICARE, there is widespread dissatisfaction with the other aspects of the benefit. Table 2 provides the results for FY 2017 of beneficiary satisfaction surveys for TRICARE beneficiaries compared to civilian benchmarks.

**Table 2. Measures of Access for TRICARE Beneficiaries and Civilian Benchmark (FY 2017)**

<b>Metric</b>	<b>TRICARE</b>	<b>Civilian Benchmark</b>	<b>Delta</b>
Getting Needed Care	78.1%	86.1%	-8.0%
Getting Care Quickly	79.1%	84.2%	-5.1%
Getting an Appointment with a Specialist	74.8%	83.0%	-8.2%
Getting Timely Routine Appointments	74.3%	81.1%	-6.8%

Source: "Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress."

These satisfaction challenges are reflections of underlying plan attributes. One readily quantifiable attribute is network size. Table 3 provides a comparison of the numbers of TRICARE network providers in three geographic markets for selected specialties to the numbers in two plans available to federal civilians in those markets: GEHA (formerly the Government Employees Health Association plan) and Blue Cross Blue Shield (BCBS). The federal civilians working side-by-side with the military members have much greater access to providers (although they pay more for it).

**Table 3. Network Comparison**

<b>Area</b>	<b>Specialty</b>	<b>TRICARE</b>	<b>GEHA</b>	<b>BCBS</b>
Fayetteville, NC 28310 (Ft. Bragg)	Family Practice	64	123	148
	OB/GYN	28	86	111
	Orthopedic Surgery	19	43	163
Phoenix, AZ 85004	Family Practice	94	158	124
	OB/GYN	114	126	138
	Orthopedic Surgery	84	111	108
San Diego, CA 92136	Family Practice	111	149	149
	OB/GYN	53	93	78
	Orthopedic Surgery	90	142	130

Surveys conducted by the Military Compensation and Retirement Modernization Commission (MCRMC) revealed that beneficiaries perceive a relationship between their cost shares and quality—“you get what you pay for” was a common response. Many beneficiaries told the MCRMC that they would be willing to pay more if they received higher quality (e.g., choice and access) in return.

### **3. Utilization Rates**

TRICARE beneficiaries have significantly higher rates of healthcare utilization than demographically similar civilians. This imbalance is most pronounced for inpatient care (the most expensive care); TRICARE beneficiaries in Select have almost twice as many inpatient discharges as demographically similar civilians. For outpatient care and pharmacy services, TRICARE Prime users have more utilization than similar civilians, while Select users have less. Table 4 provides these utilization comparisons for FY 2017. Prime beneficiaries are compared to demographically similar individuals in HMO plans and Select beneficiaries are compared to demographically similar individuals in PPO plans.

**Table 4. Utilization Comparison**

Utilization Category	TRICARE Plan	TRICARE	HMO/PPO
	Inpatient (Discharges per 1,000 Beneficiaries)	Prime	56.9
Select		95.2	48.1
Outpatient (Encounters per Enrollee)	Prime	10.34	6.89
	Select	6.15	8.17
Pharmacy (Prescriptions per Enrollee)	Prime	11.78	9.33
	Select	8.32	10.52

Source: "Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress," 161–78.

#### 4. Cost

Finally, TRICARE costs significantly more than private insurance coverage. Table 5 provides a comparison of the care costs per family—for ADFM families and retiree families—to demographically similar families in private insurance. The comparison is for FY 2017 and the costs included are the OOP costs of the beneficiaries plus the care costs paid by the insurance plan (TRICARE or private sector insurer). ADFM families in Prime consume over twice as much care (measured in dollars) as demographically similar civilian families.

**Table 5. Per Family Cost Comparison**

Family Category	TRICARE Plan	TRICARE	HMO/PPO
	Active Duty Families	Prime	\$9,625
Select		\$7,408	\$5,362
Retiree Families (non-Medicare)	Prime	\$13,438	\$8,190
	Select	\$9,235	\$9,163

Source: "Evaluation of the TRICARE Program: Fiscal Year 2018 Report to Congress," 178, 180.

When these cost differences are aggregated across the relevant DoD beneficiary population, the MCRMC found that the total cost of the current TRICARE program is about \$3 billion higher than it would be with a program that allowed for beneficiaries to choose among a variety of private sector plans.<sup>7</sup>

<sup>7</sup> Military Compensation and Retirement Modernization Commission (MCRMC), *Report of the Military Compensation and Retirement Modernization Commission: Final Report*, January 29, 2015; and Sarah K. Burns, Philip M. Lurie, and Stanley A. Horowitz, "Analyses of Military Healthcare Benefit Design and Delivery: Study in Support of the Military Compensation and Retirement Modernization Commission." IDA Paper P-5213 (Alexandria, VA: Institute for Defense Analyses, January 2015).



### **3. TRICARE in Context of US Healthcare Reform**

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Healthcare reform remains one of the most significant issues facing United States (US) policy makers. The nation’s last significant reform, the Patient Protection and Affordable Care Act (ACA), signed into law eight years ago, attempted to tackle one of the nation’s most salient healthcare problems—limited access to healthcare by millions of uninsured individuals. By deploying a strategy that simultaneously combined a mandate to buy health insurance, tax credits, and Medicaid expansion, the reform appears to have achieved success in expanding coverage to many previously uninsured individuals. However, the reform did not offer comprehensive strategies for tackling other major problems facing the American healthcare system—rising healthcare costs and suboptimal health outcomes.

The Centers for Medicare and Medicaid Services (CMS) Office of the Actuary has recently projected national health expenditures to rise at 5.3 percent in 2018—even higher than the 4.6 percent estimated growth in 2017. Furthermore, the predicted growth rate over the next decade is expected to average 5.5 percent annually.<sup>8</sup> The economic implications of such growth include healthcare costs rising as a share of total labor costs (potentially suppressing future wage increases), as a share of our public budgets (threatening the solvency of the Medicare and Medicaid programs), and as a share of the economy in general.

TRICARE operates within this broader context of US healthcare. TRICARE’s challenges with satisfaction, the management and coordination of utilization, and cost are similar to those faced across the healthcare sector, and in some respects (e.g., high utilization) worse. This chapter discusses the root causes of these challenges and how they relate to TRICARE.

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<sup>8</sup> Additional projections include an increase of national health spending as a percent of Gross Domestic Product from 17.9 percent to 19.7 percent and an increase in the share of health expenditures financed by federal, state, and local governments (projected to rise from 45 percent in 2016 to 47 percent in 2026). “CMS Office of the Actuary Releases 2017-2026 Projections of National Health Expenditures,” Centers for Medicare & Medicaid Services, February 14, 2018, <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-02-14.html>.

## A. US Healthcare Policy Context

The majority of the US population receives health insurance coverage through large institutional payers (e.g., an employer or a large public program such as Medicare or Medicaid). These payers generally use insurance carriers to manage the health benefit and interface with the delivery system. One major element of healthcare reform is identifying ways to improve the alignment of incentives across these four sets of actors (beneficiaries, institutional payers, insurance carriers, and providers) to promote improved health outcomes and control cost. A key question is how the financial intermediary (insurance carrier) can improve healthcare value by coordinating and managing utilization, improving health outcomes, and enhancing the choices available to beneficiaries.

Private sector health insurance has evolved through a wide range of utilization management approaches, with the most notable public debate occurring in the 1990s between fee-for-service (FFS) insurers and health maintenance organizations (HMOs). FFS insurers played a smaller role in utilization management while HMOs, as originally conceived and executed, vertically integrated the insurance function and healthcare delivery system to provide intensive utilization management. Neither of these extremes became dominant, and private healthcare today is engaged in a dynamic period exploring new ways to improve value that include greater engagement with the delivery system (e.g., capitating primary care practices, bundling surgical episodes of care, and the formation of accountable care organizations (ACOs)) and beneficiaries (e.g., high-deductible health plans (HDHPs) and health savings accounts (HSAs)).

Historically, public health benefit programs (e.g., Medicare, Medicaid, and TRICARE) minimized utilization management and focused instead on procedure prices for cost control. Key elements of this approach include the FFS payment model, centrally directed “take-it-or-leave-it” procedure reimbursement rates, and little or no substantive risk bearing for the insurance carrier (which is basically a pass-through claims processing function in these programs).<sup>9</sup> This “price control” model provides little incentive to insurers or the delivery system to coordinate and manage utilization (and can even incentivize overutilization), limiting the ability to focus on improving health outcomes and leaving the only option for cost control the further reduction of reimbursement rates (with the result being further reduction of network size and access). These incentive problems

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<sup>9</sup> Some of these individual elements are still used in private sector healthcare, e.g., private PPO insurance plans that use FFS payments and large companies that self-insure. But the traditional public plans are unique in the degree to which they combine these elements. For example, private PPO plans are often capitated (risk bearing), providing incentives to manage utilization and replace FFS payments when needed, and, even when used by a self-insured company, must compete on performance results to be selected again the following year by that company.

are now well recognized and public health benefit programs have begun to transition away from a sole reliance on the traditional FFS reimbursement model. Examples include:

- **Medicare.** About two-thirds of Medicare beneficiaries remain in traditional Medicare. The first major reform was the introduction of a capitated option now called Medicare Advantage (MA), which creates a formal risk-bearing role for insurance carriers to coordinate and manage utilization for beneficiaries who opt into MA (approximately one-third of Medicare beneficiaries). CMS, which administers Medicare, has set goals for increasing the share of the remaining Medicare payments to be tied to alternative value-based purchasing (VBP) models (including 50 percent of individual Medicare payments made through alternative (non-FFS) methods by 2018).
- **Medicaid.** Unlike Medicare, Medicaid programs are run at the state level. Starting in the late 1990s, many states began shifting from the price control model to what are referred to as Medicaid managed care programs. Medicaid managed care programs use insurers to coordinate and manage utilization, but restrict their ability to change other benefit attributes, such as cost shares. CMS reports that, as of July 2016, over 43 million individuals—68 percent of the national Medicaid population—were enrolled in comprehensive managed care programs. CMS has established a core set of quality indicators for states to measure and report on using a standardized format; Medicaid managed care companies contracted to the states are held accountable for performance on these measures.
- **Veterans Choice.** The Department of Veterans Affairs (VA) has traditionally relied on producing most of its care in VA hospitals with minimal purchase of civilian healthcare. As the veteran population changes over time (e.g., shifting geographic patterns and generational differences in desired care experience), this “brick-and-mortar” approach has become less sustainable, and VA is now in the process of determining how to expand its use of PC. It is beginning to face the same challenge as the other public programs and faces the choice of adopting the price control-based model or leapfrogging over the legacy public programs by adopting what may prove to be a more sustainable approach.

## **B. Relating TRICARE’s Challenges to Root Causes**

Prior to the end of the Cold War, DoD provided the large majority of its healthcare in-house (as VA still does today). PC was used primarily for recruiters and others located far from military hospitals. However, the demand for PC expanded rapidly in the 1990s as the health benefit became more standardized and many DoD medical facilities closed as part of post-Cold War base closing initiatives. Although originally providing “spill over” care around military hospitals and between hospitals, the TRICARE PC contracts now

deliver over 60 percent of healthcare to DoD beneficiaries. The introduction of TRICARE Prime and what is now TRICARE Select coincided with the start of the shift from DC to PC. Their benefit designs are reflective of the delivery approaches that existed at that time: HMOs (especially the concept of assigning primary care providers) and FFS-PPO models. However, while private insurance models have continued to evolve, TRICARE's has remained largely static—even as the share of care delivered in the PC market has more than doubled.

While the price control model may have been appropriate for small amounts of spill over care around military hospitals, it is now at the root of many of TRICARE's challenges. Some basic issues include the following:

- **TRICARE cost control strategies are based on costs per procedure instead of the total cost for the care received.** One unfortunate impact of pass-through FFS contracting is that it focuses attention on per-procedure costs while distracting attention from, and providing few tools to manage, utilization and total cost. DoD's system is anchored in its use of Medicare reimbursement rates for procedures, and TRICARE often contracts for procedures below Medicare rates. This has become an overriding focus in DoD and a primary measure by which reform alternatives are evaluated (i.e., a key evaluation criterion is often whether it raises per-procedure rates). But, a key challenge with TRICARE is high utilization, and the price control model both incentivizes increased utilization (the non-risk bearing FFS payment model) and provides DoD with few tools to manage it. The result is that despite paying less per procedure, DoD pays more in total per beneficiary.

The private healthcare sector is trying to increase the focus on total cost and the value received for the amount paid. To take a common example (taken specifically from interviews conducted in Alexandria, Louisiana), a particular market may have several orthopedic surgeons performing total knee replacements. The best surgeons may charge higher rates for the surgery (there is higher demand for their services) but may also have lower costs for the entire episode of care (driven by such factors as lower failure rates, faster healing rates, and shorter physical therapy requirements). Private insurers will observe this difference and be willing to pay the higher surgical rate, incentivizing their patients to use the more expensive surgeons. This cannot be done in the TRICARE system; regardless of health outcomes and total cost, the surgeons with the lowest per-procedure cost will be the only ones allowed.

- **TRICARE cost control strategies reduce benefit quality.** DoD operates in healthcare markets. Medicare reimbursement rates to the delivery system average 20 percent below commercial insurance rates. TRICARE rates are lower than Medicare rates. This means that TRICARE is among the lowest payers in



the market and, thus, has among the narrowest networks and poorest access in the market. Most DoD beneficiaries have experience with private insurance (e.g., prior to joining the military, or perhaps with employer-based plans among the younger retirees) and work side-by-side with federal civilians who enjoy larger networks and access, highlighting this difference in care experience. But in the price control model, further reducing these rates (with the further reduction in networks and access) is one of the only tools available to DoD to control costs.

- **TRICARE contracts are long-lived and winner-take-all instead of competitive evergreen contracts.** TRICARE uses winner-take-all (one successful contractor per region) five-year (often extended) contracts. The process by which TRICARE's contracts are awarded is complicated, prolonged, and characterized by protests and delays, increasing TRICARE's costs. More importantly, the lack of annual competitions limits the winner's incentives to innovate and keep pace with healthcare trends and advances. Other public sector programs (such as Medicaid, Medicare Part C and D, and the Federal Employee Health Benefit Program (FEHBP)) make greater use of competitive mechanisms such as multiple offerors and annual price setting. Large, multi-year, winner-take-all contracts can appear simple at first and may be attractive for this reason, but TRICARE's experience demonstrates otherwise.
- **TRICARE contracting is based on pass-through (non-risk bearing) contracting for procedures instead of purchasing a benefit for an individual with a risk-bearing contract.** TRICARE is built on the employer purchasing individual procedures or visits (FFS contracting) rather than purchasing a comprehensive benefit (from an insurer) for the individual or family (premium-based model). Purchasing a benefit rather than procedures incentivizes the financial intermediary to coordinate care, manage utilization, and promote health outcomes—the key outcomes of interest. It is important that this purchase of a benefit transfers risk to the contractor (through capitated contracts and/or through competition),<sup>10</sup> creating the incentive for the contractor to control the cost of providing the benefit (e.g., by coordinating care, managing utilization, etc.) and improve quality. The payment arrangements used between risk-bearing carriers and the delivery system are rapidly evolving as carriers shift towards paying for value and outcome rather than services (a VBP model).

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<sup>10</sup> Some employers self-insure, motivated in some cases by regulatory incentives (self-insuring exempts employers from some insurance regulations). In these cases, an insurer is frequently hired with a performance-based contract to manage the health benefit. The insurer faces two key incentives in these relationships: the performance-based contract and the threat of not being rehired the following year (i.e., competition).

## C. US Healthcare Policy Questions

The previous sections identified challenges facing national healthcare and their connection to TRICARE's problems. Of most direct relevance is the reform of the large public health benefit programs (e.g., Medicare and Medicaid) whose traditional structure is the basis for TRICARE. The central policy questions are:

- What is the performance (cost control, beneficiary satisfaction, and health outcomes) of the traditional price control-based structure compared to a competitive, utilization management (i.e., insurance-based) structure for public health benefits?
- What is the best competitive insurance-based program design to transition to?
- How can the transition from the traditional price control-based program to a competitive insurance-based program be implemented to minimize disruption to beneficiaries?

These are the same central questions for TRICARE reform. For the first question, there is reasonably broad agreement that the traditional price control-based approach is not sustainable and transition to a competitive structure is required. Medicare's movement away from the traditional model was unchanged by the transition from the Obama to the Trump administrations, there is widespread support for continuing Medicaid transformation in the United States, and the Senate Armed Services Committee has been a leading advocate for reform of TRICARE. Agreement is not universal, however, and additional evidence on the relative merits of the two program structures would be a valuable addition to the public debate.<sup>11</sup> More importantly, the second and third questions are fundamental to the design and implementation of a reform agenda. They have been at the center of Medicare and Medicaid reform debates for over 20 years and are the same fundamental questions DoD faces now as it considers TRICARE reform. TRICARE reform pilots provide an opportunity for direct, controlled testing of alternative program design and transition options.

These high-level policy questions about modernizing program design lead to subsidiary questions about the specific mechanism by which a competitive insurance-based

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<sup>11</sup> One exception to this broad agreement is the Congressional Budget Office (CBO). It has long been an advocate for the price control-based approach in Medicare (see CBO, "Long-Term Analysis of a Budget Proposal by Chairman Ryan" (Washington, DC: CBO, April 2011), <https://www.cbo.gov/publication/22085>; and CBO, "A Premium Support System for Medicare: Analysis of Illustrative Options" (Washington, DC: CBO, September 2013), <https://www.cbo.gov/publication/44581>) and TRICARE (see CBO, "Approaches to Changing Military Health Care" (Washington, DC: CBO, October 2017), <https://www.cbo.gov/publication/53137>). Robert Samuelson provides another recent example (Robert J. Samuelson, "There's a Genuine Solution to Our Health-Care Problem," *Washington Post*, April 29, 2018, [https://www.washingtonpost.com/opinions/theres-a-genuine-solution-to-our-health-care-problem/2018/04/29/2d82bdf2-4a3e-11e8-9072-f6d4bc32f223\\_story.html?utm\\_term=.ae890b9a2df3](https://www.washingtonpost.com/opinions/theres-a-genuine-solution-to-our-health-care-problem/2018/04/29/2d82bdf2-4a3e-11e8-9072-f6d4bc32f223_story.html?utm_term=.ae890b9a2df3)).

program structure affects cost and outcomes. There are two key sets of questions at this level:

- What is the relative importance of the incentives facing beneficiaries (demand-side incentives) for improvements in cost control and outcomes, and what are the most important design attributes for demand-side reform?
- What is the relative importance of the incentives facing the delivery system (supply-side incentives) for improvements in cost control and patient outcomes, and what are the most important design attributes for supply-side reform?

The next chapter reviews historic and ongoing research that has focused on these questions and how TRICARE reform pilots can further expand this evidence base.



## **4. Healthcare Experiments and Pilots**

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The design and impact of demand-side and supply-side healthcare interventions have been tested in previous experiments and pilot programs. The most prominent experiments on these topics are the RAND Health Insurance Experiment (HIE) (focused primarily on demand-side incentives) and the ongoing pilots being conducted by the CMS Center for Medicare & Medicaid Innovation (CMMI) (focused largely on supply-side incentives). Here we review these programs and discuss the evidence they provide as well as the information gaps left for subsequent study. We then turn to identifying specific questions DoD could address with TRICARE pilots.

### **A. The RAND Health Insurance Experiment**

One of the most influential health experiments to date was the HIE, which began in the early 1970s. This experiment, which focused on demand-side incentive reforms, provided some of the best evidence to date on the impact of cost-sharing and helped encourage the restructuring of private insurance and managed care. The research was funded by the Department of Health, Education, and Welfare (now the Department of Health and Human Services).

The RAND HIE tested the impact of different coinsurance rates and HMO membership on healthcare utilization and health outcomes. Results indicated that cost sharing reduced utilization and, in most circumstances, did not negatively affect health. It involved random assignment of beneficiaries into treatment groups, which ensured a high level of validity in these findings. Appendix A contains a more detailed review of the RAND HIE.

One key element of the value of the RAND HIE was that it was a true experiment. It had a simple intervention with clear mechanisms of impact (e.g., the testable hypothesis is that raising beneficiary cost shares lowers utilization and thus cost). The clear nature of the hypothesis and evaluation structure led to fairly conclusive evidence with a high degree of validity. A challenge with it today is that, at age 40 years, the results are dated. Healthcare has evolved significantly since the RAND HIE and now differs in fundamental ways from how it functioned in the 1970s. Medicine has become more specialized, and emphasis on

preventative care and prescription drug use has grown.<sup>12</sup> Cost sharing has also changed with the use of such methods as tiered networks and co-pays and waiving of co-pays for some preventative services. The composition and needs of the US population have changed, and questions about cost shares (e.g., the impact of HDHPs) have evolved since the time of the study. While a large body of literature has studied the elasticity of demand for healthcare, plan choice, and the impact of the newer HDHPs or consumer-driven health plans (CDHPs), evidence is often mixed and many questions remain.<sup>13</sup> In short, we have new information gaps on the demand side of healthcare management and new experimentation with demand-based healthcare interventions would aid policy makers. By studying the past literature, we can pin down key research questions and develop experiments that can be used to answer them.

## **B. CMS Innovation Center Pilots**

A major component of the ACA was the creation of the CMMI, or CMS Innovation Center, tasked with testing innovative payment and service delivery models designed to reduce expenditures while preserving or enhancing the quality of care.<sup>14</sup>

Today there are over 40 specific reform options being tested across several categories by CMMI. Unlike the way the RAND HIE was conducted, these models are not being tested with a randomized controlled trial (RCT) framework. Instead, providers or organizations interested in testing some form of intervention apply to participate in a given CMMI program. The impact of the intervention is determined by comparing participant outcomes to outcomes of non-participants with similar characteristics (e.g., similar-sized hospitals in the same market area or Medicare beneficiaries not enrolled in an ACO). This approach offers several advantages, specifically the speed at which new programs can be tested and the flexibility of the participants to adapt and make real-time changes based on what they are learning. A disadvantage is that findings obtained in less rigid evaluation frameworks can lack internal and/or external validity—it may be hard to determine whether

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<sup>12</sup> Robert H. Brook et al., “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate,” RB-9174-HHS (Santa Monica, CA: RAND Corporation, 2006), [https://www.rand.org/pubs/research\\_briefs/RB9174.html](https://www.rand.org/pubs/research_briefs/RB9174.html).

<sup>13</sup> For a good discussion of empirical literature in the context of the MHS, see Jeanne S. Ringel et al., “The Elasticity of Demand for Healthcare: A Review of the Literature and Its Application to the Military Health System,” MR-1355-OSD (Santa Monica, CA: The RAND Corporation, 2002), <http://www.dtic.mil/dtic/tr/fulltext/u2/a403148.pdf>. For a summary of empirical evidence on the impacts of CDHPs, see Melinda Beeuwkes Buntin et al., “Consumer-Directed Health Care: Early Evidence About Effects on Cost and Quality,” *Health Affairs* 25, no. 6 (November-December 2006): w516–30, <https://doi.org/10.1377/hlthaff.25.w516>.

<sup>14</sup> The CMS CMMI was created by section 3021, “Establishment of Center for Medicare and Medicaid Innovation within CMS,” of the ACA, Pub. L. No. 111-148.

the intervention actually drove the outcomes of interest (as opposed to some other factor) and, if so, how broadly the findings can be applied.

Appendix A contains a more detailed description of a sample of CMMI programs. The CMS CMMI demonstration programs have not been able to yield the same degree of concrete findings to date as the RAND HIE. Although valuable information is being obtained from this work, there is still a significant need for additional healthcare policy experiments to inform the broader healthcare debate. Evidence suggests that insurance carriers and delivery systems are achieving success in generating savings through supply-side interventions.<sup>15</sup> However, much of the evidence on private sector innovation is proprietary and yields a competitive advantage, reducing available public information about the reforms. The CMS CMMI is contributing to filling this knowledge gap by conducting pilot programs on supply-side interventions, but its limitations with respect to experimental design are reducing its ability to answer key questions.<sup>16</sup> In addition, the CMMI programs are focused on the Medicare and Medicaid programs, whose beneficiaries are not representative of the US population as a whole. Moreover, CMMI experiments are not designed to test important questions such as the value of plan choice and the behavior of beneficiaries when given plan choice. In short, we still have information gaps on the supply side of healthcare management that will not be conclusively addressed by the CMMI, and new experimentation with supply-based healthcare interventions would aid policy makers.

### **C. Specific Questions to Address with Pilots and Experiments**

Two central policy questions identified in Chapter 3 were how to design reforms and how to manage transitions. These questions can be further divided into concrete questions that can be concretely tested using pilots.

#### **1. Designing Reforms**

As revealed in Section 3.C, there are many considerations in designing public health benefit programs to focus on maximizing incentives for competition and utilization management. Although it is not a perfect categorization, for practical use, Section 3.C

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<sup>15</sup> Testimony of Marinan Williams (former Chief Operating Officer, Scott & White Health Plan), Esteban López (President, San Antonio Region, Blue Cross Blue Shield of Texas), Herb Fritch (CEO, Cigna-HealthSpring), and Sandra Guerra Delgado (Chief Medical Officer for Humana Government Business) to the MCRMC, January 7, 2014, San Antonio, TX.

<sup>16</sup> For a discussion of such challenges, see Gina Kolata, “Method of Study is Criticized in Group’s Health Policy Tests,” *The New York Times*, February 2, 2014, [https://www.nytimes.com/2014/02/03/health/effort-to-test-health-policies-is-criticized-for-study-tactics.html?hpw&rref=politics&\\_r=0](https://www.nytimes.com/2014/02/03/health/effort-to-test-health-policies-is-criticized-for-study-tactics.html?hpw&rref=politics&_r=0).

loosely designated key incentives as either demand-side (beneficiary) or supply-side (delivery system):

- **Demand-Side Incentive Reforms.** These reforms target beneficiary demand for healthcare services. The most common examples are using cost shares to affect healthcare service choices, such as increasing beneficiary OOP fees for routine healthcare, but can include a wide range of other changes that affect the demand for care, such as tiered networks, smart phone applications, wellness awards, and step trackers to monitor (and, in some cases, incentivize) healthy lifestyles.
- **Supply-Side Incentive Reforms.** These reforms target waste and inefficiency in the production and delivery of healthcare services (e.g., use of ineffective or unnecessary treatments, prescribing expensive pharmaceuticals when generics are available, and duplicate services due to lack of coordination). Academic studies of the US healthcare sector have generally concluded that wasteful spending consumes somewhere between \$500 billion and nearly \$1 trillion of all spending or—perhaps more pointedly—that somewhere between 18 and 37 cents of every dollar spent on healthcare is wasteful.<sup>17</sup> Much of the effort on supply-side reforms involves shifting away from reimbursing providers on an FFS basis, which rewards the volume and intensity of services they provide, and towards VBP reimbursement models, which tie payments to patient outcomes while also rewarding (penalizing) cost savings (cost growth).

Determining the relative impact of specific demand- or supply-side interventions is of great interest to those charged with designing reforms. For example, over much of the last 15 years, DoD has assumed that demand-side changes (more specifically, raising cost shares) were the most important element of TRICARE reform. Testimony by healthcare researchers and private insurers to the MCRMC, however, revealed that their experience in transitioning unmanaged populations into a reformed structure generally found about half the gain coming from demand-side changes and half coming from supply-side changes.<sup>18</sup> In addition, important testimony by beneficiary groups pointed out that isolated cost share increases are a cut to compensation; they may save some money by improved efficiency of healthcare utilization but they also simply shift costs to later years in the defense budget when compensation has to be increased elsewhere to maintain recruitment and retention of the force. Enhancing choice, access, and networks, along with shifting to lump sum compensation as per unit subsidies are reduced, are steps that can be taken to incorporate demand-side changes while minimizing unintended harm to the force.

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<sup>17</sup> For an excellent review of the literature on waste in the US healthcare sector, see “Reducing Waste in Health Care,” *Health Affairs* (December 13, 2012), <https://doi.org/10.1377/hpb20121213.959735>.

<sup>18</sup> Testimony of Dr. Gail Wilensky, Project HOPE, to the MCRMC on April 9, 2014.



These interconnecting relationships among all elements of reform make designing reforms particularly complex. Pilots allow for direct testing of specific elements of reform. Specific questions that need to be addressed to inform policy reform and that can be tested with properly conducted experiments and pilots include the following:

**a. Demand-Side Incentive Questions**

Important demand-side questions and testable key subordinate questions include:

- **How do demand-side interventions affect plan choice and utilization?**
  - If consumers are offered a range of plan options with different premiums and cost sharing provisions, how will they shop for care? Will they choose high-cost plans that maximize provider choice, mid-range plans with greater care management, or lower-cost HDHPs with HSAs?
  - Will consumers take advantage of price tools and quality ratings in making their decisions?
  - The plans chosen will contain higher and lower levels of cost sharing for individual services. These varied levels of cost sharing will influence healthcare utilization. What is the magnitude of the savings associated with the reduced utilization?
  - For which services will utilization change? Can smart benefit design result in utilization reduction for unnecessary/non-effective treatments and increased use of beneficial/effective treatments?
- **How do demand-based interventions affect patient outcomes and overall health?**
  - Will patients have poorer health outcomes as a result of reducing their consumption of medical services? If so, what is the impact of exempting certain services from cost-sharing requirements (e.g., preventative care and screenings, certain pharmaceuticals, services for the chronically ill)?
  - Will they respond to financial incentives to adopt healthier lifestyles, e.g., premium differentials for non-smokers, efforts to quit, wellness incentives and reward programs, etc.?
  - Will greater incentives for seeking out higher value providers and treatments lead to better health outcomes?
- **How do demand-based interventions effect compensation?**
  - Is a lump-sum cash increase compensating for increased cost shares considered a compensation improvement by beneficiaries?

- How much do beneficiaries value expanded choice and ownership of their healthcare plan?

#### **b. Supply-Side Incentive Questions**

Important supply-side questions and testable key subordinate questions include:

- **How do supply-side interventions like VBP affect the cost of delivering the benefit?**
  - Does increasing competition among carriers result in better value for employers and beneficiaries?
  - Does increasing the use of risk-bearing contracts result in a reduction in the quantity or total cost of the services provided to beneficiaries?
- **How do supply-side interventions affect patient outcomes and overall health?**
  - Will supply-side interventions result in quality improvements due to better care coordination, and a focus on higher value treatments?
  - Alternatively, will supply-side interventions result in quality regressions if the delivery system tries to minimize expenditure by rationing care?
  - What quality monitoring requirements and incentives are necessary to avoid reductions in care quality and patient satisfaction?

## **2. Managing Transitions**

Equally important to policy makers as getting the reform designed correctly is building support for the reform and implementing it in a way that maximizes its acceptance and chances for long-run success. The backlash against HMOs in the 1990s, the controversies stemming from the mandatory aspects of the ACA, the lack of a congressional majority in favor of Medicare reform, and the repeated congressional resistance to DoD's initiatives to raise retiree cost shares are all examples of why understanding the implementation challenges and distributional effects of policy changes can be just as important as understanding the expected efficiency improvements. New regulatory structures and new public healthcare programs will be complex, may be difficult to implement, and may have unintended consequences. Timing can be another major factor if the savings from better utilization management take time to materialize, while the costs of the reform may appear immediately. To enable TRICARE beneficiaries to experience price signals from cost-sharing provisions without experiencing a significant loss in their overall compensation, there will need to be some type of additional payment for health-related expenses. In the medium to long term, lower utilization may pay for the increased compensation, but without the short-term expenditure, the experiment may never get off

the ground. Similarly, provider reimbursement rates will be different and it will take time to for this to be reflected in networks and access. Finally, even the best-designed policy reform will likely have both winners and losers among the affected populations (both within the set of beneficiaries and between beneficiaries, insurers, employers, and the delivery system).

Pilots are key ways to test for support for reform, implementation challenges, and unintended consequences. Large, seriously conducted reform pilots will generate news coverage and interest among beneficiaries, even those not part of the pilot. Successful pilots will earn positive reviews from the beneficiaries that participate and this word will spread to non-participating beneficiaries, generating momentum for expansion of reform. Pilots also will reveal challenges, generate lessons learned, and provide insights on how to do better next time. For changes as complex and personal as healthcare reform, learning these lessons on a smaller scale can be critical to achieving success for full and comprehensive reform. And, no matter how well designed, all programs risk having unintended consequences. Learning what these are and how they can be mitigated in pilots can improve the chances of success for full reform.



## 5. Potential TRICARE Interventions

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A great variety of interventions could be tested with TRICARE pilots, but these can generally be placed into three primary categories: integrated supply- and demand-side changes, demand-side-only interventions, and supply-side-only interventions. This chapter outlines potential interventions in these categories. There are many other variations of these options that could be implemented, but the focus here is to identify only the major categories; most other options will be variants of the three broad categories outlined here.

### A. Full Reform: Integrated Demand- and Supply-Side Interventions

A full reform of TRICARE would incorporate both demand- and supply-side interventions. This would entail a cafeteria-style menu of private insurance options like the FEHBP, the ACA exchanges, and the range of plans offered by some large employers. Beneficiaries would be exposed to premium costs and co-pays to introduce demand-side incentives, and the insurance plans competing in the marketplace would be fully risk-bearing at a fixed annual premium level. Beneficiaries could be compensated for the premium and co-pay cost increases with a lump-sum payment like the Basic Allowance for Healthcare (BAHC) proposed by the MCRMC.

A pilot using this design would allow for the testing of the full range of supply- and demand-side high-impact questions, including:

- How do cost shares affect utilization and health outcomes?
- How much do beneficiaries value choice, expanded networks and access, and different plan designs?
- How effective are insurer non-price tools (e.g., VBP) at coordinating and managing utilization, and does this affect health outcomes?
- What is the impact to DoD of using all reform tools together?

By moving to a full market for plans, this reform pilot design provides the largest improvement to incentives and maximizes DoD's impact in the market in which it operates (the DoD-to-carrier market). One challenge with assessment strategies in this pilot design would be separating out the demand- and supply-side impacts on utilization and health outcomes; this would likely require additional and unique data collection—e.g., on the extent of VBP tools used by the carriers—over the course of the pilot.

## **B. Partial Reform: Testing Demand-Side Incentive Interventions**

When the marginal cost of consuming healthcare services is zero or very low, beneficiaries are less likely to consider the marginal benefit of doing so—they fail to ask whether the services are necessary or useful (what is the benefit of going to the doctor today if I likely have a minor virus, what is the benefit of having that test every year as opposed to every other year, etc.). Providers also have less incentive to rigorously communicate the costs and benefits of alternative options to the beneficiary. This incentive problem can be reduced by raising beneficiary cost shares. This represents a reduction in compensation, and beneficiaries can be protected from this by providing cash compensation in coordination with the increased cost shares, the classic economic example of shifting from a distorting per unit subsidy to a non-distorting lump-sum payment. In a full market with choice over plans, these cost shares include both the premium cost to the beneficiary and incremental costs of healthcare services such as co-pays and deductibles. A more limited intervention can focus on just co-pays and deductibles.

As previously discussed, a challenge associated with TRICARE is that its cost sharing is low and out of step with civilian healthcare, and that this is likely a cause of the high utilization levels of TRICARE beneficiaries. A pilot intervention to examine this factor in isolation would be to provide a higher cost share option of TRICARE along with a DoD-funded HSA to compensate for the cost increase. This pilot design would be much like an HDHP and use the civilian HSA concept to neutralize the cost increase for the average beneficiary. HDHPs offer lower premium rates than traditional health plans (which TRICARE already does) but require beneficiaries to meet a higher deductible—the OOP amount they must pay before insurance coverage kicks in. For 2018, the minimum deductible that classifies a plan as an HDHP is \$1,350 for individuals/\$2,700 families.<sup>19</sup> To help cover OOP expenditures, DoD could provide its beneficiaries with DoD-funded HSAs. The money contributed to these accounts would be owned by the beneficiaries, and funds remaining at the end of the coverage year would roll over each year (not “use it or lose it”). The TRICARE program design and contract structure would be otherwise unchanged. A more expansive pilot would increase OOP and premium costs (for both Prime and Select) while providing a BAHC.

This pilot design would provide a clear and direct test of the impact of (non-premium) cost shares on utilization and health outcomes, and a test of the programmatic design change of replacing a per unit subsidy with a lump-sum subsidy. It would be limited to only affecting some demand-side incentives, provide no change to supply-side incentives, and would leave other benefit attributes (e.g., network size and access) unchanged—a major disadvantage when trying to evaluate beneficiary satisfaction and valuation of

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<sup>19</sup> The Internal Revenue Service sets maximum OOP amounts (or catastrophic caps) for HDHPs to shield beneficiaries from excessive costs. These are currently \$6,650 for individuals/\$13,300 for families.

benefit attributes. It would allow for an examination of potential employee satisfaction and retention issues with this form of compensation change.

### **C. Partial Reform: Testing Supply-Side Interventions**

As previously discussed, the TRICARE program uses a five-year, winner-take-all, pass-through contracting structure based on FFS reimbursement. The cost control strategy inherent in this model emphasizes minimizing per-procedure rates (price control strategy). Managing utilization and procedure value are de-emphasized. Alternative models put less emphasis on minimizing per-procedure rates and more emphasis on managing utilization and value (e.g., use higher-cost providers with better quality/outcome ratings). These models control costs by placing greater financial pressures on the carriers and delivery system to keep total healthcare expenditure costs down.

Medicare and Medicaid have experimented extensively with program designs that attempt to capture these benefits while stopping short of providing a full range of plans in a market that uses premium price to facilitate beneficiary choice of plans. Examples include the following:

- **Medicare Part C (Medicare Advantage).** A health insurance program that serves as a substitute for “traditional” Medicare (Part A and B). Each year, plans submit “bids” (per enrollee cost) to cover the standard Medicare Part A and B benefits (i.e., the benefit, including cost shares, is being held constant). Every plan that meets specified requirements is accepted. The bids are compared to formula benchmarks that establish the maximum amount Medicare will pay to a plan in a given area. Plans with bids higher than the benchmark are permitted (enrollees pay the difference as a monthly premium). Plans that bid below the benchmark split the difference between the bid and the benchmark (government savings is one share and the other share is used to provide additional benefits or reduced costs to enrollees). The government maintains direct authority to specify the minimum benefit provided.
- **Medicare Part D (Pharmacy Benefit).** The pharmacy benefit in Medicare. Each year, plans submit bids to provide a pharmacy benefit meeting minimum benefit requirements. The national average of the bids is then used to develop a government subsidy amount and monthly premiums for beneficiaries. Beneficiaries are administratively allocated to the included plans using a formula based on plan bids.
- **Medicaid Managed Care Programs.** In most Medicaid managed care programs, states use a modified competitive bid process. Operating under guidance from CMS, states set the parameters for the bid package in terms of benefits, network adequacy, quality measures, access, and other features. Plans

bid on their ability to provide the required package of services, and may offer additional services to enhance the value of their bid. The state then selects a number of plans (3–5 is common) from which recipients can choose. Recipients can change plans for cause or during an annual open enrollment period. The contracts are usually rebid on a five-year cycle.

What all of these programs have in common is that they stop short of creating a complete price (premium)-based market and instead use risk-bearing carriers to offer a fixed benefit. They differ in the allocation mechanism of beneficiaries to plans (e.g., in Medicare Advantage the beneficiaries select plans and in Medicare Part D beneficiaries are administratively assigned to plans). The key characteristic for TRICARE reform pilot design is that the carriers are risk bearing and incentivized to use the full range of supply-side interventions to manage and coordinate utilization and improve health outcomes.



## 6. Assessment Strategies for TRICARE Pilots

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A TRICARE pilot program with well-designed reform interventions can still fail to provide the type of evidence required to inform reform decisions if the right data are not collected or if the program's experimental design does not produce clear conclusions. To avoid these common pilot pitfalls, DoD must carefully determine three key pilot parameters prior to the start of the pilot. These include the following:

- **Pilot Evaluation Goals.** DoD should set clearly defined goals prior to pilot implementation that will be used to determine what it means for the pilot to work or be successful. These goals should correspond to the underlying reform objectives and, if necessary, be prioritized.
- **Pilot Evaluation Design.** One of the most common reasons pilot programs fail to provide useful information is poor evaluation design—evaluators are unable to demonstrate whether or not the pilot intervention is actually behind the observed changes in variables of interest (e.g., utilization changes or quality improvements). Defining evaluation criteria and determining their data requirements in advance increases the chances of getting clear results. There must also be clearly defined treatment and control groups.
- **Pilot Scale.** Pilot scale can greatly influence the external validity of pilot findings. The results of a single pilot program conducted in a single market area may not be viewed with much confidence, even if they are very conclusive, due to a concern that the program's success or failure might be driven by local factors and may not take into account the significant variation in healthcare markets across the country. Using multiple test sites will increase the external validity of pilot findings. The number of participants at each site should be determined based on statistical considerations.

The remainder of this chapter discusses each of these factors in more detail.

### A. Pilot Goals

Pilots must start with specific and well-defined questions (see sections 3.C and 4.C) and then identify clear evaluation criteria. The primary evaluation criteria for TRICARE reform pilots include:

- **Cost.** What is the cost of the benefit in the pilot and how does this compare to control groups? What are the most effective methods of controlling cost?

- **Utilization.** How do incentive changes for beneficiaries in the plan designs (premiums, cost sharing, etc.) influence care-seeking behavior? How do incentive changes for the delivery system influence the coordination of care and the services provided? How does this compare to control groups?
- **Satisfaction.** How satisfied are beneficiaries with their insurance coverage and care experience? How did plan and provider choice, access, and network size change? Do beneficiaries believe they are getting higher quality care? Does the ability to choose from multiple insurers and plan types increase their satisfaction? How does this compare to control groups?
- **Quality Assurance/Performance.** How do private plans perform compared to the standard TRICARE package on quality and performance measures?
- **Health Outcomes.** Are there any changes in the health outcomes of pilot participants compared to control groups?

## **B. Pilot Evaluation Structure**

The evaluation design should be set prior to beginning the pilots, as it will influence both design decisions and contracting requirements (i.e., insurer data and reporting requirements). There are numerous factors that can cast doubt on the internal validity of pilot findings. These include but are not limited to selection bias (are the treatment and control groups systematically different), attrition bias (are the participants who remain in the treatment group different from those who drop out), and omitted factor bias (is some factor other than the intervention driving the results). Because factors such as these can cast doubt on the results, every effort should be made to ensure the results will have a high degree of internal validity. Random assignment should be used when feasible.

Two of the most important design elements are determining the treatment and control populations and determining data requirements. Pilot design decisions determine which individuals will be exposed to the pilot intervention and which individuals will serve as the benchmark or comparison group. Potential strategies for this decision include:

- **Random assignment of participants.** Ideally, beneficiaries in the pilot area would be randomly assigned to pilot and control groups, where the control group is offered the same TRICARE program as before. This approach controls for local or temporal factors affecting the insurance market and enables a true comparison. Random assignment also ensures that the beneficiaries receiving the treatment are not somehow systematically different from the control group (e.g., that only the healthiest beneficiaries are selected to participate in a new plan). Such an approach, however, has enormous practical problems (communications, contractual issues, etc.) that can make it very challenging to implement. One way to partially overcome these problems is to allow voluntary

application into the pilot and then randomly divide the group of volunteers into a treatment group (given the pilot benefit) and a control group (not given the pilot benefit).

- **Pre-post analysis.** In this type of analysis, key population metrics are observed prior to the implementation of the pilot intervention and then compared to results collected as the pilot progresses (e.g., compare a given population's total healthcare utilization and spending before intervention and during intervention). This approach is relatively straightforward to implement, but presents challenges when interpreting findings, as conditions that affect outcomes of interest can change over time independent of the pilot (e.g., independent changes in a local healthcare delivery system may affect quality or costs, or changes in economy may affect beneficiaries' willingness to utilize healthcare services).
- **Comparisons to groups outside the pilot.** Another approach is to identify populations with similar characteristics in non-pilot areas that can be compared to those in the pilot areas (e.g., expose beneficiaries in one catchment area to a pilot intervention and compare their metrics to beneficiaries in a different catchment area where no intervention occurred). Such an approach addresses some of the issues in a pre-post analysis but results may be obscured by local market conditions.
- **Mixed methods using more than one design.** A mix of methods, usually pre-post and comparison group analysis, is often used to allow evaluators to consider observed changes from several perspectives.

Along with the type of evaluation, the types of data that will be collected and analyzed should also be established early. To address a range of program parameters, data of several different types will be needed.

- **Survey data on enrollee satisfaction and behavior.** Surveys of individuals are useful for getting information on the experience of care (e.g., whether a beneficiary could find a physician, or whether appointments were available). Some survey tools, such as the Consumer Assessment of Health Plans Survey (CAHPS), are conducted nationally and can provide useful benchmarks. Surveys are not particularly useful for answering utilization and quality process questions.
- **Claims/encounter data.** Encounter and claims data are very useful for measuring utilization and assessing how well the overall population is served. Claims and encounter data also can help address ad hoc questions that may arise as the pilots progress. Finally, if the expectation is that plans will provide encounter data for analysis of the pilots, those requirements will need to be clearly addressed in contracts.

- **Audited performance measures.** Measure sets, such as the Healthcare Effectiveness Data and Information Set (HEDIS), can also provide important insights into the performance of the pilots. These measure sets use standardized rules whose application by plans is subject to outside auditors. They allow plan performance to be assessed against national benchmarks.

### **C. Pilot Scale**

Here we discuss three key issues relating to the scale of TRICARE pilots: (1) the number of pilots, (2) the size of each pilot program, and (3) the duration of each pilot. Another issue closely related to pilot scale is pilot location. This is addressed in Chapter 7.

The pilot size can be measured by the number of individuals exposed to the pilot treatment (e.g., 1,000 people, 5,000 people, 5,000 families, etc.). To select the right number of participants, DoD will have to weigh statistical considerations such as power against administrative costs and management complexity factors.

As previously discussed, conducting pilots in a single area has limitations, as it can only provide insights into that area, making it challenging to determine the role that local factors might have played in the ultimate success or failure of the pilot. Ideally, pilots should be conducted in multiple markets with recognizable differences in certain market features that could affect pilot outcomes (e.g., population size, market concentration, market competitiveness, urban versus rural, etc.). Selecting the optimal number of pilots will be a tradeoff between the enhanced validity created by including more sites and the administrative costs and complexity associated with doing so.

If the pilots are to provide valuable information, they will also need sufficient time to demonstrate their strengths and weaknesses. Moving TRICARE to a value-based system will represent a significant departure for many involved and their response to new structures and incentives will not be immediate. Therefore, the pilots will need to run for multiple years to provide useful information. The constraining factors on the length of pilots will include administrative costs, issues with attrition, and any timelines imposed by DoD.

## 7. Implementing TRICARE Reform Pilots

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In this chapter, we discuss key implementation considerations for TRICARE pilots. These include selecting the location of pilots, as well as operational issues such as selecting insurers, managing enrollment, and ensuring the required health insurance capabilities/infrastructure needed to manage the pilots is in place.

### A. Location of Pilots

A number of factors should be weighed when deciding where to locate the pilots. The locations will both influence the likely success of the pilots and provide insights into the challenges that might affect a wider roll-out of the approach. Factors to consider include:

- **Availability of Military Treatment Facilities (MTFs) in the service area.** MTFs present special challenges to any pilot as their presence will require specific workarounds by insurers and/or adaptations by MTFs to participate fully as contracted providers. Therefore, a pilot in an area with no MTFs might be desirable, as that would be a “clean” experiment. Conversely, any large-scale roll-out will require addressing MTF issues, so having some pilots with MTF availability in the area will be important to inform a wider program roll-out.
- **TRICARE population.** For any pilot to provide useful information, it must have a population sufficient to test the various aspects of the model. Will individuals choose? What types of plans do they prefer? How well do plans perform? These questions cannot be answered unless a sufficient population participates in the pilot. At a minimum, an enrollment base of several thousand is essential.
- **TRICARE concentration.** Similarly, the share of TRICARE members in the local market will influence the response of the local market. In densely populated areas, where TRICARE is a small share of all enrollment, insurers may not aggressively pursue TRICARE business (especially if TRICARE is believed to present additional administrative burdens). Conversely, if TRICARE represents a large share of the local market, insurers will be more likely to aggressively seek the business, potentially leading to lower prices and better value.
- **Local market for insurance.** Insurance markets across the country are not homogeneous. While much has been made of counties with only one insurer in

exchanges, those counties are generally located in rural areas. Most urban areas will have multiple insurers, although those insurers may not offer different approaches to care. Ideally, the pilot markets will have multiple insurers that offer a range of products (HSA vs PPO), use varying delivery systems (highly integrated vs. FFS), and have experience with VBP.

- **Local market delivery system.** Local delivery systems will have varying degrees of integration. For example, markets will have highly concentrated hospital-centered delivery systems (including salaried providers, outpatient facilities, etc.). If one large system dominates an area, insurers may have little leverage to offer competing products.

## **B. Operational Issues**

Separate from the design of the pilots, there are operational issues that, if poorly handled, determine the success or failure of the pilots before anyone has even been enrolled.

### **1. Selecting Insurers**

TRICARE does not have the ability to use an unstructured selection process, as might be the case in the private sector. It will need to follow the lessons of other public programs when selecting plans. These are several approaches that can be used.

#### **a. Open Application Process**

Under this approach, DoD would begin the process by establishing a set of plan standards. Insurance carriers interested in offering a plan to the TRICARE population would then submit bids that represent the payment amount they would need in order to cover the expected costs of the benefit offered by the plan for an average-risk beneficiary. DoD would accept all bids that meet some pre-determined benchmark. This process would occur annually to allow for new entrants. Plans already in the market would remain unless they choose to withdraw or are consistently very poor in quality and overall performance (a rare occurrence). This is referred to as “evergreen” contracting, as the annual contracts are automatically renewed. This type of approach is used by the FEHBP, the MA program, and state health insurance exchanges. The benefits of this approach include:

- **Low barriers to entry.** Any insurance carrier wishing to participate in the TRICARE program can offer a bid to provide a plan. The process also occurs more frequently (annually) than bid processes with a limited number of winners (typically every five years).

- **Maximizes competition.** Plans that are accepted to the exchange must compete with other plans to attract beneficiaries. The number of plans is not limited for any geographic area or time period.
- **No bid protests.** Under this type of contracting, all plans meeting the predetermined plan standards and cost benchmarks are accepted. This avoids the risk of bid protests, which are currently very prevalent in the TRICARE program. Bid protests can impose large financial and time costs on the TRICARE program.

While the benefits associated with these plans appear large, in practice, there are also drawbacks associated with this approach:

- **Can discourage new entrants to the market.** Most individuals, if healthy, have relatively little contact with the delivery system and their insurer. As such, they tend to stay in their plan from year to year unless a significant event (illness that leads to dissatisfaction with coverage or options) or a significant change in premium cost occurs.<sup>20</sup> An insurer seeking to come into that market will need to have a long time horizon for growing their patient population under such circumstances.
- **Limits market leverage.** The TRICARE population represents a very attractive business opportunity for any insurer. However, the value of the TRICARE population is directly proportional to the number of covered lives it represents to the insurer. The larger the population, the greater the incentive for the insurer to offer competitive pricing and products responsive to the particular needs of the TRICARE recipients.
- **Can lead to non-optimal number of choices for consumers.** Sometimes having a large number of health plan choices can overwhelm beneficiaries and have the counter-intuitive effect of reducing engagement.

#### **b. Bid Process with Multiple Winners for One Location**

Under this approach, DoD would announce that it is accepting bids for TRICARE plans and the number of contracts that it intends to award (e.g., five contracts will be awarded to offer a TRICARE plan in a given area). Insurers will then submit proposals to DoD, which will evaluate those proposals and award contracts to those plans that best meet its criteria. Contracts are then awarded for a set period (five years is common). While this has many similarities with the current TRICARE bid process, a key difference is that no single carrier is awarded monopoly rights for a given region. This process would be similar

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<sup>20</sup> In any given year, slightly under 10 percent of the non-annuitant FEHBP population will change plans.

to the way many State Medicaid managed care contracts work. The benefits of this approach include:

- **Increases market leverage.** By limiting the number of plan entrants, the participating plans can assume that they will have fewer competitors for the available population (even if it is the individual who makes the ultimate choice) and seek to offer the most competitive package they can.
- **Assures opportunity for new plans on a regular interval.** Application processes, like that used by the FEHBP, tend to award evergreen contracts. Rates and benefits are negotiated regularly, but, absent exceptional circumstances, plans can remain in the program indefinitely. Regular re-bidding of contracts assures that a sufficiently large potential population is available for new entrants to capture.

The limitations of such an approach are:

- **Works best for standard product design.** This approach works best for a standard product design where the comparison is between identical (or almost identical) products. If the desire is to have some variation in plan designs (high cost sharing vs. high premium, or PPO model vs. integrated delivery system), this becomes more challenging.
- **Risk of bid protest.** Bid protests are a risk whenever there are winners and losers. As previously mentioned, bid protests have been very common in the TRICARE program. To minimize the risk of protests, the product carrier's offer should be standardized as much as possible so that winners can be clearly established. Comparing products that are not "apples to apples" is very difficult.
- **Choice limited.** Under this approach, there will likely be fewer choices in both plan type (e.g., PPO, HMO, or HDHP) and number of plans and carriers (e.g., Humana, BCBS, Aetna, or United Healthcare).

## 2. Managing Enrollment

Shopping for insurance has some unique aspects that need to be considered in developing an enrollment process. The products are complex, the individual's needs and expectations unclear, and weighing options is time-consuming. How the enrollment process is handled can have a significant impact on the utility of the pilots.

- **Length of open enrollment.** An open enrollment period should be long enough so that individuals have an opportunity to become informed about their choices and make their decisions without being rushed. It should also be short enough so that outreach and education efforts can be concentrated to promote interest and



action. The FEHBP Open Season is five to six weeks, similar to many large employers.

- **Enrollee education efforts.** An often underemphasized element of the enrollment process is educating consumers regarding their options, or even about how insurance works. Efforts to engage consumers about their new options under the pilot will significantly improve the pilot's chances of success. Some of this education will occur by the government and some by the plans themselves. DoD will need to facilitate plan outreach to beneficiaries.
- **Plan comparison tools.** If an individual is seeking to sort among 6–12 options, simply reading a summary of benefit documents is both tedious and often uninformative. Tools that allow individuals to sort among available plans according to parameters important to them (e.g., premium, cost sharing, or providers) using common terminology can greatly improve open enrollment.
- **Forced choice vs passive enrollment.** A key question for enrollment is whether there should be a default option (if the eligible beneficiary fails to select a plan) and what the default option should be. In most choice models (FEHBP, large employers), failure to choose means the individual defaults into the plan they had the year before. This could present a challenge if the pilot options do not include the traditional TRICARE benefit (what the beneficiary had last year). Forced choice will ensure that individual actively chooses one of the pilot options. However, forced choice also presents real outreach and operational challenges when seeking to make sure the entire population enrolls.

### 3. Health Insurance Infrastructure

Operating an insurance market and overseeing health insurance contracts will also require that DoD acquire the capacity to perform key functions that are not currently part of TRICARE. Early in the process, DoD will need to decide to “build or buy” either some or all of the infrastructure necessary to operate the pilots. DoD could invest in the infrastructure necessary to operate the pilots, or, alternatively, could enter into a Memorandum of Understanding with another government agency such as the Office of Personnel Management (OPM) that already possesses the experience and many of the tools to manage many aspects of the pilot. An abbreviated list of the insurance plan management functions includes:

- **Premium collection and distribution to carriers.** The number of carriers, plan options, and premium levels will influence the complexity of this task. If there are multiple plans and coverage options available, processes must be developed to collect premium contributions, transmit them to carriers, and reconcile

payments and enrollments. In addition, annual plan changes during an open enrollment period will also need to be processed.

- **Disputed claims.** Under TRICARE, DoD is the first—and last—arbiter of any claim or contract dispute. Under a private insurance model, DoD’s role would shift to that of final appeal after the insurers’ appeals processes have been exhausted. This is the role played by OPM in the case of the FEHBP, or by state insurance commissioners for most private plans. Disputes fall into two general categories. First, is the service covered under the contract? If multiple private insurers are used, they will have differences in how they provide certain services; hence, a service provided by Plan A might be denied by Plan B. The second category of disputes will pertain to the medical necessity of specific treatments in specific cases. Typically, an external medical review organization contracted to the purchaser provides outside medical expertise to resolve such disputes.
- **Plan selection and premium negotiation.** If the pilots follow the broad-based market approach, or one where multiple bidders are accepted, the administrator of the pilots will need to develop processes for receiving and evaluating proposals, and negotiating final premium rates.
- **Plan contract oversight and auditing.** Once plans are accepted, how will they be monitored on an ongoing basis? While TRICARE is well versed in the oversight of its current contract model, the oversight of an insurance model requires a different set of tools. For example, rather than evaluating whether medical services and administrative costs were appropriate, TRICARE may need to evaluate whether medical loss ratios were calculated properly.
- **Changing enrollment status.** One of the advantages of a single national delivery model such as TRICARE is that individuals retain the same coverage arrangements when they move. If the pilots use multiple carriers, processes will need to be developed to manage how individuals who are transferred into the pilot area are given the opportunity to participate in the pilots, or conversely, how individuals who leave the area will be re-enrolled into TRICARE. These processes are especially important for individuals who are actively engaged in treatment when their coverage changes.

## 8. Conclusion

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Healthcare reform is one of the most important challenges facing US policy makers today. In the past, policy experiments and pilot programs have provided key evidence towards answering various reform debates and have ultimately helped in shaping the reform strategy. The healthcare pilots currently being conducted by the CMS CMMI will provide evidence on some key elements of healthcare reform, but there are many key questions that they are not addressing.

TRICARE is suffering from the same challenges as other large public healthcare programs, which means that DoD is facing many of the same questions and challenges as national healthcare policy makers. Congressionally directed TRICARE pilots present an opportunity for DoD to not only inform its own reform strategy but also provide results that help to inform the national reform agenda. TRICARE's defined population, long-term association with beneficiaries, and strong mandate for reform make it an ideal venue for gaining information of national significance. TRICARE can extend the range of evidence CMS CMMI is producing to a non-elderly population and, perhaps more importantly, address questions that CMS CMMI is not currently able to address (e.g., combining supply-side with demand-side reforms). TRICARE pilots could also inform VA's consideration of how it expands its use of PC.

DoD is in the unique position of being able to use the reform process directed by the Congress to not only gain information to improve the performance of its own healthcare programs, but to also generate information of national significance that could help US policy makers confront one of the most important challenges our national faces.



# Appendix A.

## Health Insurance Pilots and Experiments

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### A. RAND HIE

Key elements of the Rand Health Insurance Experiment (HIE) included:<sup>1</sup>

- **Research question**
  - How does cost sharing or membership in an HMO affect use of health services compared to free care?
  - How does cost sharing or membership in an HMO affect appropriateness of care received?
  - What are the consequences for health?
- **Experimental design**
  - Evaluation Structure: The RAND HIE was a large-scale, randomized controlled trial (RCT). RCTs minimize selection bias by randomly assigning participants to intervention and control groups.
  - Sample: 2,750 families (around 7,700 individuals) under age 65 chosen from six sites to provide a regional and urban rural balance
  - Intervention: participants were randomly assigned to one of four basic types of FFS plans or an HMO plan. The FFS plans had different levels of cost sharing (zero or “free care,” 25 percent, 50 percent, or 95 percent coinsurance).<sup>2</sup> The HMO plan offered free care.
  - Study Period: The study period was 3–5 years
- **Results**
  - Participants with coinsurance had lower utilization of both inpatient and outpatient services.

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<sup>1</sup> The main source of the summary material here is taken from Robert H. Brook et al., “The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate,” RB-9174-HHS (Santa Monica, CA: RAND Corporation, 2006), [https://www.rand.org/pubs/research\\_briefs/RB9174.html](https://www.rand.org/pubs/research_briefs/RB9174.html).

<sup>2</sup> Coinsurance plans had out-of-pocket spending caps set to 5, 10, or 15 percent of income or \$1000 (in 1973 dollars—roughly \$3000 dollars today), whichever was less.

- Consumers in HMO-style free plan had 39 percent fewer hospital admissions than consumers in FFS free plan. Use of outpatient services was very similar.
- Participants in cost sharing plans spent less on health care by reducing utilization.
- Cost sharing reduced the use of effective and non-effective services.
- In general, the reduction in services induced by cost sharing had no adverse effects on participants' health.<sup>3</sup>
- Patient satisfaction did not vary at different levels of cost sharing among FFS plans, but it was lower among participants initially assigned to the HMO.

## **B. CMMI**

To further illustrate the format of the CMMI pilot programs, we summarize four of the earliest CMMI initiatives (focused on ACOs and episode-based payments). We selected these earlier programs to ensure there would be evaluation data available to summarize. Table A-1 and Table A-2 present a summary focused on four program elements of greatest importance: the pilot intervention, the intended mechanism or mechanisms through which the intervention is expected to work, the evaluation results, and the evaluation structure.

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<sup>3</sup> The poorest and sickest 6 percent of the starting sample had better outcomes under the free plan for 4 of the 30 measured conditions. See Brook et al., *The Health Insurance Experiment*.”

**Table A-1. Summary of CMMI Pilot Programs: ACO Models**

<b>The Pioneer Accountable Care Organization (ACO) Model, 2012–2016</b>			
<b>Intervention</b>	<b>Mechanism</b>	<b>Evaluation Results</b>	<b>Evaluation Structure</b>
<p>ACOs agreed to payment arrangements that shared savings (losses) if spending was under (over) a set benchmark.</p> <p>ACOs had to exceed the minimum savings rate (MSR) in order to share in savings or the minimum loss rate (MLR) to be accountable for losses. The sharing rate for savings/losses was tied to quality.</p>	<p>The theory behind ACO models is that the opportunity to share financial rewards will reduce fragmentation and duplication in medical care by incentivizing enhanced coordination across providers. Better patient management may also help avoid high cost episodes such as inpatient hospitalizations for preventable conditions.</p>	<p>Estimated Medicare savings varied significantly across the 32 Pioneer ACOs, as did changes in utilization.</p> <p>There was little conclusive evidence that quality (as measure by clinical measures or patient satisfaction) improved or worsened.</p>	<p>ACOs were selected via a competitive process. Medicare beneficiaries were aligned to these ACOs based on where they received care.</p> <p>The control group was FFS Medicare beneficiaries in the same market who were not aligned to any Medicare ACO.</p> <p>Many ACOs terminated their participation early.</p>
<b>The Advance Payment (AP) Accountable Care Organization (ACO) Model, 2012–2015</b>			
<p>ACOs were given an up-front payment of \$250,000 and ongoing per member per month payments for 24 months. For each performance year, advance payments were to be recouped against any shared savings an ACO accrued according to a benchmark spending level.</p>	<p>The advance payments were intended to help overcome financial barriers typically faced by small physician-based organizations interest in forming ACOs. They were intended to be used for investments in staff and infrastructure for delivering better coordinated and higher quality care to their assigned patient population.</p>	<p>AP ACOs had non-statistically significant lower-than-expected total spending in 2012 and 2013 and statistically significantly higher-than-expected total spending in 2014.</p> <p>Quality results generally showed no statistically distinguishable differences.</p>	<p>CMS developed eligibility and selection criteria for AP model participants.</p> <p>Physician-based organizations meeting the eligibility criteria could apply.</p> <p>Beneficiaries were aligned to the AP ACOs based upon where they received care.</p> <p>The control group was FFS Medicare beneficiaries in the same market who were not assigned to any Medicare ACO.</p>

**Table A-2. Summary of CMMI Pilot Programs: BPCI Models**

<b>Bundle Payment for Care Improvement (BPCI) Model 1: Retrospective Acute Hospital Stay Only, 2013–2016</b>			
<b>Intervention</b>	<b>Mechanism</b>	<b>Evaluation Results</b>	<b>Evaluation Structure</b>
<p>Awardee hospitals enroll practitioners to help implement “care redesigns” that will result in internal hospital cost savings. Awardees then share internal cost-savings generated under this model (gainsharing) with the enrolled practitioners. Participation requires that awardees offer Medicare a predetermined discount for inpatient episodes.</p>	<p>Gainsharing is expected to promote the required alignment between providers and hospitals necessary for successful development and implementation of care redesigns. The redesigns are meant to achieve efficiency gains primarily in the form of reduced care redundancies and improved care processes.</p>	<p>Some evidence indicated awardee hospitals achieved small but statistically significant savings. However, the results were driven by the 9 awardees that dropped out early. Quality changes were generally small and statistically insignificant.</p>	<p>Awardee hospitals were compared to similar non-awardee hospitals. The similarity of comparison hospitals and awardee hospitals was determined based on observable characteristics such as hospital beds, patient case mix, and baseline measures of select measures such as average length of stay. Nine of the 24 awardee hospitals terminated their participation early.</p>
<b>Bundle Payment for Care Improvement Model 2: Retrospective Acute &amp; Post-Acute Care Episode, 2013–2018</b>			
<p>CMS set target “bundle” prices for 48 clinical episodes of care. The bundle includes the anchor hospitalization and all other services delivered within a designated episode length. When awardees’ Medicare payments are less than the bundle target price, they get to keep the difference and share the savings among participating providers. When payments are higher, they must pay the difference to CMS.</p>	<p>Bundling is a form of capitation. It incentivizes the delivery system to minimize the overall cost for a care episode by allowing providers to share savings (or losses). Improved care coordination, use of better value services/providers (e.g., using surgeons’ lowest complication rates/ quickest recovery periods), and other process improvements are potential channels for gaining cost efficiencies.</p>	<p>Medicare payments for major joint replacements of the lower extremity (MJRLE) episodes declined by 4.5% for model participants relative to the comparison group. No other episodes had statistically significant savings. There were few statistically significant differences in quality.</p>	<p>Participants selected which of the 48 clinical episodes they wished to bundle and the episode length (30, 60, or 90 days). Participants were, on average, larger facilities with more resources (typically large non-profit, urban facilities with teaching programs). Participants’ episodes of care were compared to episodes of care managed by non-participants.</p>



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## Abbreviations

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ACA	Patient Protection and Affordable Care Act
ACO	Accountable Care Organization
ADFM	Active Duty Family Member
AP	Advance Payment
BAHC	Basic Allowance for Health Care
BCBS	Blue Cross Blue Shield
BPCI	Bundle Payment for Care Improvement
CAHPS	Consumer Assessment of Health Plans Survey
CDHP	Consumer-Driven Health Plan
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare and Medicaid
DC	Direct Care
DoD	Department of Defense
FEHBP	Federal Employees Health Benefits Program
FFS	Fee-for-Service
FY	Fiscal Year
GEHA	Government Employees Health Association
HSA	Health Savings Account
HDHP	High-Deductible Health Plan
HEDIS	Healthcare Effectiveness Data and Information Set
HIE	Health Insurance Experiment
HMO	Health Maintenance Organization
MA	Medicare Advantage
MCRMC	Military Compensation and Retirement Modernization Commission
MHS	Military Health System
MJRLE	Major Joint Replacement of the Lower Extremity
MLR	Minimum Loss Rate
MSR	Minimum Savings Rate
MTF	Military Treatment Facility
NDAA	National Defense Authorization Act
OOP	Out-of-Pocket

OPM	Office of Personnel Management
PC	Purchased Care
PCM	Primary Care Manager
PPO	Preferred Provider Organization
PRWORA	Personal Responsibility and Work Opportunity Reconciliation Act
RCT	Randomized Controlled Trial
US	United States
USFHP	Uniformed Service Family Health Plan
VA	Department of Veterans Affairs
VBP	Value-Based Purchasing

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