



Center for a  
New American  
Security

## **Working Paper:**

Improving Federal Health and Benefits Programs to Support  
Seriously Wounded, Ill and Injured Veterans

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## About the Author



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## About the CNAS Military, Veterans, and Society Program

The Military, Veterans, and Society (MVS) program addresses issues facing America's service members, veterans, and military families, including the future of the All-Volunteer Force, trends within the veteran community, and civil-military relations. The program produces high-impact research that informs and inspires strategic action; convenes stakeholders and hosts top-quality public and private events to shape the national conversation; and engages policymakers, industry leaders, Congress, scholars, the media, and the public about issues facing veterans and the military community.

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## I. Introduction

Over the past several decades, a fragmented array of government programs has emerged to provide health care or health insurance for Americans. Several of these programs serve the veterans and military community, either directly or indirectly, including Department of Defense (DoD) medical care and health insurance, Department of Veterans Affairs (VA) health care and disability compensation; Social Security Disability Insurance (SSDI), Medicare, and others. Over the past several decades, these programs each came into being separately. Consequently, they do not mesh cleanly, and cannot have their interactions easily fixed, because they fall under the jurisdiction of myriad agencies and Congressional oversight committees. This area's complex political landscape makes reform even more difficult, because each program has large and politically powerful stakeholders.

This working paper examines the overlap of these programs with respect to a specific sub-population: seriously wounded, ill and injured veterans who retire from active military service with disabilities so severe that they cannot work after leaving service. The web of government programs serving this population does not mesh well, creating challenges for veterans as they move between these programs. This set of problems has been described by stakeholders as the “TRICARE-Medicare trap,” which ensnares veterans and their family members who fail to perfectly navigate the system of benefits, potentially losing health coverage or incurring substantial costs and penalties, or both. To better understand this problem, this paper estimates the size of this population and some of its relevant characteristics, including levels of disability compensation. Next, this paper outlines the health choices facing this population after leaving service, including some of the dilemmas created by messy interplay of DoD, VA, SSDI, and Medicare programs. Finally, this paper concludes with several potential solutions for these issues, including:

- Improving data sharing and coordination among agencies, both to identify veterans and families that experience difficulty (and require assistance), and to identify macro-level policy issues that may arise in the future from this fragmented array of benefits programs.
- Decoupling TRICARE from Medicare for severely wounded, ill and injured retirees, such that the nation's most severely disabled veterans do not have to opt into Medicare Part B in order to obtain TRICARE.
- Eliminating penalties for this category of veterans for delayed enrollment in Medicare Part B, or TRICARE, or vice-versa, creating a more forgiving health care system for this class of severely wounded, ill or injured veterans.
- Enabling movement between systems for veterans as their life circumstances change, such as when veterans return to work.
- Creating cost parity between health care systems such that the most severely wounded, ill or injured veterans do not pay more for their health care than ordinary DoD retirees using TRICARE, or non-retired veterans using the VA or Medicare for their health care.

## II. Background

### A. The Veterans and Military Population

The VA and Census Bureau estimated that there were approximately 21.4 million U.S. veterans in 2016, including all generations and segments of the veteran population.<sup>1</sup> These veterans make up 6.6 percent of the total national population. In the aggregate, the current veterans population is an older, white, male population; its median age is approximately 64, and more than 90 percent of veterans are male. However, these demographics are changing. In 2015, Gulf War-era veterans overtook Vietnam-era veterans as the largest segment of the population. The post-9/11 cohort of veterans now numbers 2,874,820, including those who have deployed to Iraq, Afghanistan, or other theaters of war since 9/11.<sup>2</sup> This makes the post-9/11 deployment cohort roughly equal in size to the number of veterans who served in Vietnam, and substantially larger than the number who served in Korea, although smaller than the number of veterans who served during both eras because the military itself is smaller.<sup>3</sup>

The active duty and reserve population make up an important part of the veteran community – both in terms of size and need, and because the military produces the veteran population of tomorrow. The current military population includes approximately 1.3 million active duty personnel in all four services, and 1.1 million active reservists spread among the various Guard and reserve elements. Military families represent an important part of the active military community, too. There are approximately 1.82 million dependents of active duty personnel, and another 682,000 dependents for active reserve personnel.<sup>4</sup> DoD has primary authority for serving the active and reserve population and their families.

Each year, at its current size, the active military takes in approximately 175,000 recruits, and discharges a similar number. The reserves turn over about half that number, with many of their recruits coming from active service. Of those military personnel leaving the service, approximately three quarters leave at the end of their service period, with little or no continuing eligibility for DoD benefits. The remaining quarter “retire” from military service, earning some type of DoD retirement pension as well as the lifetime provision of other benefits such as health insurance, base access, and commissary shopping privileges. Within this DoD retiree population, three quarters retire after 20 years (or more) of service; one quarter retire because of a medical reason that renders them ineligible for continued military service. The table below summarizes the annual turnover of the active duty military in FY2015, the last year for which complete data is available:

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<sup>1</sup> Department of Veterans Affairs, Veterans Population (“VetPop”) data, 2014 update, projection for 2017; U.S. Census Bureau, American Community Survey.

<sup>2</sup> Department of Defense, Contingency Tracking System data, as of May 2017.

<sup>3</sup> Department of Veterans Affairs, “Fact Sheet: America’s Wars,” April 2015, available online at: [http://www.va.gov/opa/publications/factsheets/fs\\_americas\\_wars.pdf](http://www.va.gov/opa/publications/factsheets/fs_americas_wars.pdf).

<sup>4</sup> Department of Defense, “Evaluation of the TRICARE Program: Access, Cost and Quality, Fiscal Year 2016 Report to Congress.” Note that the population of reserve dependents includes those reserve families who are eligible for DoD family benefits, including but not limited to TRICARE, because of their duty status or other reason. The majority of reserve families are not eligible for such benefits while they are in a non-active duty status.



<b>FY15<sup>5</sup></b>	<b>Active Duty Accessions</b>	<b>Active Duty Discharges</b>	<b>Total Active Duty Retirees</b>	<b>Active Duty Medical Retirees</b>
<b>Army</b>	65,563	83,628	26,920	16,273
<b>Navy</b>	39,162	36,750	9,105	2,280
<b>Air Force</b>	28,552	33,400	12,738	2,984
<b>Marines</b>	31,258	34,498	6,457	2,979
<b>Totals:</b>	164,535	188,276	55,220	24,516 <sup>6</sup>

Within this population, this paper focuses on a set of issues that affect a relatively narrow slice of the military and veterans population: those individuals who are so severely wounded, ill, or injured on duty that they are medically retired, and who then cannot work and begin receiving disability insurance from the Social Security Administration.

## B. Federal Programs

The VA has primary statutory authority for serving the veterans population. The majority of the VA's legal mandate, captured in Title 38 of the United States Code, focuses on veterans; however, the agency also has some limited authority and funding to provide support to family members or caregivers. Despite the VA's size (at \$186 billion, the VA's budget is second only to DoD), the agency shares responsibility with other agencies including DoD, the Department of Health and Human Services (HHS), the Department of Labor (DoL), Department of Justice (DoJ), and the Social Security Administration (SSA). This section describes the major programs operated by these agencies that affect the population of severely wounded, ill or injured veterans.

### 1. Medicare

Medicare was born in 1965, as part of the Johnson Administration's "Great Society" package of social programs designed to provide greater economic security for America's middle and working class.<sup>7</sup> Today, Medicare provides health insurance coverage to more than 55 million people: 46.3 million people ages 65 and older, and 9 million people with permanent disabilities under age 65.<sup>8</sup> The Medicare program operates through a number of parts, each of which provides specific coverage and benefits:

<sup>5</sup> The data for FY15 shows a net loss of 23,741 service members between new officers and enlisted personnel accessed, and those discharged or retired. This likely reflects the shrinkage of the services during this fiscal year, based on reductions to service end strength authorized by law.

<sup>6</sup> 2015 Demographics: Profiles of the Military Community," (Office of the Deputy Assistant Secretary of Defense, 2015), <http://download.militaryonesource.mil/12038/MOS/Reports/2015-Demographics-Report.pdf>; CNA Population Representation in the Armed Force, 2015, Table D-38, [https://www.cna.org/pop-rep/2015/appendixd/d\\_38.html](https://www.cna.org/pop-rep/2015/appendixd/d_38.html); DoD Statistical Report on the Military Retirement System ("MRS"), 2015, [http://actuary.defense.gov/Portals/15/Documents/MRS\\_StatRpt\\_2015%20Final%20v2.pdf](http://actuary.defense.gov/Portals/15/Documents/MRS_StatRpt_2015%20Final%20v2.pdf).

<sup>7</sup> Medicare Act, Pub. L. 89-97 (79 Stat. 286), signed July 30, 1965.

<sup>8</sup> Department of Health and Human Services, FY2016 Budget in Brief: Strengthening Health and Opportunity for All Americans, 2015 (available online at: <http://www.hhs.gov/budget/fy2016/fy-2016-budget-in-brief.pdf>).

- Part A covers inpatient services such as stays in a hospital, or short-term and long-term stays in skilled nursing facility.
- Part B covers outpatient health care such as doctor visits, physical therapy, and durable medical equipment. Medicare Part B has a monthly premium, some veterans may have their premiums paid by Medicaid, or deducted from their DoD retirement or SSDI, depending on their circumstances.
- Part C is an optional Medicare that lets beneficiaries enroll and receive their Medicare benefits through a private “Medicare Advantage” plan (such as an HMO, PPO or private fee-for-service plan).
- Part D provides prescription drug coverage, after a beneficiary enrolls in a private Part D prescription drug plan that serves their geographic region.

These Medicare programs matter for the military and veteran population for a number of reasons. The vast majority of veterans, including all non-DoD-retirees, will become eligible for Medicare at age 65; most will use some combination of Medicare benefits and private insurance to cover their health care. For DoD retirees, Medicare matters because the Medicare trust fund is the fiscal vehicle used by the federal government to pay for TRICARE benefits, for all who are eligible for TRICARE. This linkage of the two programs is part of the reason for the trap described later in this paper.

## 2. DoD Retirement and Health Insurance (TRICARE)

Approximately one quarter of all personnel leaving military service do so as retirees, either because they served for 20 years or longer, or because they retired from service with a disability. Consequently, these veterans leave the service with some continuing entitlement to a package of DoD benefits including a retirement pension, health coverage, base access, and more. For purposes of this paper, the two most important parts of this retirement package are retirement pay and health care.

Non-disability DoD retirees earn a retirement pension based on their length of service and pay during service. Under current law, retirement is formulated through three distinct formulas (depending on date of enlistment or commissioning, and service member election).<sup>9</sup> For service members who joined the military before September 8, 1980, retired pay equals the number of years in service (20 or greater) times the multiplier of 2.5 percent times final base pay. Under this formula, a service member who leaves the service at year 20 is entitled to 50 percent of their final base pay, payable immediately upon retirement, for the duration of their lifetime. These amounts may increase each year, based on a discretionary cost of living adjustment (COLA) enacted by Congress and implemented by the DoD. For service members who joined after September 8, 1980, the retiree draws 2.5 percent times the number of years in service, multiplied by the average of the last three years in income (as opposed to basic pay during the final year; referred to as “high-36”). Under a third formula, known as “REDUX,” service members earn less credit for their first 20 years of service, and more for each year after 20 years. Thus, a retiree leaving after 20 years would get 40% of

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<sup>9</sup> For more background on the military retirement system, see David F. Burrelli and Barbara Salazar Torreon, “Military Retirement: Background and Recent Developments,” Congressional Research Service Report RL34751, May 28, 2014.

his or her base pay in retirement, but a retiree leaving after 30 years would earn 75% of his or her base pay, at which point REDUX retirees break even with “high-3” retirees.<sup>10</sup> The majority of DoD retirees today fall under the second formula, with their retirement pensions calculated on the basis of their last three years of base pay. However, beginning in 2018, DoD will begin to phase in a new “Blended Retirement System” that combines the traditional defined-benefit formula (at a lower percentage of base pay) with a government matching contribution to service members’ Thrift Savings Plan retirement accounts.

Alongside this retirement pay, DoD retirees also earn continued health care for themselves and their dependents. This health care includes access (on a space-available basis) to military treatment facilities on base, and access to private health care providers through DoD’s TRICARE health insurance system. TRICARE evolved during the 1990s from out of an earlier program called the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). It is essentially an insurance scheme that pays for health care obtained by DoD beneficiaries outside of military treatment facilities.

The evolution of the TRICARE system matters greatly for the issue at hand, because of the funding mechanisms and design principles baked into the TRICARE statute and regulations in the early 2000s. In 2002, partly in response to significant public pressure and litigation, Congress legislated a new benefit that DoD would eventually call “TRICARE for Life (TFL),” which was meant to supplement Medicare for DoD retirees and their families who also were eligible for Medicare.<sup>11</sup> Prior to this legislative change, retirees and their families lost their TRICARE benefits upon becoming eligible for Medicare, though they retained the ability to access military treatment facilities on a “space available” basis.<sup>12</sup> In making this change, Congress legislated that Medicare would become the primary payer for Medicare-eligible DoD retirees’ care, with DoD as the second payer for these beneficiaries. To fund this arrangement, the new system required DoD to make accrual payments to the MERHCF each year, to cover the costs of Medicare paying for DoD retirees’ health care once they become Medicare-eligible.<sup>13</sup> The statutes which created this larger system required all Medicare-eligible DoD retirees – including both those eligible because of their reaching age 65, and those made eligible by operation of other rules, like SSDI receipt – to purchase Medicare Part B coverage in order to keep TRICARE For Life.

The total TRICARE beneficiary population includes approximately 9.6 million individuals from a number of different segments: active duty military personnel, mobilized reservists, drilling reservists, DoD retirees, and their family members. TRICARE is an umbrella term that includes a number of specific TRICARE insurance programs, including specific programs for active duty service members, reserve component service members, military retirees, and their respective family members. The most important of these TRICARE programs are Prime, which supports active duty

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<sup>10</sup> The CSB/REDUX retirement system applies to a relatively narrow class of service members who entered service on August 1, 1986 or afterwards, and received a \$30,000 retention bonus at their 15<sup>th</sup> year of service.

<sup>11</sup> See Sections 712 and 713 of the Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001 (P.L. 106-398, 114 Stat. 1654A–176).

<sup>12</sup> See CBO, “Costs of Military Pay and Benefits in the Defense Budget,” November 2012.

<sup>13</sup> Notably, “DoD projects that the cost for the department to provide health care to Medicare-eligible retirees and their families will exceed the accrual contribution.” Id.

troops, non-Medicare-eligible retirees, and their families, and TRICARE For Life, which supports DoD retirees who are Medicare eligible (by reason of age or disability), and their family members.

A service member, veteran, or family member's eligibility for TRICARE depends on a number of factors, including military status (active duty, reserve, or retired), geographic location, and Medicare eligibility, among others. Each program has slightly different benefits and out-of-pocket costs. In general, the severely disabled population will fall under TRICARE Prime while on active duty and following medical retirement from DoD until they are Medicare eligible. Severely disabled retirees become Medicare eligible at the 25<sup>th</sup> month of SSDI entitlement or turning 65. (Note, however, that if a severely wounded veteran leaves the service without a medical retirement, they will not be entitled to TRICARE, although they will likely have VA eligibility, and possibly also Medicare eligibility if they pursue SSDI.) When a service member leaves the service, their TRICARE eligibility, and that of their family members, will end, unless they retire from the military after 20 years or more of service, or with a medical retirement.

### 3. VA Health Care and Disability Compensation

Upon leaving service, all veterans<sup>16</sup> are eligible for health care and benefits from the VA, including medical treatment for service-connected health issues, and in some cases, treatment for other health issues that do not relate to service. Approximately 9 million veterans choose to enroll in the VA's health care system; nearly 7 million of these veterans utilized the VA's health system last year. Within this population, the VA prioritizes certain veterans for access to care, and sets co-pay requirements as well, based on a 8-tier priority group system mandated by statute.

Veterans may also apply for disability compensation from the VA. The VA evaluates veterans' claims for disability, adjudicates those claims, and provides veterans with a percentage rating for their claims between 0 percent and 100 percent. VA disability compensation is a function of rating percentage and certain other variables such as dependent status, with 10 percent disability providing \$133.57 per month, and 100% disability with a spouse and two children providing \$3,458.06 per month. VA health care is not dependent upon the award of a service-connected disability. However, the two systems are linked, to the extent that the VA prioritizes veterans with service-connected disability ratings over other classes of veterans for access to VA health care, and the VA requires smaller (or no) co-payments from veterans with service-connected disabilities.

Prior to 2004, federal law prevented "concurrent receipt" of DoD retirement pay and VA disability compensation. Under the previous legal regime, retirees who received VA disability compensation had their military retirement pay reduced on a dollar-for-dollar basis to offset their VA disability benefits. Congress changed the law in 2004 to allow concurrent receipt for retirees who had a combined disability rating of 50 percent or greater, with the new policy phased in over ten years between 2004 and 2014. Beginning in 2014, veterans who qualify for "concurrent receipt" are able

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<sup>16</sup> According to federal statute, "The term 'veteran' means a person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable." See 38 U.S.C. 101. Importantly, this definition excludes reservists and Guardsmen who did not mobilize for a federal tour of active duty, and those veterans discharged with less-than-honorable or dishonorable discharges.



to receive the full amount of both DoD retired pay and VA disability compensation, with no offset. Military retirees or veterans who do not qualify for “concurrent receipt” have an option to choose between receiving DoD retirement pay offset by their VA disability benefits, or waiving their DoD retirement pay and receiving VA disability compensation instead.

Importantly, a veteran’s status with respect to VA health care and benefits does not generally affect their status with respect to DoD, HHS, or SSA benefits. Veterans health care is a separate earned benefit, for which eligibility is determined by military service and the existence of an injury or illness that may relate to service. Veterans disability compensation is based on service, and an adjudication by the VA that a veteran has a service-connected illness or injury. These determinations are made independently of whether a veteran is entitled to DoD retirement pay and benefits, whether a veteran is entitled to Medicare, or whether a veteran is entitled to SSDI.

#### 4. Social Security Disability Insurance (SSDI)

The SSDI program is a program administered by the SSA to provide financial support to severely disabled Americans. In addition to DoD and VA benefit programs, veterans may also be eligible for SSDI if they have a medically determined physical or mental impairment that (1) has lasted (or is expected to last) at least 1 year or is expected to result in death; and (2) that prevents the individual from engaging in “substantial gainful activity.”<sup>17</sup>

Characteristic	Veterans under age 66 who report receiving Social Security disability benefits	
	Number (thousands)	Percent
Total	771	100
Age		
39 or younger	22	2.9
40–49	96	12.5
50–59	262	34.0
60–66	390	50.6
Sex		
Male	707	91.6
Female	65	8.4
Married	437	56.7
Education		
At least a high school diploma	707	91.7
At least a bachelor's degree	109	14.1
Race and ethnicity		
Black <sup>b</sup>	133	17.3
Hispanic	37	4.8
No Medicare	238	30.8
Income below—		
Poverty threshold	88	11.5
150% of poverty threshold	201	26.1

SOURCE: March 2010 CPS.

NOTE: Weighted estimates are based on the public-use March 2010 CPS (income year 2009), and are subject to nonsampling error (such as respondent error in reporting characteristics and amount and type of income).

a. Social Security disability benefits are converted to retirement benefits when the beneficiary reaches full retirement age.

b. More than one race can be reported in the CPS. Data include people who identify themselves as black alone or in combination with one or more races.

<sup>17</sup> The SSA defines “substantial gainful activity” as work activity that involves significant physical or mental activities performed for pay or profit. Notably, this definition differs from the disability definitions used by DoD and VA when determining disability, creating additional gaps and tensions between these adjudication and benefits systems.

It is difficult to estimate the precise size of the veteran population drawing SSDI before the age of 65 – those veterans who fall into the “TRICARE-Medicare trap.” Sources of aggregate federal data, such as the Current Population Survey (CPS) or Survey of Income and Program Participation (SIPP), provide only aggregate counts of how many veterans receive various types of federal benefits. One recent estimate using these data sources found that approximately 15 percent of veterans receiving VA disability compensation also receive SSDI.<sup>18</sup> A recent estimate by SSA economists found there were 771,000 veterans under the age of 66 drawing Social Security benefits, with the vast majority of these veterans above the age of 60, as the table<sup>19</sup> above shows.

However, the 771,000 number includes many more veterans than the population who fall into the “TRICARE-Medicare trap” because it includes all veterans who are disabled – not just those who are medically retired from service because of wounds, illness, or injury sustained on duty. Without the DoD medical retirement, there is no entitlement to TRICARE, and therefore these veterans do not face the same issue with respect to the interface between TRICARE health insurance, Medicare, and SSDI. Other recent analyses, such as those examining the number of veterans using multiple federal benefits programs, likely also fail to measure this population for similar reasons.<sup>20</sup>

Consequently, this paper uses a different method to estimate the number of veterans who fall into the “TRICARE-Medicare trap.” Instead of using public data regarding Social Security utilization and veterans disability ratings, this paper estimates the size of the population using Defense Department data regarding military retirements, and estimates developed through stakeholder interviews and discussions.

According to DoD’s most recent statistical report on its retiree population, there are approximately 2 million retired personnel, including 1,446,046 enlisted retirees and 536,138 officer retirees.<sup>21</sup> Of these 2 million retirees, 241,650 retired because of a disability.<sup>22</sup> The average age at the time of military retirement for these disability retirees was 38.0 for officers, and 33.1 for enlisted personnel, several years younger on average than the normal retirement age for DoD personnel. On average,

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<sup>18</sup> See CNA Corporation, “Disabled Veterans Receiving SSDI” (prepared for the Veterans’ Disability Benefits Commission, March 29, 2006).

<sup>19</sup> Anya Olsen and Samantha O’Leary, “Military Veterans and Social Security: 2010 Update,” SSA, <https://www.ssa.gov/policy/docs/ssb/v71n2/v71n2p1.pdf>.

<sup>20</sup> A recent GAO study of Social Security Administration data found 59,251 individuals (out of 1.9 million total DoD retirees) who drew the combination of DoD retired pay, VA compensation, and SSDI.<sup>20</sup> The majority (68 percent) of this population drawing concurrent DoD, VA and SSDI benefits received between \$25,000 and \$75,000 in total annual benefits; just 4 percent received more than \$100,000 in combined benefits. Roughly half of this population was age 60 or higher, and 81 percent had a VA disability rating that exceeded 50 percent. See GAO Letter to Sen. Tom Coburn, “Disability Compensation: Review of Concurrent Receipt of Department of Defense Retirement, Department of Veterans Affairs Disability Compensation, and Social Security Disability Insurance,” Sept. 30, 2014, <http://www.gao.gov/assets/670/666267.pdf>.

<sup>21</sup> DoD Statistical Report on the Military Retirement System (“MRS”), 2015, [http://actuary.defense.gov/Portals/15/Documents/MRS\\_StatRpt\\_2015%20Final%20v2.pdf](http://actuary.defense.gov/Portals/15/Documents/MRS_StatRpt_2015%20Final%20v2.pdf).

<sup>22</sup> This figure includes two categories of disabled retirees: 112,260 whose retirements are paid with DoD appropriated funds, and an additional 129,390 disabled DoD retirees who are not part of DoD retirement appropriations. See 2015 MRS at 157. Based on discussions with the DoD Office of the Actuary, these retirees include those who earned a traditional DoD retirement because of their length of service, and then received a disability from VA after retirement, such that their disability compensation is paid with funds appropriated to VA, not DoD.

disability retirees are significantly younger than their non-disability retiree peers. Within the total population of DoD retirees, the average retired officer is currently 67.5, and average enlisted retiree is currently 62.6.<sup>23</sup> Within the disabled retiree population, the average retired officer is currently 60.8, and the average enlisted retiree is currently 51.0.

Medical retirees depart the service with a rating that indicates their degree of disability, as evaluated by DoD prior to retirement. The table below describes the degree of disability for the current population of 241,650 DoD retirees, including both those in and outside of the DoD retirement appropriation.

<b>Disability Rating</b>	<b>Army</b>	<b>Navy</b>	<b>Air Force</b>	<b>Marines</b>	<b>Total</b>
<b>10%</b>	1,150	2,674	645	735	<b>5,204</b>
<b>20%</b>	1,443	1,422	626	474	<b>3,965</b>
<b>30%</b>	33,385	12,962	10,876	8,372	<b>65,595</b>
<b>40%</b>	22,961	6,578	5,303	5,477	<b>40,319</b>
<b>50%</b>	19,565	4,207	4,397	3,666	<b>31,835</b>
<b>60%</b>	17,494	3,119	2,922	2,877	<b>26,412</b>
<b>70%</b>	15,397	1,981	2,288	2,438	<b>22,104</b>
<b>75%</b>	0	104	16	26	<b>146</b>
<b>80%</b>	9,621	835	863	1,345	<b>12,664</b>
<b>90%</b>	4,348	344	260	568	<b>5,520</b>
<b>100%</b>	11,004	3,286	2,298	2,428	<b>19,016</b>
<b>Unk.</b>	198	199	8,340	133	<b>8,870</b>
<b>Total</b>	<b>136,566</b>	<b>37,711</b>	<b>38,834</b>	<b>28,539</b>	<b>241,650<sup>24</sup></b>

Of these DoD disability retirees, 117,697, or roughly half, left the service with a 50 percent disability rating or higher. This sub-population constitutes the most severely wounded, ill or injured segment of the DoD retiree population. Based on research, including interviews with subject matter experts, and working group discussions with stakeholders and government officials, this paper estimates that approximately one quarter of this sub-population (DoD medical retirees with a disability rating of 50 percent or greater) will apply for (and likely receive) SSDI from SSA. Consequently, this paper estimates there are approximately 29,400<sup>25</sup> DoD medical retirees who are currently drawing SSDI, or have drawn SSDI since their separation from service.<sup>26</sup> Assuming this estimate is correct, this is the

<sup>23</sup> Id. at 59.

<sup>24</sup> FY2015 MRS at 197.

<sup>25</sup> Based on DoD data regarding the ages of disability retirees, this paper estimates that approximately 66,000 of these 241,650 retirees are at or above the age of 65. See FY2015 MRS at 61-62.

<sup>26</sup> Two caveats are necessary when describing the veteran population drawing SSDI. The first is that some veterans will leave the service with a DoD medical retirement and eventually draw SSDI for reasons having nothing to do with their service, such as a car accident in civilian life that causes severe disability and an inability to work. The second caveat is that veterans may draw SSDI benefits for a period of time, and then relinquish these benefits when their condition

population that *could* fall into the “TRICARE-Medicare trap,” based on its eligibility for DoD retirement pay and benefits (including TRICARE), eligibility for SSDI, and likely utilization of the latter. However, it is unclear how many veterans within this pool actually do fall into the trap because they fail to navigate the uncertain seams between these federal benefits programs. All of these 14,000 veterans are affected by the statutory mandate to obtain Medicare Part B in order to maintain and access TRICARE; only some fail to timely select coverage, or smoothly move between the systems, such that they risk losing health care or incurring penalties.

### III. Analysis

The fragmented network of government health programs serving severely wounded, ill and injured veterans creates a number of problems. At a national level, these overlapping, redundant systems create inefficiencies by virtue of their separate, parallel existence. Although just one system will bear the costs for any particular episode of care, each system costs money to maintain, regardless of utilization. Relatedly, the existence of overlapping and competitive systems creates a navigational challenge for veterans and their families. In the absence of sound data regarding quality, access, and cost, among other factors, veterans and their families may make sub-optimal decisions about where best to get their care. Uneven cost structures and geographic distribution may drive care decisions more than any other factors.

On an individual level, this fragmented approach creates the “TRICARE-Medicare trap” – the problem that severely wounded, ill and injured veterans face if they begin receiving SSDI insurance, thus becoming eligible for Medicare Part B. These individuals must purchase Medicare Part B, or else they will lose their TRICARE coverage. Individuals who fall into this situation, but then begin working again (and relinquish their SSDI), must retain (and pay for) their Medicare coverage for 8 years after losing SSDI, because they remain “Medicare-entitled” during that time by virtue of their eligibility for “rapid re-enrollment” in Medicare as a former SSDI recipient. Once they exit this 8-year window, these veterans must then reapply for TRICARE Prime in order to re-enter the system. The U.S. Government arguably owes a greater debt to severely wounded, ill and injured veterans than any other group who has worn the nation’s uniform. And yet, because of the ways these separate benefits programs interact, the Government exacts a greater monetary and bureaucratic toll on this group.

#### A. Overlapping Eligibility for Benefits Programs

Within the current system, a severely disabled veteran will likely qualify for at least three federal agencies’ programs for health care, disability compensation, and wellness support. In the health care arena specifically, severely disabled veterans likely have eligibility and/or entitlement to obtain care under at least three programs as well. Because these programs were all enacted separately, with slightly different mandates and agency contexts, they do not perfectly duplicate each other. However, the overlap between them creates some confusion in the minds of veterans, family

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improves and they return to the workforce. These caveats make precise calculation of the “TRICARE-Medicare trap” population difficult based on aggregate data.

members, policy makers, and health providers, and contributes to the complexity of the landscape. These overlapping programs include:

Program	Population Served
SSDI	Provides disability benefits to veterans who are disabled and unable to work; 25 months of SSDI eligibility triggers Medicare enrollment for veterans under the age of 65.
Medicare	Health insurance for Medicare-eligible persons, including two main categories of veterans: those 65 or older, and veterans who receive SSDI benefits.
TRICARE	Health insurance for DoD retirees and their immediate family members, which pays nearly all of the costs of obtaining health care through TRICARE network providers and non-network providers.
VA Health Care	Available to all eligible veterans (and certain caregivers) who enroll in the VA health care system. Veterans without service-connected disability ratings may pay some co-pays, or wait longer for services.

Although the actual costs of health care will only be borne by one of these systems for any given episode of care, each system has infrastructure costs that exist regardless of utilization. Consequently, allowing separate systems to exist with overlapping eligibility is not cost-free; there are inefficiencies associated with maintaining these overlapping and parallel systems, particularly to the extent they are administered by different agencies with different appropriations and little administrative interaction.

The slight differences between quality, competency, eligibility and benefits among these systems also creates confusion among veterans, caregivers, and providers as to the optimal system to use for any given episode of care. Ideally, patients would make choices about health care using a blend of quality, cost, access, and preference data. However, in the current health ecosystem, cost and access data are more readily accessible, despite recent efforts by DoD and VA to make health data more transparent.<sup>27</sup> Consequently, patient surveys suggest that veterans and their families make health care decisions based primarily on cost considerations (i.e. What is cheapest?) and access considerations (i.e. What is closest? Where can I get in today?). This results in uneven care for veterans, and uneven distribution of resources across the systems, in ways that do not generally lead to the best health outcomes for veterans.

<sup>27</sup> Both DoD and the VA have begun to make information public regarding the quality and health outcomes of their facilities. The Defense Health Agency currently shares data online (<http://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Patient-Portal-for-MHS-Quality-Patient-Safety-and-Access-Information>) regarding patient satisfaction, patient outcomes, patient safety, and other metrics. The VA publishes similar information regarding its health care facilities, including access (<http://www.va.gov/health/access-audit.asp>), quality (<http://www.qualityandsafety.va.gov/> and [http://www.va.gov/QUALITYOFCARE/measure-up/Strategic\\_Analytics\\_for\\_Improvement\\_and\\_Learning\\_SAIL.asp](http://www.va.gov/QUALITYOFCARE/measure-up/Strategic_Analytics_for_Improvement_and_Learning_SAIL.asp)), and patient satisfaction as well. Recently, the VA also began to publish near-real-time access information for its facilities, both in tabular form (<https://www.va.gov/health/access-audit.asp>) and map-based form (<https://www.accesstocare.va.gov/>).



## B. Individual Costs and the TRICARE-Medicare Trap

Under federal law and regulation, the TRICARE and Medicare programs are linked at the macro and micro levels in important ways that affect both the programs as a whole, and individuals who are eligible for each. At the macro level, the TRICARE and Medicare programs are linked through their funding. In 2000, Congress passed legislation creating the TRICARE For Life (TFL) program, and establishing the Medicare-Eligible Retiree Health Care Fund (MERHCF) to pay for Medicare-eligible retiree health care beginning in 2002.<sup>28</sup> In doing so, Congress created a system where Medicare served as the primary payer for TRICARE-eligible retirees, regardless of age. To effectuate this linkage, Congress mandated in federal law that TRICARE-eligible retirees who were also eligible for Medicare Part B must opt into (and pay for) Medicare Part B – or risk losing their TRICARE coverage. By setting up a system where Medicare underwrote TRICARE as the primary payer for DoD retiree health care, and then requiring TRICARE beneficiaries to opt into Medicare Part B, Congress enabled the MERHCF to support the costs of providing the TFL benefits to the DoD retiree population.<sup>29</sup> However, this also inadvertently forced medical retirees into the same system, along with those who retire after twenty years and reach age 65, for whom it was intended.

This macro-level linkage between the systems is important because it establishes the MERHCF and facilitates its use as a funding reservoir for the TFL program. The majority of TFL beneficiaries are DoD retirees with 20 or more years of service, and their families. This is an important constituency within the DoD community, which now includes more than 2 million retired career enlisted personnel and officers. After retirement pay itself, the TFL benefit is viewed by this community as the next most valuable benefit, both because of its intrinsic value, and its value in comparison to the highly volatile and expensive U.S. health care market.

However, this macro-level linkage sets up a Catch-22 situation at the individual level, wherein the most severely wounded, ill and injured veterans may end up paying more for their health care coverage because of the need to opt into Medicare Part B in order to keep their TRICARE coverage. Additionally, this coverage will consist of TRICARE For Life as a wraparound option for Medicare Parts A and B, rather than TRICARE Prime, a benefit these service members are entitled to due to their retirement status. Thus, we are penalizing those wounded, ill and injured service members who are eligible to draw SSDI by forcing them into the Medicare system at a young age, reducing their SSDI benefit and potentially compromising their healthcare. Consider the cases of four hypothetical DoD retirees:

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<sup>28</sup> See Floyd D. Spence National Defense Authorization Act for Fiscal Year 2001, Pub. L. 106-398, Oct. 30, 2000 (<http://www.dod.mil/dodgc/olc/docs/2001NDAA.pdf>).

<sup>29</sup> The MERHCF works by taking accrual deposits from the military services, Coast Guard, and Public Health services to cover future TFL expenses for currently serving personnel and their families. The Treasury Department also deposits money in this account to cover the unfunded liability associated with existing retired personnel, and health costs that exceed those covered by the accrual deposits. MERHCF funds are then transferred out and into the Defense Health Program each year based on estimates of how much it costs DoD to provide health care for TFL beneficiaries, both through DoD facilities and through TRICARE networks. For a good primer on this system, see MOAA Blog at <http://www.moaa.org/blog/healthcare/2013/03/how-is-tricare-for-life-funded/#sthash.zCa76AeT.dpuf>.

- Alvin is an Army Colonel who will retire in 2016 at the end of 30 years of service. When he retires, he will be 52 years old. Alvin will draw \$97,893 in retirement pay in his first year of retirement; this amount will be adjusted each year by DoD to keep up with inflation.<sup>30</sup> As a DoD retiree, Alvin will be entitled to TRICARE to cover himself, his spouse, and his children up to a certain age, at a cost of \$565.20 per year in enrollment fees, plus network co-payments.<sup>31</sup> At age 65, Alvin will become Medicare eligible, and also eligible for TFL. At this point, Alvin must opt into Medicare Part B in order to get TFL coverage for himself. From the age of 65 on, Alvin must pay Medicare Part B premiums, currently \$187.50 per month (for a retiree with his income<sup>32</sup>) plus \$183 per year in a Part B deductible.<sup>33</sup> The combined coverage of Medicare Part B and TFL then cover all his health costs, including any additional out-of-pocket costs not covered by either policy, with each filling in for the other.
- Beth is a Navy Senior Chief Petty Officer who will retire in 2016 at the end of 30 years of service. When she retires, she will be 50 years old. Beth will draw \$50,976 in retirement pay in her first year after leaving service; this amount will increase each year with inflation. As a DoD retiree, Beth will also be entitled to TRICARE for herself and her dependents, at the same cost as Alvin: \$555.84 per year in enrollment fees, plus network co-payments. At age 65, Beth will also transfer from TRICARE Prime to TFL, and be required to purchase Medicare Part B in order to get TFL coverage, at a cost of \$134 per month (at her income level) plus \$183 per year in a Part B deductible.
- Carl is a Marine Sergeant with 6 years of service who gets severely wounded in Afghanistan by an improvised explosive device; he loses one leg at the knee, and sustains other injuries to his arms and face. Carl is married with two young children. While he is recuperating at Balboa Naval Hospital, Carl's case manager encourages him to also seek SSDI support through SSA's Wounded Warrior Program. The program allows him to receive SSDI while still on active duty, giving him an additional benefit of approximately \$14,000 per year. The Marine Corps decides to medically retire Carl in 2014, and award him an 80 percent disability rating for his injuries, including an 80 percent combat-related special compensation award percentage. This will entitle him to \$27,101.76 for his first year of retirement pay, an amount that will be adjusted by DoD each year for inflation.<sup>34</sup> Because of his medical retirement from DoD, Carl is entitled to TRICARE coverage, with the same enrollment fees as Alvin and Beth. His disability rating and veteran status also entitles him to VA health care as a member of Priority Group 1. After he retires from the Marine Corps, he is not immediately able to work and he continues to receive SSDI benefits. After 25 months of SSDI eligibility, he becomes automatically enrolled in Medicare and TFL. SSA notifies him of his Medicare eligibility and his right to opt out of Medicare Part B. If he opts out of Medicare Part B, he loses his TFL coverage. Because he is not working at the time, his Medicare Part B

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<sup>30</sup> DoD Retirement Pay Calculator, using O6 with 30 years of service retiring in 2015 under the "High 36" system currently in place for DoD retirees. (<http://militarypay.defense.gov/mpcalcs/Calculators/FinalPayHigh3Result.aspx>).

<sup>31</sup> <http://www.tricare.mil/Costs/HealthPlanCosts/PrimeOptions/EnrollmentFees.aspx>

<sup>32</sup> <https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html>

<sup>33</sup> <https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html>

<sup>34</sup> <http://www.dfas.mil/militarymembers/woundedwarrior/disabledretireest.html>

premiums are automatically deducted from his SSDI payment. However, as he recovers, Carl eventually returns to the workforce, leveraging a volunteer internship he did while recovering at Balboa, which he found gave him a sense of purpose after his injury. Carl knows that if he returns to work full time, he will lose his SSDI benefits, but he chooses to do so because of the lifetime benefits (monetary and non-monetary) from employment. Carl starts working again, losing his SSDI benefits but continuing to draw disability compensation for his 80 percent rating. But because he loses his SSDI, he also loses the requirement to opt into Medicare Part B, because he's no longer Medicare-eligible. Consequently, Carl becomes eligible again for the traditional TRICARE program, like Alvin and Beth, until he turns 65 and becomes Medicare-eligible again.

- Dan is a Marine Corporal with 4 years of service who is part of Carl's squad; he also gets severely wounded in Afghanistan by the same improvised explosive device. Dan is paralyzed below the waist by a piece of shrapnel that reaches his spine, and he suffers other injuries as well. At the time, Dan is married with two young children. While he is recuperating at Balboa, Dan also applies for SSDI, giving him an additional benefit of approximately \$14,000 per year. The Marine Corps decides to medically retire Dan in 2014, and award him a 100 percent disability rating for his injuries, including a 100 percent combat-related special compensation award percentage. This will entitle him to \$42,073.44 for his first year of retirement pay, an amount that will be adjusted by DoD each year for inflation.<sup>35</sup> Because of his medical retirement from DoD, Dan is entitled to TRICARE coverage, with the same enrollment fees as Alvin, Beth, and Carl. His disability rating and veteran status also entitles him to VA health care as a member of Priority Group 1. After he retires from the Marine Corps, he is not immediately able to work and he continues to receive SSDI benefits. After 25 months of SSDI eligibility, he becomes automatically enrolled in Medicare and TFL. CMS notifies him of his Medicare eligibility and his right to opt out of Medicare Part B. If he opts out of Medicare Part B, he loses his TFL coverage. As he is not working, his Medicare Part B premiums are automatically deducted from his SSDI payment.

The first and second scenarios of Alvin and Beth demonstrate the way the system was intended to work in peacetime, when TFL and the MERHCF was established in 2000. In each of these scenarios, Alvin and Dave are also likely to continue working after retirement, earning additional income and/or private health insurance coverage (although working will not decrease their retirement pay nor change eligibility for TRICARE). However, when each turn 65, and they retire and also begin to use health care more (as is the norm for retirees), they will become Medicare eligible. At that point, TRICARE and Medicare will share the costs of their health care, with TRICARE effectively becoming a very good and cost-advantageous form of supplemental Medicare coverage.

Scenarios three and four, those of Carl and Dan, show the operation of the system in wartime, as applied to two medical retirees with varying degrees of injury. In the third scenario, Carl's retirement and TRICARE eligibility functions much like any other retiree, with no restrictions on whether he can work. However, in Dan's case, he falls into what has been called the "TRICARE-

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<sup>35</sup> <http://www.dfas.mil/militarymembers/woundedwarrior/disabledretireest.html>

Medicare trap.” Because he is so severely disabled that he cannot work, he opts to get SSDI benefits, and therefore becomes Medicare-eligible. In doing so, he triggers his own Medicare eligibility, such that he will now be automatically enrolled in Medicare Part B, and pay for its premiums (which are nearly three times the cost of TRICARE), in order to retain his TFL coverage.

Person	Retirement Pay	Disability Benefits	Work?	Medicare Premium	TRICARE Fees <sup>36</sup>
<b>Alvin (O6, 30 years)</b>	\$97,893 <sup>37</sup> per year as non-disability retiree		Yes	Not until age 65	\$565.20 per year for family plus co-pays and network costs for family
<b>Beth (E8, 30 years)</b>	\$50,976 per year as non-disability retiree		Yes	Not until age 65	\$565.20 per year for family plus co-pays and network costs for family
<b>Carl (E6, 80% disability)</b>	\$27,101.76 in DoD medical retirement	\$14,000 per year for period of time on SSDI	Yes (but loses SSDI)	\$1,308 <sup>38</sup> per year while on SSDI, plus co-pays and deductible	TRICARE For Life (which has no enrollment fees) while on SSDI and Medicare; \$565.20 for family afterwards
<b>Dan (E4, 100% disability)</b>	\$42,073.44 in DoD medical retirement	\$14,000 per year in SSDI	No	\$1,308 per year, plus co-pays and deductible	TRICARE For Life (which has no enrollment fees) while enrolled in Medicare

At the individual level, this disparity between benefits schemes results in the paradox where Dan – the most severely disabled of the four veterans, and arguably the veteran to whom the Government owes the most – must pay the most for health insurance, and navigate the most difficult

<sup>36</sup> The TRICARE fees in this memorandum are based on current amounts published by DoD. These amounts have been the subject of intense attention and public debate, and are likely to change in the future.

<sup>37</sup> Department of Defense retirement pay is adjusted for inflation through Cost of Living Adjustments (COLAs) which reflect Department of Labor adjustments to the Consumer Price Index. The COLA will reflect the percentage increase in the CPI from the 3rd quarter of the current year as compared to the average 3rd Quarter CPI of the year before; if there is no increase or a decrease, there will be no COLA. Department of Defense, "Military Compensation: Retirement," Accessed August 2016. <http://militarypay.defense.gov/Pay/Retirement.aspx>; Department of Defense, "Military Compensation: Retirement Cost of Living Adjustments," Accessed August 2016. <http://militarypay.defense.gov/Pay/Retirement/COLA/>

<sup>38</sup> Medicare part B premiums are a monthly cost based upon yearly income, ranging from \$134 for those making \$85,000 or less to \$428.60 for individuals making over \$214,000 or households making over \$428,000, with varied exceptions that lower the premium cost, with the average Medicare Part B recipient drawing Social Security in 2016 paying \$109/month. See "Part B Costs," <https://www.medicare.gov/your-medicare-costs/part-b-costs/part-b-costs.html>, accessed June 2017; see also "Medicare 2016 costs at a glance," Medicare.gov, Accessed August 2016. <https://www.medicare.gov/your-medicare-costs/costs-at-a-glance/costs-at-a-glance.html#collapse-4809>.

bureaucracies to obtain and keep such insurance as well. The most severely injured veterans also lose access to TRICARE Prime healthcare, and its network of providers with military cultural competency, simply by virtue of having drawn 25 months of SSDI. At the macro level, the overlap and underlap between these benefits schemes, and their lack of coordination or integration, creates a complex menu of choices for veterans and their family members to choose from. Ideally, veterans would choose the option that best balances access, cost (for them and the taxpayer), health outcomes, and other factors. In practice, this menu is difficult to understand and navigate, with opaque options that make it difficult to assess access, quality, and cost. This opacity causes veterans to make choices based on the most apparent factors, such as which benefit will enable them to use the health provider of choice in their neighborhood, or which offers the best price, regardless of care quality.

### C. An Inflexible and Unforgiving System

A related problem for the TRICARE-Medicare trap is the lack of fluidity and flexibility in these options, and the lack of forgiveness for veterans who make a misstep. Consider the case of Dan: if he fails to stay enrolled in Medicare Part B, he may lose the TFL benefit permanently. If, through good casework and a forgiving bureaucracy, he is able to subsequently opt into Medicare Part B and get back into TFL, he will likely be assessed a substantial penalty premium for his late enrollment in Medicare.<sup>39</sup> Down the road, if he obtains gainful employment that provides better health coverage, he can theoretically substitute that coverage for Medicare Part B and keep his TFL benefits intact at age 65. In practice, however, this substitution works imperfectly, leading many veterans to continue paying (or have their employers pay) for Medicare Part B no matter what in order to maintain their TFL eligibility.

Consider the hypothetical case of Carl: While at Walter Reed, he participated in a work therapy program which provided a “trial work period” during his recovery. He was encouraged to apply for SSDI as a wounded warrior, as he fit the criteria for this special program. After transitioning from service, he returned to work, eventually losing eligibility for SSDI and for Medicare Part B. Ultimately, if Carl continues on this trajectory, he will revert to eligibility for TRICARE Prime, paying what other DoD retirees do for their health care, and potentially earning other health insurance options through his employment. However, this is a bureaucratically perilous process fraught with pitfalls, particularly if certain benefits are not turned off and on in a timely, closely coordinated manner. Anecdotal reports suggest this difficult process can itself be a barrier to recovery or workplace return for some severely wounded, ill and injured veterans, leading to outcomes at odds with the overall intent of these benefits systems.

### D. Overlapping Agency and Congressional Boundaries

Just as these support programs are fragmented, so too are the agency structures and Congressional committee structures that oversee these benefits. This fragmentation makes navigation of these benefits difficult for veterans and their families; it also makes casework difficult for agencies and

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<sup>39</sup> See Lisa Zamosky, “Signing up late for Medicare Part B can trigger a lifelong penalty,” L.A. Times, April 26, 2015, <http://www.latimes.com/business/la-fi-healthcare-watch-20150427-story.html>.



external support organizations (like Disabled American Veterans or the Wounded Warrior Project). And, this fragmentation makes reform difficult, because of the extent to which the problems outlined in this paper cross agency lines, statutory authorities, appropriations accounts, and Congressional committee jurisdictions. The table below outlines the structural fragmentation that exists with respect to the overlap of DoD, VA, HHS, and SSA benefits for seriously wounded, ill and injured veterans:

<b>Program</b>	<b>Agency</b>	<b>Oversight Committee</b>	<b>U.S. Code Authority; Regulatory Sources</b>	<b>Appropriations Mechanism</b>
<b>TRICARE</b>	DoD	House/Senate Armed Services Committees	Title 10 DoD Directives	DoD appropriations, MERHCF
<b>Medicare Parts A and B</b>	HHS	House Committee on Oversight and Government Reform; House Ways and Means Committee; Senate Committee on Health, Education, Labor and Pensions; Senate Finance Committee	Title 42, U.S. Code  Title 42, Code of Federal Regulations	Mandatory spending
<b>Social Security Disability Insurance</b>	Social Security Administration	House Ways and Means Committee; House Committee on Oversight and Government Reform; Senate Committee on Homeland Security and Governmental Affairs; Senate Committee on Health, Education, Labor and Pensions; Senate Finance Committee	Title 42, U.S. Code	Mandatory spending
<b>VA Health Care and Disability Compensation</b>	VA	House/Senate Committees on Veterans' Affairs	Title 38, U.S. Code	VA appropriations, Mandatory spending

This fragmented structure makes the benefits system difficult to navigate. It also frustrates reform efforts, because most of the parameters for these benefits are carved into statute that can only be changed with the involvement of multiple agencies and their Congressional oversight committees.

## IV. Recommendations

During the course of this project, CNAS conducted a number of working group discussions and research interviews with government leaders, organizational leaders in the veteran and military family community, and veterans affected by this policy issue. A surprising amount of consensus existed across these disparate groups and individuals about the scope of the problem, and the extent to which it represented a breakdown of governance rather than any deliberate or explainable policy choice to purposely create the TRICARE-Medicare trap. The only rationale for the trap appears to be the fiscal linkage of TRICARE and Medicare, which requires that beneficiaries be enrolled in Medicare Part B in order to make Medicare the primary payer for TRICARE beneficiary medical care.

Beyond this explanation, however, there also seemed to be consensus among government leaders, veteran leaders, military family leaders, and policy experts that reform was needed to create better alignment between these systems. In reforming these systems, there was general agreement (although not consensus) that, as a normative matter, the government should prioritize those veterans with the most severe wounds, illness, or injuries. This obligation stands above and apart from other policy imperatives in this space, such as the need to help veterans find employment after service, or support them with home loan guarantees. It is arguably the *core* obligation of a nation that recruits, trains, and equips a military – let alone the nation that sends that military into harm's way. This policy preference has been explicitly stated by numerous presidential commissions and policymaking bodies.<sup>40</sup> It is also reflected in the extent to which the current VA prioritizes veterans with the most severe disabilities in its health care system, and pays disability benefits on the basis of a graduated scale of disability, from 0 to 100 percent. At the most basic level, this policy preference means that the most severely wounded, ill and injured should have access to the best care, at the lowest cost, because of their level of medical need and the tremendous sacrifices they made for this country.

Notwithstanding this preference, there was also consensus that the current array of systems providing care to the seriously wounded, ill and injured veteran population is severely fragmented, difficult to navigate, and often at odds with national policies regarding support for this population. This disarray is paradoxically worst for the most severely wounded, ill and injured veterans, because of their eligibility for multiple benefits, and the subsequent extent to which they are also dependent on many of these benefits for continued care (including specialty care predominantly available from DoD or VA providers, such as prosthetic or mental health care). This fragmented system creates

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<sup>40</sup> In 1956, a commission chaired by retired Gen. (and former VA administrator) Omar Bradley articulated this principle in its final report – a document that provides much of the basis for the modern VA system. [http://www.cnas.org/sites/default/files/Bradley\\_Commission\\_Report1956.pdf](http://www.cnas.org/sites/default/files/Bradley_Commission_Report1956.pdf) This principle has been echoed by similar commissions since, including the Dole-Shalala Commission (2007) and the VA Commission on Care (2016).

financial, logistical, and medical issues for veterans and their families. Financially, the most severely wounded, ill and injured veterans (i.e. those medically retired and drawing SSDI) end up paying more for their health insurance than their peers, assuming they successfully navigate the benefits bureaucracy. And once they navigate this system successfully, the financial incentives of the system can penalize veterans who recover and resume work, especially if they do not perfectly navigate the complex benefits bureaucracy to turn off their benefits in precisely the right way. Worst of all, none of these financial incentives align with health care outcomes in any meaningful way. They do not incentivize veterans and their families to use the system with the best quality or access, or the system that will likely produce the best health outcomes. In some cases, these financial incentives may even lead veterans or their families to make decisions that run contrary to their health.

Regardless of what system is chosen for support, the government is likely to pay all--or nearly all-- of the health costs for severely wounded, ill or injured veterans. There may be cost advantages to the government procuring care through a particular system (such as Medicare or the VA). However, there are other costs and factors to consider too, such as the different capabilities available from these systems, and the aggregate level of quality as measured by patient outcomes and patient satisfaction. Short-term savings through the utilization of one health care system over another may be fleeting, particularly if these savings come at the expense of veterans' outcomes.

With these points of consensus or general agreement in mind, this paper proposes several reforms to better integrate the government systems supporting severely wounded, ill and injured veterans. Some of these reforms will improve the operation of the systems through better coordination; others aim to fix the "TRICARE-Medicare trap" outlined above, or alleviate its effects.

### A. Improve data sharing and coordination among agencies

Even among government offices inside DoD and VA responsible for supporting wounded, ill and injured service members and veterans, there existed little knowledge or understanding about this problem, let alone knowledge about how to effectively help those veterans affected by the collision of these benefits programs. Better interagency data sharing and coordination would help inform responsible policy makers about this problem, and also equip responsible offices with the data they need to conduct outreach, inform veterans and their families, and shape behavior by veterans and their families in the situations outlined above.

A regular interagency policy coordination process should be created that brings together key leaders from DoD, VA, HHS, and SSA to share data, identify issues, and recommend solutions to agency leaders. At a minimum, these agencies should share aggregate, administrative data about their respective beneficiary populations in order to identify aggregate numbers of individuals with overlapping benefits and potential conflicts between those benefits. Beyond this aggregate level analysis to inform policy, agencies should develop data sharing agreements to enable casework that crosses agency lines.

## B. Decouple TRICARE eligibility from Medicare for severely wounded, ill and injured retirees

When the TRICARE For Life benefit was created in 2000, it made sense to link this benefit to Medicare in order to create a public finance mechanism that could pay for this program over time. It also made sense to require traditional DoD retirees to opt into Medicare Part B at age 65 in order to keep their TRICARE coverage, in order to share health costs of DoD retirees more broadly across the government. However, this linkage makes far less sense for seriously wounded, ill and injured veterans who become Medicare-eligible much earlier in life, by virtue of their drawing SSDI. For one, it creates a situation where the most severely disabled veterans must pay more for their health insurance than their peers, as well as being forced out of the TRICARE Prime system. It also creates an administratively difficult system that must be navigated with great precision in order for veterans to keep health insurance benefits that they earned.

A better system might simply decouple these benefits for severely disabled veterans, excluding DoD medical retirees who draw SSDI from the requirement to purchase Medicare Part B in order to keep their TRICARE coverage. This could be done with a carveout in 10 U.S.C. 1086, the statute governing eligibility for the TRICARE benefit, that would enable veterans under age 65 who receive SSDI benefits as a result of service-connected injuries or conditions to remain in traditional TRICARE rather than being compelled to enroll in Medicare Part B. Both the Medicare and TRICARE statutes have carveouts for related populations (such as an extended enrollment period for severely disabled veterans to opt into Medicare Part B), so there is no legal reason why such a carveout could not be created for this class of veterans, particularly given the government's stated policy priority for supporting severely disabled veterans.

However, making this change could have significant fiscal consequences, to the extent that it might affect Medicare as the payer for these veterans' health care under TRICARE.<sup>41</sup> In that case, DoD would likely bear the health costs for these veterans until they turn 65. However, DoD currently bears the health costs for its non-disability retiree population under 65 (and their families). Arguably, DoD has a higher duty to its wounded, ill or injured veterans than another class of retirees, and a powerful normative case can be made that DoD should bear the costs for these retirees' health care, particularly if doing so helps reduce the out-of-pocket health insurance costs for this group that has sacrificed so much.

## C. Create a more forgiving and flexible health care system for severely wounded, ill or injured veterans

The current opt-in mechanism for Medicare Part B works well for non-disability DoD retirees who leave the service, on average in their early 40s, work for another two decades, and then retire fully in

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<sup>41</sup> See MCRMC report (<http://www.mcrmc-research.us/02%20-%20Final%20Report/>): "Medicare-Eligible Retiree Health Care Fund (MERHCF) should be expanded to cover the health care and pharmacy programs for non-Medicare eligible retirees. The health care for non-Medicare eligible retirees should be accrual funded, similar to how Medicare-eligible retiree health care is today. A portion of the outlays from the MERHCF should be paid to the OPM Employee Health Benefits Fund to purchase insurance plans for non-Medicare eligible retirees."

their 60s. The Medicare penalty system also serves a valuable purpose, to incentivize behavior within this beneficiary population. However, in the case of severely wounded, ill and injured veterans, the opt-in and penalty mechanisms add up to an inflexible and unforgiving system that does not properly support this particular beneficiary population well. The system should be reformed to be more flexible, and penalty-free, both to better support veterans in this category at the time of their retirement, and to enable flexibility as their lives change after service.

In addition to automatic Medicare Part B enrollment for veterans drawing SSDI, Congress should amend the statutes governing TRICARE, Medicare, and SSDI to enable veterans to move more easily between these systems based on their health needs, economic situations, and preferences. Such flexibility would help veterans who recover from their wounds, illnesses or injuries to the point where they can work again, and come off SSDI by easing the process by which such veterans leave one benefits system and enter another. Flexibility would also create a more compassionate system for those veterans who do not successfully navigate this complex system, enabling them to move in and out of the benefits systems without penalty or prejudice to their health care.

In concrete terms, such flexibility likely consists of a few discrete changes to the benefits systems. First, Congress and the SSA should expand the current authorities for “equitable relief” to empower agencies to help severely disabled veterans when they do not successfully navigate this complex system.<sup>42</sup> In addition to the power to grant equitable relief in the case of a government mistake, the government should be authorized and encouraged to grant equitable relief to severely disabled veterans where necessary to ensure they obtain timely access to quality health care. The benefit of the doubt should go to the veteran, just as it does within the veteran disability adjudication process, and there should be a rebuttable presumption in SSA’s regulations that the veteran is entitled to government health care support as an earned benefit.

In addition to this equitable relief authority, the statutes governing these systems should be amended to allow lifelong movement between these systems, reflecting the likelihood that needs and disabilities will change over time. Further, a single office should be created or identified within SSA, CMS or DoD to serve as an ombudsperson for severely disabled veterans, to serve as the “single front door” for these veterans and their families to the benefits bureaucracy, in order to help them navigate these systems and make the best decisions possible about their health care.

Finally, Congress should waive penalties for late Medicare or TRICARE enrollment for the nation’s most severely wounded, ill or injured veterans. These penalties turn innocent or unknowing mistakes into costly burdens for veterans and their families, and constitute as the most unfriendly part of a difficult-to-navigate system. Waiving these penalties in total – or giving agencies the discretion to waive them under certain circumstances – will create a better, more forgiving health care system for these veterans and their families.

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<sup>42</sup> See Social Security Act as Amended in 1972, Section 1837(h); see also 42 CFR 406.26 and 407.32; see also HHS POMS HI 00805.170 Conditions for Providing Equitable Relief, June 5, 2015, <https://secure.ssa.gov/poms.nsf/lnx/0600805170>.



#### D. Create cost equity between health care systems so the most severely wounded, ill or injured veterans do not pay more for their health care

Finally, the government should reduce the financial costs for the most severely disabled veterans, to correct the current inequity whereby the most severely disabled veterans pay more for their health care than less severely disabled DoD retirees. This can be done in a number of ways, such as by eliminating the requirement for DoD retirees drawing SSDI to opt into Medicare Part B to keep their TRICARE coverage (as outlined above), or by waiving the Medicare Part B premium for this class of veterans, or even by increasing the payment amounts for severely disabled veterans to offset the cost of purchasing Medicare Part B. The U.S. has a longstanding, explicit policy of providing support for veterans who are wounded, ill and injured in the line of duty. Congress should operationalize this commitment by creating health care cost equity between the different classes of DoD retirees.

Creating such cost equity would add modest cost across the potential beneficiary population. Medicare premiums are approximately 2.3 times the premiums assessed for TRICARE: \$1,305 per year for Medicare, as compared to \$565.20 for TRICARE. Assuming the population estimates above, creating out-of-pocket premium cost parity for 29,400 DoD retirees on SSDI would translate into a total differential of \$21,844,200 per year in premiums that the federal government would not collect. There could be additional costs to the government as well based on the comparative cost of care for each respective health care system. However, these costs are far more uncertain and difficult to ascertain. Such costs may also net out given the government remains the ultimate payer for these veterans' care, regardless of which agency's program acts as intermediary or administrator.

### V. Conclusion

The federal government rightfully carries the burden of providing for service members and veterans who are wounded, ill or injured during their service to our country. Although this burden may be heavy and costly, particularly for those most disabled by their service, it is a core part of the social contract between the nation and those who serve in uniform, and their families. Indeed, this responsibility to provide health care for the wounds, illnesses and injuries of service is arguably the most central of all obligations to those who have served.

Despite its breadth and resources, the current federal system does an uneven job of supporting seriously wounded, ill and injured veterans. Both the DoD and VA health care systems have room to improve with respect to timely access, health care quality, consistency, and patient satisfaction. The DoD and VA benefits bureaucracies can similarly improve their processes for adjudications, appeals, and delivery as well. It is in this context that the "TRICARE-Medicare trap" exists, along with the problems described in this paper regarding movement between these massive agencies and their health care systems. Over the past several decades, as these massive bureaucracies have grown separately, seams have emerged between these systems with the potential to ensnare service members, veterans, and their families. Such is the problem outlined in this paper, made more difficult by the size, scope and complexity of these interlocking systems and agencies.

The current system is flawed by design in several key respects. Overlapping bureaucratic agencies and benefits mechanisms create an exceedingly difficult to navigate path for seriously wounded, ill and injured veterans who deserve the very best care and most streamlined processes of all. The current governance and finance structures for these programs cause the forfeiting of TRICARE Prime and forced enrollment in Medicare Parts A and B, among other issues. This can impede veterans from access to quality healthcare at a military treatment facility or TRICARE provider. Though likely an unintended consequence created by the desire to have Medicare be the primary payer for DoD retiree health care, this now results in significant challenges for seriously wounded, ill and injured veterans. Under the current system, not only do wounded, ill, and injured veterans lose TRICARE Prime healthcare due to receipt of 25 months of SSDI, but their Medicare premiums are drawn from their SSDI payments and cost substantially more than TRICARE annual enrollment fees, leaving those who are injured paying far more for healthcare than their non-disability retiree counterparts. Given the relatively small size of this population, and the nation's enormous debt to those who have served and been seriously wounded, ill or injured in service, these costs should be borne by the government and not the veteran or his/her family.

Ultimately, Congress and the executive branch should aim to redesign the system of care for seriously wounded, ill and injured veterans to promote positive health outcomes, positive economic outcomes, and long-term independence for these veterans and their families. The national debt to this population of severely wounded, ill and injured warriors can never be calculated, let alone repaid. And yet, we have an obligation to do what we can, through concrete programs such as the health care and disability compensation provided by DoD, VA, SSA, and other agencies. After 15 years of war, the time is past due for reform of the system that cares for those most seriously wounded, ill or injured in the line of duty.



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