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September 26, 2011

The Honorable Carl Levin
Chairman
The Honorable John McCain
Ranking Member
Committee on Armed Services
United States Senate

The Honorable Howard P. "Buck" McKeon
Chairman
The Honorable Adam Smith
Ranking Member
Committee on Armed Services
House of Representatives

Subject: *DOD Health Care: Cost Impact of Health Care Reform and the Extension of Dependent Coverage*

The Department of Defense (DOD) offers health care to eligible beneficiaries through TRICARE, its health care program.[1] Recently enacted health care reform legislation—the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA)[2]—has implications for much of the nation's health care system, including TRICARE.[3] One particular health reform provision directed certain health insurance plans to extend coverage to dependents up to age 26.[4] Though this provision does not apply to TRICARE because it is not considered a health insurance plan,[5] the subsequent Ike Skelton National Defense Authorization Act for Fiscal Year 2011 (NDAA 2011) included a similar provision that extends TRICARE coverage to certain dependent children of TRICARE beneficiaries.[6] In response, in May 2011, DOD began implementing

[1]Eligible beneficiaries include active duty personnel and their dependents, medically eligible National Guard and Reserve personnel and their dependents, and retirees and their dependents and survivors. Active duty personnel include members of the National Guard and Reserves on active duty for at least 30 days.

[2]See Pub. L. No. 111-148, 124 Stat. 119 (2010); Pub. L. No. 111-152, 124 Stat. 1029 (2010). Several sections of HCERA amended sections of PPACA.

[3]PPACA and HCERA include a wide range of provisions, such as those that will require individuals, large employers, and health insurers to meet certain health care coverage requirements and other provisions that make changes to Medicare reimbursement rates.

[4]See Pub. L. No. 111-148, § 1001, 124 Stat. 119, 132 (2010) (amended by Pub. L. No. 111-152, § 2301(b), 124 Stat. 1029, 1082 (2010) and to be codified at 42 U.S.C. § 300gg-14).

[5]See 42 U.S.C. § 300gg-21 (limiting the applicability of certain provisions of the Public Health Service Act, including coverage for dependents up to age 26).

[6]See Pub. L. No. 111-383, § 702, 124 Stat. 4137, 4244-45 (2011) (to be codified at 10 U.S.C. § 1110b).

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TRICARE Young Adult (TYA), a premium-based health care plan[7] that extends TRICARE coverage to dependents of TRICARE beneficiaries up to age 26 who do not have access to employer-sponsored health care coverage and are unmarried.[8]

The NDAA 2011 directed us to assess the cost to DOD of complying with PPACA and HCERA. You also asked us to examine DOD's costs of implementing, administering, and providing benefits under TYA. In this report, we assess DOD's costs of (1) complying with PPACA and HCERA and (2) implementing and providing benefits under TYA.

To examine DOD's costs of complying with PPACA and HCERA, we reviewed documents from DOD's Office of General Counsel and interviewed DOD officials to identify the provisions of PPACA and HCERA with which DOD has determined it is required to comply. We also obtained DOD's cost estimates for complying with these provisions, when such estimates were available. We analyzed the costs directly associated with implementing these provisions, which did not generally include estimates of any indirect costs or potential offsetting savings that may result.

To examine DOD's costs of implementing and providing benefits under TYA, we reviewed the methodology DOD used in establishing premium rates for TYA and DOD's cost estimates for implementing the plan. We examined DOD's estimated costs because actual cost data were not available at the time of our review. Our review included examining whether TYA's premiums are likely to fully cover DOD's costs of providing benefits and associated administrative costs, and the extent to which DOD relied on its costs of implementing other recently established TRICARE plans, such as TRICARE Reserve Select and TRICARE Retired Reserve,[9] in estimating implementation costs for TYA. We also interviewed DOD officials about how they established TYA premium rates and cost estimates for implementing the plan. Additionally, we met with representatives of a national actuarial association to obtain their perspectives on TYA premiums.

We conducted this performance audit from May 2011 through September 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results in Brief

Overall, DOD expects to incur minimal costs to implement the 21 PPACA and HCERA provisions with which department officials have determined it is required to comply. In particular, DOD officials estimated that 11 of the provisions could be implemented at no cost, and the estimated costs of complying with another third of the provisions (8) are minimal because no new staff or significant additional

[7]TYA enrollees pay a monthly premium to receive health care coverage under the program.

[8]The PPACA provision, as amended by HCERA, extended dependent coverage to both married and unmarried adult dependents up to age 26.

[9]TRICARE Reserve Select is a premium-based health plan established in 2005 that qualified National Guard and Reserve members may purchase, while TRICARE Retired Reserve is a premium-based health plan established in 2010 that qualified retired National Guard and Reserve members and survivors may purchase.

resources will be required to implement them. Officials told us that they could not determine the exact costs for these 8 provisions until they are fully implemented. At this time, DOD has not yet estimated its costs for complying with the remaining 2 provisions—including providing written statements to beneficiaries affirming that coverage was provided—because according to department officials, it is awaiting regulations from other federal agencies on how to implement them. Nonetheless, department officials told us that DOD believes its costs to comply with these provisions will also be minimal. Department officials said that DOD is unable to determine whether it is practicable to implement additional PPACA and HCERA provisions that relate to Medicare reimbursement rates until the Department of Health and Human Services (HHS)[10] issues detailed regulations regarding their implementation.

DOD has estimated that its costs to implement TYA will be about $4.4 million over fiscal years 2011 and 2012. These costs will be partially offset by a 2 percent markup included in the TYA premiums, beyond the level it believes to be necessary to cover TYA benefits and associated administrative costs. DOD's actual implementation costs for TYA may differ from its estimated costs and will not be known until after the program has been fully implemented. Additionally, although the NDAA 2011 requires the premiums for TYA to fully cover DOD's costs of providing the benefit, including associated administrative costs, these costs may initially exceed premium amounts. According to department officials, DOD plans to adjust TYA premiums based on the actual average cost of providing benefits and administrative costs starting with the calendar year 2014 premiums. In commenting on a draft of this report, DOD stated that it concurred with the report as written.

Background

Recent health care reform laws affect many aspects of the nation's health care delivery and financing systems, including DOD's TRICARE program. In addition, the NDAA 2011 expanded TRICARE coverage to eligible dependents of TRICARE beneficiaries up to age 26.

Health Care Reform Laws

PPACA was enacted in March 2010. Among other things, by calendar year 2014, PPACA will require individuals, large employers, and health insurers to meet certain health care coverage requirements. For example, PPACA will require that most individuals obtain minimum essential health care coverage;[11] those that opt not to will be required to pay a financial penalty beginning in 2014.[12] Furthermore, PPACA

[10]HHS's Centers for Medicare & Medicaid Services administers Medicare.

[11]The TRICARE Affirmation Act, enacted in April 2010, explicitly stated that TRICARE coverage satisfies the minimum essential health care coverage requirements under PPACA. See Pub. L. No. 111-159, 124 Stat. 1123 (2010).

[12]See Pub. L. No. 111-148, §§ 1501(b), 10106(b)-(d), 124 Stat. 119, 244-49, 909-10 (2010), as amended by HCERA, Pub. L. No. 111-152, §§ 1002, 1004, 124 Stat. 1029, 1032-33, 1034 (2010) (to be codified at 26 U.S.C. § 5000A). Beginning in January 2014, individuals must maintain minimum essential coverage for themselves and their dependents. Minimum essential coverage includes employer-sponsored health plans, individual plans, and government-sponsored plans. Individuals must pay a penalty for each month they fail to do so. Certain individuals, such as members of qualifying religious groups, are exempt from this requirement, and other individuals, such as federal taxpayers whose household income is below the applicable filing threshold, are also exempt from the penalty.

will prohibit private health insurers from excluding coverage based on any preexisting conditions,[13] or rejecting applicants based on health status;[14] it also required an extension of coverage to unmarried dependents up to age 26.[15] Additionally, PPACA makes various changes to Medicare, including provisions that substantially reduce the growth of Medicare's payment rates for most services and a provision that directs the Secretary of HHS to develop and implement a value-based payment modifier that will adjust Medicare physician payments based on the quality and cost of the care they deliver.

HCERA, which also was enacted in March 2010, amended numerous PPACA provisions. For example, HCERA eliminated the requirement that adult children be unmarried in order to be offered extended dependent coverage up to age 26.[16] Other sections of HCERA included changes to Medicare, such as changes to its reimbursement rates.

Expansion of TRICARE Dependent Coverage

The NDAA 2011 required, among other things, that TRICARE coverage be extended to unmarried dependents of TRICARE beneficiaries up to age 26 who are not eligible for employer-sponsored health insurance, which is similar to a provision in PPACA.[17] The NDAA 2011 also required that the premiums for this extension of coverage be equal to DOD's costs to provide it and that coverage would begin on January 1, 2011. In response, DOD developed TYA, a premium-based health care plan, which extended the opportunity for eligible dependents of TRICARE beneficiaries, who would otherwise be ineligible for TRICARE coverage, to enroll in TRICARE.[18] DOD's TRICARE Management Activity (TMA) was responsible for developing TYA, and TMA's contractors—which develop networks of civilian providers and perform other customer service functions—have primary responsibility for implementing TYA in the three TRICARE regions (North, South, and West) and overseas.

[13]PPACA prohibits group health plans and insurers offering group and individual coverage from excluding coverage for any preexisting conditions. This prohibition is generally effective for plan years beginning on or after January 1, 2014, for adults and for plan years beginning on or after September 23, 2010, for individuals under age 19. See Pub. L. No. 111-148, §§ 1201(2), 1253, 1562(c)(1), 10103(e),(f), 124 Stat. 119, 154, 162, 264-65, 895 (2010) (to be codified at 42 U.S.C. § 300gg-3).

[14]For plan years beginning on or after January 1, 2014, PPACA prohibits group health plans and insurers offering group or individual coverage from establishing rules for eligibility for enrollment based on health status and other related factors. See Pub. L. No. 111-148, §§ 1201(4), 1253, 10103(e), (f), 124 Stat. 119, 156, 162, 895 (to be codified at 42 U.S.C. § 300gg-4).

[15]See Pub. L. No. 111-148, § 1001, 124 Stat. 119, 132 (2010) (amended by Pub. L. No. 111-152, § 2301(b), 124 Stat. 1029, 1082 (2010) and to be codified at 42 U.S.C. § 300gg-14).

[16]Pub. L. No. 111-152, § 2301(b), 124 Stat. 1029, 1082 (2010).

[17]Prior to the enactment of the NDAA 2011, dependents of active duty personnel and retirees as well as TRICARE Reserve Select and TRICARE Retired Reserve enrollees were eligible for TRICARE coverage until age 21, or age 23 if they were full-time students.

[18]See 76 Fed. Reg. 23,479 (Apr. 27, 2011) (to be codified at 32 C.F.R. §§ 199.2(b), 199.26). Eligible dependents for TYA must be unmarried dependents of an eligible uniformed service sponsor (such as active duty personnel or retiree), at least 21 but not yet 26 years old, and not eligible to enroll in an employer-sponsored health plan as defined in the Internal Revenue Code or otherwise eligible for TRICARE program coverage.

TYA will eventually offer coverage under two options, TYA Standard[19] and TYA Prime,[20] both of which have cost sharing requirements that vary based on the dependent sponsor's status. Like other TRICARE beneficiaries, TYA enrollees have the option of obtaining health care and pharmacy services from providers at military treatment facilities or from civilian providers. (See table 1 for a summary of TYA Standard and TYA Prime premiums and selected cost sharing requirements.)

Table 1: Summary of TRICARE Young Adult (TYA) Premiums and Selected Cost Sharing Requirements

				Enrollee cost sharing requirements for outpatient care[b]			
				Dependents of active duty personnel[c]		Dependents of military retirees	
TYA option	Monthly premium	Civilian provider status[a]	Deductible				
Standard	$186	Nonnetwork or network	$50-$150[d] per individual for dependents of active duty personnel[c] $150 per individual for dependents of military retirees	Nonnetwork provider: 20 percent of the TRICARE reimbursement rate[e]	Network provider: 15 percent of the TRICARE reimbursement rate	Nonnetwork provider: 25 percent of the TRICARE reimbursement rate[e]	Network provider: 20 percent of the TRICARE reimbursement rate
Prime	$213	Network	None	None		$12 per visit	

Source: GAO analysis of Department of Defense data.

[a]TYA enrollees also may use military treatment facility (MTF) providers. When using MTF providers, TYA enrollees are not subject to deductibles or other cost sharing requirements. A TYA enrollee's priority at an MTF is determined by the sponsor's status (such as active duty) and coverage type (such as TRICARE Prime).

[b]Inpatient care and other types of services, including pharmacy benefits, have different cost sharing requirements. TYA Prime enrollees who are the dependents of active duty personnel incur no out-of-pocket costs.

[c]TYA Standard enrollees whose sponsor is enrolled in TRICARE Reserve Select pay the same deductibles and have the same cost sharing requirements as those whose sponsor is active duty.

[d]Dependents of lower-ranked enlisted personnel pay the lower deductible amounts. Dependents of higher-ranked military personnel pay the higher deductible amounts.

[e]On a case-by-case basis, nonnetwork civilian providers may charge up to 15 percent more than the TRICARE reimbursement rate. In these instances, the TYA beneficiary also is responsible for the additional amount charged by the provider.

TYA Standard was made available for purchase on May 1, 2011. Those eligible for TYA Standard have the opportunity to retroactively purchase coverage that is effective as of January 1, 2011.[21] TYA Prime is expected to be available for purchase starting in October 2011. However, unlike the TYA Standard option, those purchasing coverage through TYA Prime will not have the opportunity to purchase retroactive coverage.

[19]TYA Standard mirrors both TRICARE Standard and Extra, DOD's fee-for-service and preferred provider options, respectively. Under TRICARE Standard, beneficiaries obtain health care from nonnetwork providers. Under TRICARE Extra, beneficiaries obtain health care from network providers, and have lower cost shares (about 5 percentage points less) than they would if they saw nonnetwork providers under the TRICARE Standard option. Although non-TYA beneficiaries do not have to enroll in the TRICARE Standard and Extra options, eligible dependents who use TYA Standard must enroll and pay monthly premiums.

[20]TYA Prime mirrors TRICARE Prime, DOD's managed care option, for which beneficiaries are required to enroll. Under TRICARE Prime, beneficiaries have a primary care manager who either provides care or authorizes referrals to specialists. Beneficiaries can be assigned to a primary care manager at a military treatment facility or, if the military treatment facility is at capacity or no military treatment facility is available, may select a civilian primary care manager.

[21]TYA beneficiaries have through September 30, 2011 to purchase this retroactive coverage.

DOD Expects to Incur Minimal Implementation Costs to Comply with Health Care Reform Laws, but Cannot Fully Estimate All Costs at This Time

Overall, DOD expects to incur minimal costs to implement the 21 PPACA and HCERA provisions with which DOD officials have determined it is required to comply. These provisions include a range of requirements, such as reporting on amounts DOD paid for brand-name prescription drugs and data sharing to identify fraud, waste, and abuse. According to DOD officials, more than half of these provisions (11) could be implemented at no cost,[22] and the estimated costs of complying with another third of the provisions (8) are minimal because no new staff or significant additional resources will be required to implement them. DOD is unable to determine the exact costs, which may include travel expenses and other administrative costs, until these 8 provisions have been fully implemented. For the 2 remaining provisions, department officials said that DOD cannot yet estimate its costs for complying with them because it is awaiting guidance from other federal agencies, in the form of federal rules and regulations, on how to implement them. For example, DOD is waiting for the Department of the Treasury to issue regulations before it can determine how to implement a provision that requires providers of health insurance to provide written statements to beneficiaries affirming that minimum essential coverage was provided.[23] Without this guidance, DOD is unable to determine the full costs of implementing this provision. While precise estimates are not possible at this time, department officials told us that DOD expects the compliance costs for these remaining two provisions to also be minimal. (See enc. I for a list of the 21 PPACA and HCERA provisions.)

In addition to the 21 provisions that DOD identified as requiring its compliance, DOD identified 29 PPACA and HCERA provisions that relate to changes in Medicare payment methodologies and reimbursement rates. However, according to department officials, DOD has not yet determined whether and how it would implement these provisions.[24] For example, DOD cannot yet determine if it will implement a provision for a value-based payment modifier to be developed by the Secretary of HHS that adjusts Medicare's physician payments based on the quality and costs of care physicians deliver.[25] By law, TRICARE maximum allowable reimbursement rates must generally mirror Medicare rates, to the extent practicable.[26] At this time, however, DOD is unable to determine whether it is practicable to implement reimbursement rules similar to this and other provisions until HHS issues regulations regarding their implementation. Because of this uncertainty, DOD officials told us that they could not estimate the implementation costs associated with these provisions. DOD officials also noted that DOD's

[22]DOD officials told us that DOD did not incur implementation costs for some provisions because it had already implemented them before PPACA and HCERA were enacted. Additionally, they said that DOD's contractors could implement certain payment-related provisions at no cost to DOD.

[23]These written statements are in reference to the PPACA provision that will require most individuals to obtain health care coverage beginning in 2014.

[24]Department officials told us that although these provisions do not apply directly to TRICARE, DOD may implement some of them if it determines that doing so would be practicable.

[25]See Pub. L. No. 111-148, § 3007, 124 Stat. 119, 373-76 (2010) (to be codified at 42 U.S.C. § 1395w-4(p)).

[26]See 10 U.S.C. §§ 1079(h)(1), (j)(2), 1086(f), (g).

contractors may incur costs to implement these provisions and that DOD would negotiate any reimbursement with them. However, since DOD does not know at this time whether it will implement these provisions, it cannot determine whether contractors will incur such costs or estimate the magnitude of such costs.

DOD Will Incur Implementation Costs Associated with TYA and May Initially Incur Costs That Exceed Premiums for Providing Program Benefits

DOD will incur costs in fiscal years 2011 and 2012 associated with implementing TYA. Furthermore, DOD may initially incur additional costs associated with providing benefits under TYA, if the premiums paid by TYA enrollees—which are required to fully cover TYA's benefits and administrative costs—are insufficient to fully cover these costs. These premiums would then be adjusted as necessary once actual claims data are available.

- *Implementation costs for TYA*: DOD's estimated costs to implement TYA are approximately $4.4 million over fiscal years 2011 and 2012.[27] These costs will be partially offset by the TYA premiums, which include a 2 percent markup that is intended to recoup at least some of the implementation costs. However, the extent to which premiums offset DOD's implementation costs depends upon the number of TYA enrollees over the next several years. Although DOD officials told us that they do not have complete data on the number of dependents who are eligible for TYA, DOD has estimated that about 17,000 individuals would enroll in this program in 2011.[28] As of June 2011, 4,549 individuals had enrolled.

  Initially, implementation costs for TYA will be incurred by DOD's contractors, who are responsible for managing civilian health care delivery. These costs include updating websites and claims-processing systems, enrolling new TYA beneficiaries, and providing staff training on TYA. DOD officials told us that estimates for these implementation costs were based on the costs for implementing previous TRICARE health care plans, such as TRICARE Reserve Select.[29] DOD's actual implementation costs for TYA may differ from its estimated costs and will not be known until fiscal year 2012 after the contractors submit all of their costs for implementing TYA to DOD for negotiation of reimbursement.

- *Potential, additional costs for providing TYA benefits*: Although DOD developed TYA premiums to fully cover the costs of program benefits and associated administrative costs, the costs may initially exceed premium

[27]DOD performed an independent government cost estimate of contractors' probable costs for the implementation of TYA.

[28]DOD officials told us that this estimate was developed by first determining the total number of dependents of active duty personnel and military retirees who are from 21 to 26 years of age and subsequently subtracting the estimated number of dependents who would not be eligible for TYA. DOD officials assumed that about 7 percent of those eligible for TYA would enroll in 2011 and that enrollment would increase to 28 percent of the eligible population by 2014, although they acknowledged that this was a rough estimate.

[29]As TRICARE Reserve Select was established in 2005, DOD officials said that they were able to rely on the implementation costs for this program to develop an estimate of implementation costs for TYA.

amounts, in part, because of adverse selection.[30] Specifically, adverse selection may have an impact on TYA in 2011 because of TYA's retroactive coverage provision. This provision allows eligible beneficiaries to enroll in TYA Standard through September 30, 2011, and receive retroactive coverage effective as of January 1, 2011, as long as beneficiaries pay the monthly premiums for January 2011 through their date of enrollment. As of June 2011, 431 of the 4,549 individuals enrolled in TYA—about 9 percent—had purchased retroactive coverage. Although it is likely that only those TYA-eligible beneficiaries who incurred medical expenses since January 1, 2011, in excess of the TYA premiums would purchase retroactive coverage, we are unable to assess the impact of adverse selection as TYA claims data will not be available until fiscal year 2012.

DOD did not take the impact of adverse selection into account when determining TYA premiums because it lacked adequate data on the likely impact of adverse selection. DOD officials told us that the department plans to adjust TYA premiums to reflect the actual average cost of providing benefits and associated administrative costs for calendar year 2014.[31] DOD calculated its current premiums for TYA Standard and TYA Prime by using actual costs of providing benefits to 21- and 22-year-old beneficiaries currently enrolled in TRICARE Prime and by making adjustments to account for several factors that may affect TYA costs. These adjustments include subtracting costs associated with disabled TRICAREPrime beneficiaries,[32] subtracting beneficiary cost sharing under TYA Standard,[33] and accounting for expected medical care inflation and administrative costs.[34]

Agency Comments

We provided a draft of this report to DOD for review and comment. In its comments, DOD concurred with our report. DOD also provided technical comments, which we incorporated as appropriate. DOD's comments are reprinted in enclosure II.

[30]Adverse selection occurs when people who know they have a risk of incurring health care expenses buy insurance coverage, while those who have relatively less risk of incurring health care expenses decide the insurance is too expensive and therefore do not buy it. In these cases, the resulting insured population is likely to incur greater-than-average health care costs. Therefore, any premiums set to account for an insured population with average health care costs may not be sufficient to cover the claims that eventually arise.

[31]According to DOD officials, the department plans to base calendar year 2014 TYA premiums on the actual costs of providing benefits and associated administrative costs in calendar year 2012, provided the data are reliable.

[32]Disabled dependent children of active duty personnel and retirees may remain eligible for TRICARE after turning age 21 (or age 23 if they are full-time students) and would therefore not be expected to enroll in TYA. Because costs associated with disabled beneficiaries are significantly higher than costs associated with beneficiaries who are not disabled, DOD excluded the costs for these beneficiaries from the TYA premium calculations.

[33]Because TYA Standard enrollees pay higher cost sharing amounts than TYA Prime enrollees, DOD expects its costs of providing benefits under TYA Standard to be lower than its costs of providing benefits under TYA Prime. DOD set lower premiums for TYA Standard than for TYA Prime to account for the higher beneficiary cost sharing under TYA Standard and, therefore, lower costs to DOD for providing care.

[34]TYA premiums include estimated claims-processing costs and estimated monthly fees assessed by DOD's contractors.

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We are sending copies of this report to the Secretary of Defense and interested congressional committees. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff members who made key contributions to this report are listed in enclosure III.

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Director, Health Care

Enclosures – 3

Enclosure I

Health Care Reform Provisions with Which the Department of Defense (DOD) Has Determined It Must Comply and Its Estimated Costs for Compliance

Patient Protection and Affordable Care Act (PPACA) and Health Care and Education Reconciliation Act of 2010 (HCERA) provisions for which DOD estimated no costs for compliance	
1.	PPACA § 1104 (and related amendments by § 10109): Sets forth standards and operating rules governing electronic health care transactions. Establishes penalties for health plans failing to comply with requirements.
2.	PPACA § 1557: Prohibits exclusion from participation in, denial of benefits, or discrimination under any federal health program or activity or any health program or activity receiving federal financial assistance on the grounds of race, color, national origin, sex, age, or disability.
3.	PPACA § 3102 (and related amendments by § 10324(c) of PPACA and § 1108 of HCERA): Revises certain geographic adjustments to Medicare's physician fee schedule, and directs the Secretary of Health and Human Services (HHS) to make further appropriate adjustments.
4.	PPACA § 3104: Extends through 2010 an exception to a payment rule that permits laboratories to receive direct Medicare reimbursement when providing the technical component of certain physician pathology services that had been outsourced by certain (rural) hospitals.
5.	PPACA § 3105 (and related amendments by § 10311): Extends the bonus and increased payments for ground ambulance services and certain air ambulance services until January 1, 2011.
6.	PPACA § 3107: Extends the physician fee schedule mental health add-on payment provision through December 31, 2010.
7.	PPACA § 3111: Sets payments for certain bone density tests furnished in 2010 and 2011 at 70 percent of the 2006 reimbursement rates.
8.	PPACA § 3122: Extends from July 1, 2010, until July 1, 2011, the reasonable cost reimbursement for certain clinical diagnostic laboratory tests for qualifying rural hospitals with under 50 beds.
9.	PPACA § 3128: Allows a critical access hospital to continue to be eligible to receive 101 percent of reasonable costs for providing (1) outpatient care regardless of the eligible billing method such hospital uses and (2) qualifying ambulance services.
10.	PPACA § 3401 (and related amendments by §§ 10319 and 10322 of PPACA and § 1105 of HCERA): Revises certain market basket updates—the Centers for Medicare & Medicaid Services (CMS) uses market baskets to measure changes in the price of goods and services for Medicare—and incorporates a full productivity adjustment into any updates that do not already incorporate such adjustments, including inpatient hospitals, home health agencies, nursing homes, hospice providers, psychiatric hospitals, long-term care hospitals, inpatient rehabilitation facilities, and Medicare Part B providers. Also establishes a quality measure reporting program for psychiatric hospitals beginning in fiscal year 2014.
11.	HCERA § 1109: Directs the Secretary of HHS to provide for a specified payment for fiscal years 2011 and 2012 to qualifying hospitals in counties that rank, based upon age, sex, and race adjusted spending per enrollee for Medicare parts A and B benefits, within the lowest quartile of such counties in the United States.
PPACA provisions for which DOD estimated minimal costs for compliance[a]	
12.	PPACA § 3012: Directs the President to convene the Interagency Working Group on Health Care Quality. A senior-level representative of DOD is to serve on the working group.
13.	PPACA § 3110: Creates a special Medicare Part B enrollment period for disabled TRICARE beneficiaries, including military retirees, their spouses (including widows or widowers), and dependent children, who are entitled to Medicare Part A based on disability or end-stage renal disease, but who have elected not to enroll in Medicare Part B. Also requires the Secretary of Defense to collaborate with the Secretary of HHS and the Commissioner of Social Security to identify eligible individuals and provide notification to eligible individuals regarding their eligibility.
14.	PPACA § 4302: Requires the Secretary of HHS to ensure that any federally conducted or supported health care or public health program, activity, or survey collects and reports specified demographic data regarding health disparities. The Secretary of HHS is required to consult with the Secretary of Defense in carrying out this provision.
15.	PPACA § 5104 (added by § 10501(b)): Establishes the Interagency Access to Health Care in Alaska Task Force to (1) assess access to health care for beneficiaries of federal health care systems in Alaska and (2) develop a strategy to improve delivery to such beneficiaries. Requires the Secretary of Defense to appoint one representative of the TRICARE Management Activity, the Secretary of the Army to appoint one representative of the Army Medical Department, and the Secretary of the Air Force to appoint one representative from among officers of the Air Force performing medical service functions. Provides for the termination of the task force on the date of submission of a report in September 2010.[b]

16.	PPACA § 6402 (and related amendments by § 1303(a) of HCERA): Requires CMS to include in the integrated data repository claims and payment data from Medicare, Medicaid, the Children's Health Insurance Program, and health-related programs administered by the Department of Veterans Affairs, DOD, the Social Security Administration, and the Indian Health Service (IHS). Also directs the Secretary of HHS to enter into data-sharing agreements with the Commissioner of Social Security, the Secretaries of Veterans Affairs and Defense, and the Director of IHS to help identify fraud, waste, and abuse.
17.	PPACA § 6403: Requires the Secretary of HHS to furnish the National Practitioner Data Bank with all information reported to the national health care fraud and abuse data collection program on certain final adverse actions taken against health care providers, suppliers, and practitioners. Requires the Secretary to establish a process to terminate the Healthcare Integrity and Protection Data Bank and ensure that the information formerly collected in it is transferred to the National Practitioner Data Bank.
18.	PPACA § 9008 (as amended by § 1404 of HCERA): Imposes an annual fee on the branded prescription drug sales exceeding $5 million by manufacturers and importers of such drugs beginning in 2011. Requires the Secretaries of HHS, Veterans Affairs, and Defense to report to the Secretary of the Treasury on the total branded prescription drug sales with respect to government programs within their departments.
19.	PPACA § 10409: Requires the Secretary of HHS, acting through the Director of the National Institutes of Health (NIH), to implement the Cures Acceleration Network under which grants and contracts will be awarded to accelerate the development of high-need cures. Defines "high-need cure" as a drug, biological product, or device (1) that is a priority to diagnose, mitigate, prevent, or treat any disease or condition and (2) for which the incentives of the commercial market are unlikely to result in its adequate or timely development. Also establishes a Cures Acceleration Network Review Board to advise the Director of NIH on the conduct of the activities of the Cures Acceleration Network. A representative of the Office of the Assistant Secretary of Defense for Health Affairs, recommended by the Secretary of Defense, is to be appointed by the Secretary of HHS as an ex officio member of the board.[c]
PPACA provisions for which DOD has <u>not yet estimated costs</u> for compliance	
20.	PPACA § 1502: Requires providers of minimum essential coverage to file informational returns providing identifying information of covered individuals and the dates of coverage, beginning in 2014.[d]
21.	PPACA § 4004 (as amended by § 10401(c)): Requires the Secretary of HHS to provide for the planning and implementation of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the life span. Requires the Secretary of HHS to develop and implement a plan for the dissemination of information to health care providers who participate in federal programs, including programs administered by DOD.[e]

Source: DOD.

[a]DOD officials told us that they expect DOD's costs of complying with these provisions to be minimal because no new staff or significant additional resources will be required to implement them. However, DOD is unable to estimate the exact amount of these costs, which may include, for example, travel expenses, until these provisions have been fully implemented.

[b]The Interagency Access to Health Care in Alaska Task Force was terminated after issuing its final report on September 17, 2010.

[c]PPACA authorized but did not appropriate funds to implement this provision.

[d]DOD cannot estimate its costs until the Department of the Treasury issues regulations implementing this provision.

[e]DOD cannot estimate its costs until HHS issues regulations implementing this provision. PPACA authorized but did not appropriate funds to implement this provision.

Enclosure II

Comments from the Department of Defense

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

9/12/11

Ms. Debra A. Draper
Director, Health Care
U.S. Government Accountability Office
441 G Street, N.W.
Washington, DC 20548

Dear Ms. Draper:

This is the Department of Defense (DoD) response to the Government Accountability Office (GAO) Draft Report GAO-11-837R, "DoD Health Care: Cost Impact of Health Care Reform and the Extension of Dependent Coverage," dated August 11, 2011 (GAO Code #290935).

Thank you for the opportunity to review the draft report and offer comments. While the draft report does not provide any specific recommendation, the report does address the impacts of recent national health reform legislation on TRICARE, as well as the Department's implementation of TRICARE Young Adult based upon separate Congressional direction. We have carefully reviewed the draft report and concur with the report as written. Technical comments are attached to address portions of your report regarding DoD's statutory requirement to follow Medicare payment rules to the extent practicable.

Thank you again for the opportunity to review and provide a response. The points of contact on this issue are Dr. Robert Opsut (Functional) and Mr. Gunther Zimmerman (Audit Liaison). Dr. Opsut may be reached at (703) 681-8878, and Mr. Zimmerman may be reached at (703) 681-4360.

Thank you for your interest in the health and well-being of our Service members, veterans and their families.

Sincerely,

Jonathan Woodson, M.D.

Attachments:
As stated

Enclosure III

GAO Contact and Staff Acknowledgments

GAO Contact

Debra A. Draper, (202) 512-7114 or draperd@gao.gov

Staff Acknowledgments

In addition to the contact named above, Bonnie W. Anderson, Assistant Director; Jeff Mayhew; and Michael Zose made key contributions to this report. Jennie Apter assisted in the message and report development, Timothy Carr and Frank Todisco provided methodological support, and Lisa Motley provided legal support.

(290935)

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