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December 2014

# HEALTH CARE

## Information on Coverage Choices for Servicemembers, Former Servicemembers, and Dependents

# Report Documentation Page

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# GAO Highlights

Highlights of [GAO-15-4](#), a report to congressional requesters

## Why GAO Did This Study

In fiscal year 2013, there were about 53 million servicemembers and former servicemembers—those who retired from military service or left for reasons other than retirement—and their dependents. These individuals may be eligible for health care coverage through DOD, VA, Medicare, or Medicaid and may purchase coverage through the exchanges established by PPACA. These sources provide individuals opportunities for choosing the coverage that is most suited to their needs, but may also require consideration of complex factors when making choices.

GAO was asked to examine federal health care programs and exchange-purchased coverage available to servicemembers, former servicemembers, and their dependents. GAO examined

(1) eligibility for coverage, (2) the key benefits offered by this coverage and the individuals' costs, (3) the extent to which information on exchange-purchased coverage and federal subsidies is provided by DOD and VA, and (4) the extent to which these individuals have coverage through DOD, VA, Medicare, and Medicaid. GAO reviewed agency documents and relevant laws and regulations, analyzed U.S. Census Bureau data, and interviewed agency officials.

## What GAO Recommends

GAO recommends that DOD provide information on how its coverage affects individuals' qualification for federal subsidies for exchange-purchased coverage. DOD concurred with GAO's recommendation. VA generally agreed with GAO's conclusions. HHS had no comments on this report.

View [GAO-15-4](#). For more information, contact Katherine Iritani at (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov).

December 2014

## HEALTH CARE

### Information on Coverage Choices for Servicemembers, Former Servicemembers, and Dependents

## What GAO Found

Servicemembers', former servicemembers', and their dependents' eligibility for health care coverage through the Department of Defense (DOD) and the Department of Veterans Affairs (VA) is primarily based on military status, while eligibility for Medicare, Medicaid, and coverage purchased through an exchange established by the Patient Protection and Affordable Care Act (PPACA) is based on age, income, or other factors. The Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services (HHS)—oversees health care coverage provided through Medicare, Medicaid, and the exchanges. Most servicemembers, and former servicemembers who retired from military service, and their dependents are entitled to DOD coverage, according to DOD officials. Those who are not entitled to DOD coverage, such as reservists and certain of their dependents, may be eligible to purchase it. Former servicemembers who left military service for reasons other than retirement are not eligible for DOD coverage. All former servicemembers are generally eligible for VA coverage. Servicemembers, former servicemembers, and their dependents may also be eligible for Medicare or Medicaid, if they meet eligibility criteria, and may purchase coverage through an exchange.

Federal programs and exchange-purchased plans generally offer comprehensive coverage, which includes coverage for certain benefit categories such as inpatient hospital and outpatient medical services. These forms of coverage may have cost-sharing, subject to certain limits. Cost limits vary and depend on factors such as military status and income. For example, servicemembers do not pay an annual enrollment fee for certain DOD coverage, but former servicemembers do. VA does not generally require cost-sharing for those with certain service-connected conditions or low incomes, while it may for others.

DOD and VA provide information about exchange-purchased coverage on their websites, including that their coverage satisfies the requirement for minimal essential coverage (MEC) established by PPACA. VA informs its beneficiaries that they do not qualify for federal subsidies that lower the cost of exchange plans, even if they meet income and other requirements, because VA coverage satisfies the requirement for MEC. VA also informs its beneficiaries that they may opt out of VA coverage, and thus potentially qualify for federal subsidies. DOD, however, does not provide information indicating that most individuals with DOD coverage cannot opt out of it and, therefore, cannot qualify for federal subsidies. Nor does DOD inform those that have the option of purchasing DOD coverage that they may qualify for federal subsidies, if they do not choose DOD coverage. This is inconsistent with federal internal controls that require communication with stakeholders, and by providing this information, DOD could potentially help servicemembers, certain former servicemembers, and their dependents make more informed decisions regarding their health care coverage.

About 27 million servicemembers, former servicemembers, and their dependents had health care coverage through DOD, VA, Medicare, or Medicaid, or a combination of these in 2012, according to U.S. Census Bureau data. Of these, about 7 million had health care coverage through two or more programs in 2012, most often VA and Medicare (2.4 million), Medicare and Medicaid (1.3 million), and DOD and Medicare (1.2 million).

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## Abbreviations

ACS	American Community Survey
CMS	Centers for Medicare & Medicaid Services
DOD	Department of Defense
HHS	Department of Health and Human Services
MEC	minimum essential coverage
PPACA	Patient Protection and Affordable Care Act
VA	Department of Veterans Affairs

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December 12, 2014

The Honorable Patty Murray  
Chairman  
Committee on the Budget  
United States Senate

The Honorable Ron Wyden  
Chairman  
Committee on Finance  
United States Senate

In fiscal year 2013, there were an estimated 53 million servicemembers, former servicemembers, and their dependents.<sup>1</sup> Servicemembers, former servicemembers, and their dependents may be eligible for health care coverage through programs administered by the Department of Defense (DOD) or the Department of Veterans Affairs (VA).<sup>2</sup> Servicemembers, former servicemembers, and their dependents may also be eligible for Medicare, a federal health insurance program for individuals who are 65 or older or have certain disabilities or conditions, such as end-stage renal disease, or Medicaid, a joint federal-state program that finances health care coverage for certain low-income individuals.<sup>3</sup> In addition, these

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<sup>1</sup>This population of an estimated 53 million includes servicemembers—individuals who are currently serving on active duty or are members of the Selected Reserve—former servicemembers, and their respective dependents. Former servicemembers include individuals who retired from military service or the Selected Reserve, and individuals who left active duty military service for reasons other than retirement. Members of the Selected Reserve are those that have been designated as essential to wartime missions and regularly train, for pay, with active duty components. Dependents include spouses and children up to the age of 26. This population estimate is based on data reported by the Department of Defense (DOD) and the Department of Veterans Affairs (VA) in their 2014 annual reports to Congress, which are the most recent data available. See Department of Defense, *Evaluation of the TRICARE Program: Fiscal Year 2014 Report to Congress* (Washington, D.C.: Mar. 5, 2014) and VA's fiscal year 2015 Congressional Budget Submission.

<sup>2</sup>Former servicemembers, including those who retired from military service and those who left for reasons other than retirement, are also known as veterans.

<sup>3</sup>The federal government and states share in the financing of the Medicaid program. States receive federal matching funds for Medicaid expenditures in accordance with a formula established by law under which the federal share of a state's Medicaid expenditures is based on the state's per capita income. The federal contribution generally may range from 50 to 83 percent.

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servicemembers, former servicemembers, and their dependents may also choose to purchase health insurance coverage through the exchanges established by the Patient Protection and Affordable Care Act (PPACA).<sup>4</sup> The Centers for Medicare & Medicaid Services (CMS)—an agency within the Department of Health and Human Services (HHS)—oversees health care coverage provided through Medicare, Medicaid, and the exchanges. Coverage available through DOD, VA, Medicare, and Medicaid, and coverage purchased through an exchange provides a range of health care benefits at different costs to eligible servicemembers, former servicemembers, and their dependents. Eligibility for more than one program may provide servicemembers, former servicemembers, and their dependents with opportunities for choosing the health coverage that is most suited to their needs, but also may require these individuals to consider complex factors when making these choices.

These federal programs and the exchanges offer health care coverage in different ways, subject to the oversight of three federal agencies. DOD administers TRICARE, a health care program through which beneficiaries may obtain care either from military hospitals and clinics, referred to as military treatment facilities, or from civilian providers. VA's health care program provides care directly through its medical centers and clinics and, in certain situations, may pay for services provided by private providers. CMS oversees Medicare and Medicaid, public programs that, for eligible individuals, pay for specified health care services provided by participating private providers. CMS also oversees the exchanges in each state.<sup>5</sup> These exchanges facilitate the purchase of private health insurance by individuals. In addition, PPACA provides federal subsidies to qualifying individuals that reduce the cost of coverage purchased through an exchange, provides states the option to expand Medicaid to adults

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<sup>4</sup>The exchanges—also referred to as marketplaces—are where eligible individuals can compare and select among private health plans. PPACA required the establishment of exchanges in each state. In states that did not elect to operate their own exchange, the federal government was required to operate an exchange. Pub. L. No. 111-148, §§ 1311(b), 1321(c), 124 Stat. 119, 173, 186 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). In this report, references to PPACA include any amendments made by the Health Care and Education Reconciliation Act of 2010.

In this report, the term “state” includes the District of Columbia.

<sup>5</sup>CMS manages the federally facilitated exchanges, while states that established their own exchanges operate and manage exchange activities, subject to the oversight of CMS.

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who may not have been previously eligible, and requires individuals to maintain minimum essential coverage (MEC) for themselves and their dependents or be subject to a tax penalty, subject to certain exceptions.<sup>6</sup> Individuals covered by certain government-sponsored programs (including DOD's TRICARE program, VA's health care program, Medicare, and Medicaid), an employer-sponsored health insurance plan, or a health insurance plan purchased on or off the exchanges that provides certain health benefits (referred to as essential health benefits),<sup>7</sup> are generally considered to have MEC and will not be subject to a penalty when filing their federal taxes.

You asked us to review federal health care programs and exchange-purchased health care coverage available to servicemembers, former servicemembers, and their dependents. This report addresses four objectives:

1. What factors determine servicemembers', former servicemembers', and their dependents' eligibility for health care coverage through DOD, VA, Medicare, Medicaid, and the exchanges?
2. What key benefits do DOD, VA, Medicare, Medicaid, and exchange-purchased coverage offer and at what potential cost to servicemembers, former servicemembers, and their dependents?
3. To what extent is information on exchange-purchased coverage and federal subsidies available to servicemembers, former servicemembers, and their dependents through DOD and VA websites?

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<sup>6</sup>For the purposes of this report, we are defining federal subsidies as the premium tax credits and cost-sharing reductions that apply to certain plans purchased through an exchange. Under PPACA, specific types of coverage (e.g., government-sponsored) qualify, by definition, as MEC. Individuals who have MEC, other than coverage purchased through the exchange, generally do not qualify for federal subsidies for exchange-purchased coverage.

<sup>7</sup>PPACA defines essential health benefits as 10 broad categories of health care services, which include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive services and chronic disease management, and pediatric services (including dental and vision).



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4. To what extent do servicemembers, former servicemembers, and their dependents have health care coverage through DOD, VA, Medicare, and Medicaid?

To examine the factors used to determine servicemembers', former servicemembers', and their dependents' eligibility for health care coverage through DOD, VA, Medicare, Medicaid, and to purchase coverage through an exchange, we reviewed relevant federal laws, or program descriptions provided on agency websites or in program materials, such as handbooks and fact sheets. We also interviewed DOD, VA, and CMS officials knowledgeable about the eligibility requirements for these respective programs and the eligibility requirements for purchasing coverage through an exchange.

To examine the key benefits offered by DOD, VA, Medicare, Medicaid, and exchange-purchased coverage, we identified and summarized benefit categories for each form of coverage as described by program descriptions provided on agency websites or in program materials, such as handbooks and fact sheets. We also reviewed relevant federal laws, regulations, or our prior work. Due to the potential differences in the individual services offered and definitions for terms used to describe individual services provided by DOD, VA, Medicare, Medicaid, and exchange-purchased coverage, we did not compare the individual services covered by each type of coverage within each benefit category, or differences in the amount, duration, or scope of covered services. Nor did we examine the differences in coverage within individual health plans that some programs or the exchanges may offer, such as different managed care plan options. To examine the potential cost to servicemembers, former servicemembers, and their dependents, we identified and summarized individuals' costs for coverage through DOD, VA, Medicare, Medicaid, and exchange-purchased coverage as described by program descriptions provided on agency websites or in program materials, such as handbooks and fact sheets. For exchange-purchased coverage, we also identified and summarized available federal subsidies and their effect on individuals' costs. We also interviewed agency officials knowledgeable about the costs to individuals for each program and reviewed relevant federal laws, regulations, or our prior work.<sup>8</sup>

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<sup>8</sup>See the Related GAO Products section at the end of this report.

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To examine the extent to which information on exchange-purchased coverage and related federal subsidies is available to servicemembers, former servicemembers, and their dependents through DOD and VA, we reviewed agency materials that address this coverage, including information provided on agency websites and in downloadable program materials, such as fact sheets. We also reviewed federal internal control standards related to effective and timely communications, including sharing information externally and with stakeholders, and interviewed knowledgeable DOD and VA officials.<sup>9</sup>

To examine the extent to which servicemembers, former servicemembers, and their dependents have health care coverage through DOD, VA, Medicare, and Medicaid, we examined the results of VA's analysis of the American Community Survey (ACS) of the U.S. Census Bureau. The ACS provides estimates of the average characteristics of the population over a specified period, including information on individuals' military service and health insurance coverage. VA's results from the 2012 ACS were the most recent, nationally available data at the time of our analysis and included the number of servicemembers, former servicemembers, and their dependents that reported having health care coverage through DOD, VA, Medicare, Medicaid, another source, or that were uninsured.<sup>10</sup> Because the ACS data are based on a sample of the population, the numbers in this report are not the same as those that would be obtained if everyone in the population were actually counted.<sup>11</sup> To provide a sense of the magnitude for how many servicemembers, former servicemembers, and their dependents have health care coverage through DOD, VA, Medicare, and Medicaid, we reviewed VA's results from its analysis of ACS data, which provide an estimate of the number of respondents who self-identified as an individual who was either currently serving or who had previously

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<sup>9</sup>See GAO, *Standards for Internal Control in the Federal Government*, [GAO/AIMD-00-21.3.1](#) (Washington, D.C.: November 1999). Internal control is synonymous with management control and comprises the plans, methods, and procedures used to meet missions, goals, and objectives.

<sup>10</sup>These estimates from the ACS cover the January 1, 2012, to December 31, 2012, calendar year and represent the average value over the full period.

<sup>11</sup>Additionally, nonsampling errors may affect the data. For example, errors may occur because ACS data analyses are based on self-reported information. However, the U.S. Census Bureau takes steps to minimize these errors by applying logical edits to correct for obvious misunderstanding of questions.

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served on active duty and who reported having health care coverage through one or more federal programs—DOD’s TRICARE program, VA, Medicare, Medicaid, or a combination of these. We also supplemented these results with fiscal year 2012 and 2013 DOD and VA administrative data, such as eligibility and enrollment data. We used these data as a basis of comparison to the most currently available ACS data and to assess the extent to which servicemembers, former servicemembers, and their dependents had health care coverage through DOD and VA.<sup>12</sup>

We assessed the reliability of the three data sources we obtained—the ACS data provided by VA, DOD administrative data, and VA administrative data—in several ways, including reviewing each data source for reasonableness and cross-referencing the ACS data with the agencies’ administrative data from fiscal year 2012. To assess the reasonableness of the ACS data, we reviewed related documents, such as the ACS guidebooks, which describe how the ACS data are collected and processed and how researchers should use the data. To assess the reasonableness of DOD’s and VA’s administrative data, we reviewed prior DOD and VA reports to Congress that use these agency data to report on eligibility and enrollment. We also interviewed DOD and VA officials knowledgeable about these data. Based on these checks, we determined that the data we used were sufficiently reliable for the purposes of this report.

We conducted this performance audit from December 2013 to December 2014 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.

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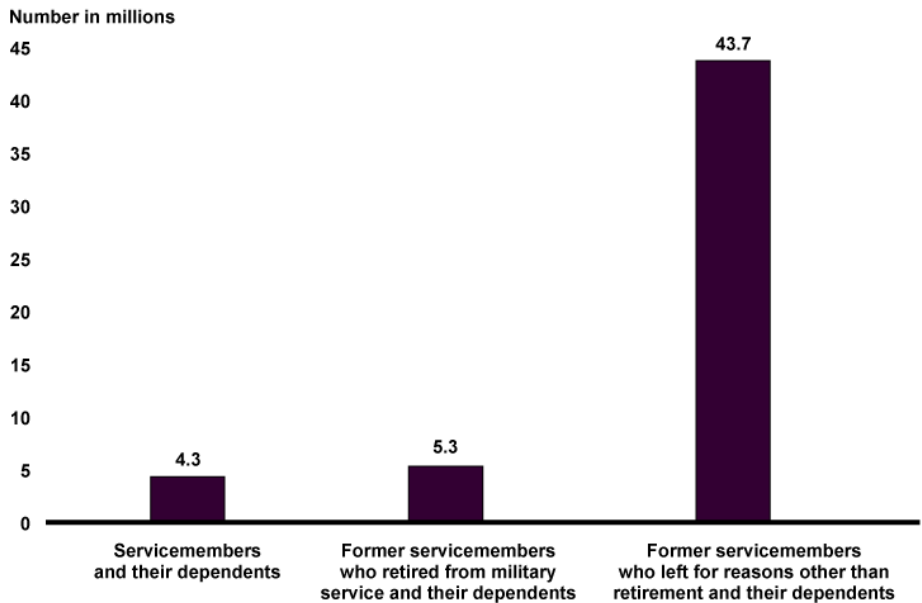
<sup>12</sup>These administrative data are more recent than the ACS data available, but do not generally include servicemembers’, former servicemembers’, and dependents’ health care coverage through Medicare and Medicaid. Nor do these data allow for an assessment of the prevalence of multiple sources of coverage. See Department of Defense, *Evaluation of the TRICARE Program: Fiscal Year 2014 Report to Congress* (Washington, D.C.: Mar. 5, 2014) and VA’s fiscal year 2015 Congressional Budget Submission.

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## Background

Individuals within the population of servicemembers and former servicemembers are generally designated by their military status. Dependents are generally designated by the military status of their sponsor—the uniformed servicemember or retiree with which the spouse or dependent child is associated. Servicemembers, which include individuals who are currently serving on active duty in the U.S. military and members of the military’s Selected Reserve, and their dependents, accounted for a small proportion of the total population—about 4.3 million of the 53 million total—in fiscal year 2013. Former servicemembers, which include individuals who either retired from active duty or the Selected Reserve, or left active duty military service for reasons other than retirement, and their dependents, accounted for the remainder of this population. Generally speaking, individuals who served on active duty for a certain period of time, usually a minimum of 20 years, may choose to retire from military service. Additionally, individuals with service connected injuries or illnesses may be retired from the military for medical reasons. Former servicemembers who retired from military service accounted for about 5.3 million of this population. All servicemembers who retire from active duty military status or the Selected Reserve are considered to be veterans, according to DOD officials. Individuals who served on active duty for less than 20 years, were not medically retired, and did not choose to re-enlist are generally not eligible to retire from the military. Former servicemembers who left military service for reasons other than retirement—who are also considered to be veterans—generally join the civilian workforce after leaving the military. Former servicemembers who left the military for reasons other than retirement and their dependents accounted for the majority—about 43.7 million of the 53 million total—of this population (see fig. 1).

**Figure 1: Number of Servicemembers, Former Servicemembers, and Their Dependents, Fiscal Year 2013**



Source: GAO analysis of Department of Defense (DOD) and Department of Veterans Affairs (VA) data. | GAO-15-4

Note: Former servicemembers who retired from military service are veterans who served on active duty for a certain period of time, generally a minimum of 20 years, then chose to retire from military service. This group also includes individuals who retired from the Selected Reserve and those who receive retired disability pay from the DOD. Former servicemembers who left military service for reasons other than retirement are veterans who generally served fewer than 20 years prior to leaving military service.

## DOD

DOD primarily provides health coverage through TRICARE, a health care program that combines the resources available at military treatment facilities with private health care providers and, for certain types of care, VA medical centers. TRICARE health plans offer standard health benefits packages nationwide for eligible individuals. Generally speaking, TRICARE consists of three main health plan options: TRICARE Prime, a managed care option; TRICARE Standard, a fee-for-service option; and TRICARE Extra, a preferred provider option. DOD also offers TRICARE for Life, a Medicare supplemental coverage option for TRICARE beneficiaries that are covered by Medicare; TRICARE Reserve Select and TRICARE Retired Reserve, coverage options available to certain current or retired reservists and their dependents; and TRICARE Young

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Adult, a program that provides services for dependent children up to age 26.<sup>13</sup>

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**VA** VA, through the Veteran’s Health Administration, operates an integrated health care delivery system. VA’s health care system provides services at its medical centers, outpatient clinics, and residential facilities located nationwide. When necessary, VA also pays for services provided by private providers.<sup>14</sup> VA provides a standard health care benefits package nationally to veterans enrolled in VA health care.<sup>15</sup> In addition, VA also provides health care for certain individuals through programs such as the Civilian Health and Medical Program of the Department of Veterans Affairs and the Spina Bifida Program.

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**Medicare** Medicare consists of four parts—Parts A, B, C (also known as Medicare Advantage), and D. Medicare Part A covers hospital, certain other inpatient stays, and hospice care services. Medicare Part B covers hospital outpatient, physician, and other medical services. Instead of choosing to receive Part A and B services through Original Medicare, Medicare beneficiaries generally also have the option of obtaining coverage for Medicare services from private health plans that participate in Medicare Advantage—also known as Part C. Individuals who select coverage through Medicare Advantage receive their Medicare Part A and Part B coverage from a Medicare Advantage plan. These plans cover all Medicare medical services, except hospice, and may cover additional services, but may charge different out-of-pocket costs than Original Medicare and these plans may have different requirements for how individuals get services, such as requiring a referral to see a specialist. All Medicare beneficiaries may purchase coverage for outpatient prescription

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<sup>13</sup>Additionally, DOD’s TRICARE programs provide coverage for eligible individuals in remote and overseas locations, such as TRICARE Prime Remote and Prime Overseas.

<sup>14</sup>If an individual is being treated at a VA medical facility or is under the jurisdiction of a VA provider and the provider determines that the individual needs care that is not available in the VA medical facility, VA is responsible for authorizing and paying for that care.

<sup>15</sup>In certain situations, individuals who are not enrolled may receive some VA care. For example, VA pays a per diem rate for nursing home care at states’ veterans’ nursing homes for some veterans who may not be enrolled.

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drugs through Part D, either as a stand-alone benefit or as part of a Medicare Advantage plan.

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## Medicaid

Medicaid is a joint federal-state health program where each state designs and operates its own program, in accordance with federal parameters. As a result, there is variation between states. For example, while states must cover certain populations, such as low-income children, they also have the option to cover additional ones, such as low-income adults without children. Additionally, states' Medicaid programs must cover a set of mandatory services, including services provided by physicians and inpatient and outpatient hospital services. States may elect to cover additional, optional benefits and services, such as clinic services or hospice, resulting in variation across the states.

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## Exchange-Purchased Coverage

PPACA required states to establish health insurance exchanges, or marketplaces, where eligible individuals can compare and select among health plans offered by participating private issuers of health care coverage. In states electing not to establish and operate such an exchange, PPACA requires the federal government to establish and operate an exchange in the state. Individuals purchasing insurance through the exchanges may also qualify for income-based federal subsidies to reduce the cost of that coverage.

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## Eligibility for DOD and VA Coverage Is Primarily Based on Military Status, and Eligibility for Medicare, Medicaid, and Exchange-Purchased Coverage Is Based on Age, Income, or Other Factors

Servicemembers', former servicemembers', and their dependents' eligibility for coverage through DOD and VA is primarily based on military status. However, these individuals' eligibility for Medicare, Medicaid, and to purchase coverage through an exchange is based on age, income, or other factors.

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## Eligibility for DOD and VA Coverage Is Based Primarily on Military Status

Eligibility for DOD health care coverage, TRICARE, is primarily based on military status—whether or not individuals are on active duty, assigned to a designated reserve component, or retired from the military. Similarly, dependents' eligibility is largely determined by the military status of their sponsor.<sup>16</sup> According to DOD officials, the vast majority of those who are eligible for TRICARE are statutorily entitled to this coverage. Certain individuals who are statutorily entitled to coverage must enroll in TRICARE Prime, while others may choose the TRICARE plan through which they wish to receive coverage. Specifically, servicemembers must enroll in TRICARE Prime.<sup>17</sup> Former servicemembers who retired from military service and their dependents who are under the age of 65, eligible spouses of servicemembers and former servicemembers, and eligible children of servicemembers and former servicemembers who are under the age of 21<sup>18</sup> may choose either enrolling in TRICARE Prime or receiving coverage through TRICARE Standard or Extra. Individuals who choose coverage through TRICARE Standard or Extra do not go through an enrollment process.<sup>19</sup> All former servicemembers who retired from military service and their dependents who are aged 65 and older are entitled to coverage through TRICARE for Life.<sup>20</sup>

Certain dependents of servicemembers and former servicemembers who retired from military service, reservists, and retired reservists are not

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<sup>16</sup>For dependent children, age and health care status also may affect their eligibility for TRICARE.

<sup>17</sup>Active duty servicemembers assigned to duty stations located in areas not served by the military health care system are required to enroll in TRICARE Prime Remote, which is a specialized version of TRICARE Prime, which provides services in these locations. Dependents who reside with servicemembers who are enrolled in TRICARE Prime Remote are eligible to enroll in and receive care through TRICARE Prime Remote for Active Duty Family Members.

<sup>18</sup>In certain circumstances, a dependent child may remain eligible for TRICARE past age 21. To remain TRICARE-eligible past age 21, the dependent child must be enrolled as a full-time student in an accredited institution of higher learning and be dependent on the sponsor for over 50 percent of his or her financial support. This dependent child may be TRICARE-eligible under student status until he or she graduates from the institution of higher learning or age 23, whichever comes first.

<sup>19</sup>TRICARE Standard and Extra are DOD's fee-for-service and preferred provider options, respectively.

<sup>20</sup>In order to be eligible for TRICARE for Life, individuals who are entitled to Medicare Part A must also enroll in Medicare Part B.



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statutorily entitled to TRICARE coverage, but may choose to purchase TRICARE coverage through specified plans, according to DOD officials. Specifically, unmarried dependent children, who lose their entitlement to TRICARE because of their age and are not eligible for coverage through an employer, may choose to purchase TRICARE coverage through the TRICARE Young Adult plan until age 26. Members of the Selected Reserve who are not serving on active duty or do not have other coverage may choose to purchase TRICARE Reserve Select for themselves or their dependents.<sup>21</sup> Retired Reserve members who are younger than age 60 may choose to purchase TRICARE Retired Reserve for themselves and their dependents.<sup>22</sup> Generally speaking, former servicemembers who choose to leave military service for reasons other than retirement are not eligible for TRICARE after their military separation.<sup>23</sup>

Eligibility for VA health care coverage is primarily based on military status, income, and service-connected disabilities. Generally, former servicemembers—both retired and those who left military service for reasons other than retirement—are eligible for VA coverage. VA assigns individuals who have enrolled in VA health care to one of eight priority groups, which are established by law. These groups, which are designed to manage access to services in relation to available resources, define

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<sup>21</sup>Members of the Selected Reserve may not enroll in TRICARE Reserve Select if they are covered under the Transitional Assistance Management Program, which provides 180 days of premium-free transitional health care benefits after regular TRICARE benefits end, or if they are eligible for or enrolled in the Federal Employees Health Benefits program. Additionally, members of the Individual Ready Reserve including Navy Reserve Voluntary Training Units do not qualify to purchase TRICARE Reserve Select.

<sup>22</sup>To purchase TRICARE Retired Reserve coverage, Retired Reserve members must be qualified for retirement as defined under federal law, be under the age of 60, and not be eligible for or enrolled in the Federal Employees Health Benefits program.

<sup>23</sup>Servicemembers who separate from military service for reasons other than retirement may be eligible for transitional coverage options, including the Transitional Assistance Management Program or the Continued Health Care Benefit Program, which is a premium-based plan that offers temporary transitional health coverage for 18 to 36 months after TRICARE eligibility ends.

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the conditions under which a particular individual is eligible for benefits.<sup>24</sup> Priority is generally determined by the individual's degree of service-connected or other disability, financial need, or other special status. Priority Group 1, which has the highest priority for enrollment, includes former servicemembers with 50 percent or more service-connected disability or those who VA has determined to be unemployable due to service-connected conditions.<sup>25</sup> Priority Group 8, which has the lowest priority for enrollment, includes individuals with no disability and an income exceeding certain VA income thresholds. Former servicemembers with a low income—individuals with an annual income or net worth that is less than certain VA income thresholds or who are eligible for Medicaid—are placed in a higher priority group than individuals with higher incomes.<sup>26</sup> Additionally, certain servicemembers are also eligible for VA coverage, such as those seeking care in emergency situations or upon referral. Although dependents are generally not eligible for VA coverage, there are certain dependents, caregivers, and survivors of certain former servicemembers who may qualify for VA coverage through the Civilian Health and Medical Program of the Department of Veterans Affairs. For example, the primary family caregiver may be eligible for this coverage if the caregiver is without other health care coverage.

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<sup>24</sup>If sufficient resources are not available to provide care that is timely and acceptable in quality, VA may restrict enrollment consistent with its priority categories. In January 2003, VA imposed a general freeze on new enrollments in Priority Group 8, the group which has the lowest priority for enrollment. In June 2009, VA began easing enrollment restrictions for individuals who may have been previously denied enrollment because their income exceeded a certain VA income threshold.

<sup>25</sup>VA calculates disability ratings for individuals with service-connected disabilities (i.e., injuries or diseases incurred or aggravated while on active military duty) according to the severity of the disability. VA's ratings are awarded in 10 percent increments, from 0 to 100 percent.

<sup>26</sup>VA has both national and regional income thresholds. For 2014, VA's national income threshold is \$31,443 or less for an individual, and \$42,055 or less for a family of four. VA's regional income thresholds vary depending on individuals' residences and may, in some cases, be higher than the national income threshold.

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## Eligibility for Medicare, Medicaid, and Exchange-Purchased Coverage Is Based on Age, Income, or Other Factors

Eligibility for Medicare is generally based on age or disability. Generally speaking, former servicemembers and their dependents are eligible for coverage through Medicare if they are aged 65 or older. If these individuals are under age 65, they may be eligible for Medicare if they are disabled; have end-stage renal disease; amyotrophic lateral sclerosis, also known as Lou Gehrig's disease; or a condition resulting from an environmental health hazard.<sup>27</sup> Part A coverage is generally automatic for eligible individuals,<sup>28</sup> but Part B coverage is voluntary, and eligible individuals who elect this coverage must generally pay a monthly premium. Certain individuals must maintain Medicare coverage in order to remain eligible for DOD or VA coverage. Specifically, former servicemembers who retired from the military and their dependents who are eligible for TRICARE for Life and entitled to Medicare Part A must be enrolled in Medicare Part B coverage to maintain their TRICARE benefits. Additionally, dependents and survivors who are covered through the Civilian Health and Medical Program of the Department of Veterans Affairs who are entitled to Medicare Part A must be enrolled in Medicare Part B coverage to maintain their VA benefits.

Medicaid eligibility for all individuals, including servicemembers, former servicemembers, and their dependents, is based on a set of factors that includes income, age, disability, citizenship status, and state residency. Minimum income and other eligibility criteria are established by federal law; although states may opt to cover additional individuals beyond these

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<sup>27</sup>In order for an individual to become eligible for Medicare due to a disability, the individual generally must have been determined disabled by the Social Security Administration and have received Social Security benefits for at least 24 months. Medicare eligibility was also expanded under PPACA to include individuals who have been exposed to certain environmental hazards and, as a result, developed certain conditions, such as asbestosis. Currently, the benefits and services for individuals exposed to these environmental hazards are provided under the Medicare Pilot Program for Asbestos Related Disease and are limited to certain areas of Montana, Washington, and Idaho. Individuals diagnosed with end-stage renal disease, amyotrophic lateral sclerosis, or environmental health hazards are not subject to this 24-month waiting period.

According to DOD officials, in certain circumstances, servicemembers may be eligible for Medicare because they are deemed disabled as a result of illness or injury and then return to duty. According to DOD officials, in some instances, these individuals may maintain their Medicare coverage while serving on active duty.

<sup>28</sup>If individuals or their spouses did not work long enough in a job where Medicare taxes were paid, Medicare Part A coverage is not automatic. Under these circumstances, individuals may be able to get Part A by signing up during designated enrollment periods and paying a monthly premium.

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federal minimums under their Medicaid state plans or under Medicaid demonstrations.<sup>29</sup> Additionally, as a result of PPACA, states have the option to expand eligibility for Medicaid to certain adults whose income does not exceed 133 percent of the federal poverty level.<sup>30</sup> As of September 2014, 28 states had expanded their Medicaid programs to cover these individuals. As a result, adults who reside in a state that has chosen to expand Medicaid and who do not fall into one of the other Medicaid-eligible population groups (e.g., are low-income parents and pregnant, aged, or disabled individuals) may now be eligible for Medicaid, whereas those residing in other states may not be. To further add to this complexity, Medicaid eligibility can affect a former servicemember's access to health care through VA. Specifically, former servicemembers who are eligible for Medicaid in the state in which they reside may be placed in a higher VA priority group. As a result, a former servicemember residing in a state with broader Medicaid eligibility criteria may receive VA health care at a lower cost than a former servicemember with an identical income that resides in a state with more restrictive Medicaid eligibility criteria.<sup>31</sup> Dependents of servicemembers and former servicemembers are primarily eligible for Medicaid coverage under the same conditions as servicemembers and former servicemembers, providing they are low-income and meet other eligibility criteria.

Individuals, including servicemembers, former servicemembers, and their dependents, may purchase coverage through an exchange if they meet certain criteria established by PPACA. Specifically, to purchase coverage through an exchange, individuals must reside in the state where the

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<sup>29</sup>Under section 1115 of the Social Security Act, the Secretary of the Department of Health and Human Services may allow states to cover additional populations or services that would not otherwise be covered if they are likely to promote Medicaid objectives, which includes allowing states to test and evaluate new approaches for delivering Medicaid services.

<sup>30</sup>Specifically, states may expand coverage to nonpregnant adults under the age of 65 who are not eligible for Medicare. Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119, 271 (2010).

PPACA also provides for a 5 percent income disregard when calculating income for determining Medicaid eligibility, which effectively increases this income level to 138 percent of the federal poverty level.

<sup>31</sup>Former servicemembers who are eligible for Medicaid are placed in VA's Priority Group 5, which has lower cost-sharing requirements than lower priority groups, such as Priority Groups 7 and 8.

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exchange is located, must be U.S. citizens or otherwise lawfully present in the United States, and must not be incarcerated. To obtain exchange-purchased coverage, individuals sign up for plans through the exchanges and pay their first monthly premiums.

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## DOD, VA, Medicare, Medicaid, and the Exchanges Generally Offer Comprehensive Coverage Subject to Certain Limits

DOD, VA, Medicare, Medicaid, and exchange-purchased coverage generally offer comprehensive health care coverage to their respective beneficiaries, which include servicemembers, former servicemembers, and their dependents. However, the key benefits within these programs may vary. DOD, VA, Medicare, Medicaid, or exchange plans may have cost-sharing requirements for their respective beneficiaries, including servicemembers, former servicemembers, and their dependents, but each is subject to certain limits.

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## DOD, VA, Medicare, Medicaid, and Exchange-Purchased Coverage Generally Offer Comprehensive Health Care Coverage; Key Benefits within Programs May Vary

DOD, VA, Medicare, Medicaid, and health plans offered through the exchanges generally offer comprehensive care to their respective beneficiaries, which include servicemembers, former servicemembers, and their dependents—coverage that includes certain benefit categories such as inpatient hospital services, outpatient medical services, and certain prescription drugs, though some of these benefits may vary. For example, DOD's TRICARE program offers a variety of plans that generally cover all of these categories of services (see fig. 2).<sup>32</sup> DOD's TRICARE program may also provide health care to servicemembers and former servicemembers who retired from military service, and their dependents who are living and working in designated overseas locations where other major federal programs may not provide care.<sup>33</sup>

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<sup>32</sup>Certain rules and limitations may apply to some types of care and some services may not be covered by TRICARE. Examples include reproductive technology services and custodial nursing home care.

<sup>33</sup>VA may also cover health care services for certain service-connected disabilities for VA beneficiaries who are residing or traveling in Canada and other foreign countries (excluding the Philippines), if that service is medically necessary and authorized by VA's Foreign Medical Program office. Former servicemembers living in the Philippines are entitled to the same VA benefits as those living in the United States.

**Figure 2: Examples of DOD’s TRICARE Benefits Categories**

<ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Emergency medical services</li> <li>• Home health care</li> <li>• Medically necessary skilled nursing facility services</li> </ul>	<ul style="list-style-type: none"> <li>• Behavioral health services, including psychological testing, outpatient and inpatient psychiatric care, and substance abuse services</li> <li>• Outpatient medical services, including office-based medical and surgical care, and rehabilitative care</li> </ul>	<ul style="list-style-type: none"> <li>• Durable medical equipment</li> <li>• X-rays and laboratory services</li> <li>• Preventative care services</li> <li>• Outpatient prescription drugs</li> </ul>
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Source: GAO analysis of Department of Defense (DOD) information. | GAO-15-4

VA offers a standard, nationwide benefits package to former servicemembers—both retired and those who left military service for reasons other than retirement—and certain dependents of these former servicemembers. VA’s benefits package includes a full range of hospital and outpatient services, prescription drugs, and long-term care services provided in individuals’ own homes and in other locations in the community (see fig. 3).<sup>34</sup> VA also provides some services that other major federal programs may not provide, such as long-term nursing home care.<sup>35</sup>

**Figure 3: Examples of VA’s Benefits Categories**

<ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Emergency medical services</li> <li>• Home health care</li> <li>• Hospice services</li> <li>• Mental health services, including inpatient and outpatient care, and substance abuse services</li> </ul>	<ul style="list-style-type: none"> <li>• Outpatient medical services</li> <li>• X-rays, laboratory and diagnostic tests</li> <li>• Gender specific care for females, including maternity care</li> <li>• Preventative care services</li> <li>• Rehabilitative care</li> </ul>	<ul style="list-style-type: none"> <li>• Certain prescription drugs that are prescribed by a VA physician and obtained through a VA facility</li> <li>• Certain long-term care services provided in individuals’ own homes and other community locations</li> <li>• Long-term nursing home care<sup>a</sup></li> </ul>
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Source: GAO analysis of Department of Veterans Affairs (VA) documents. | GAO-15-4

<sup>a</sup>Certain rules and limitations may apply to VA long-term nursing home care. For example, VA is required to provide long-term nursing home care only to certain individuals, such as those that need such care for a service-connected disability. VA may provide this care to other eligible individuals on a discretionary basis as capacity and resources permit.

<sup>34</sup>Certain limitations may apply to some types of care, such as dental services, durable medical equipment, and prosthetics.

<sup>35</sup>With respect to long-term care services, VA provides adult health day care, respite care, and other noninstitutional long-term care services as part of the medical benefits package it provides to all enrolled individuals.

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Medicare offers nationwide benefits to individuals—including former servicemembers and their dependents—through Part A (standard hospital insurance), Part B (standard medical insurance), and Part D (prescription drug coverage). See figure 4 for examples of the categories of benefits offered through Medicare Parts A, B, and D. Medicare Part A benefits include inpatient hospital services, post hospital skilled nursing facility care, hospice care, and certain home health services. Medicare Part B coverage includes medically necessary outpatient hospital services, physicians' services, and durable medical equipment—such as walkers and wheelchairs.<sup>36</sup> Part B covers a limited number of outpatient prescription drugs, such as injections administered in a physician's office. However, outpatient prescription drugs provided to individuals are generally covered through Medicare Part D. Medicare Part C—Medicare Advantage—is Medicare's private health plan option that offers coverage for all Part A and Part B services, but may charge different amounts and may cover additional services, such as vision, hearing, dental, or health and wellness programs. Additionally, Medicare Advantage plans may also include prescription drug coverage (Medicare Part D). The number of Medicare Advantage plans varies regionally, but nearly all Medicare beneficiaries—including former servicemembers and their dependents who received Medicare benefits—have a Medicare Advantage plan available to them.

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<sup>36</sup>Certain limitations apply to Part A and Part B benefits. For example, under Part A, for each benefit period, inpatient hospital services are covered up to 90 days and skilled nursing facility care is covered up to 100 days following a hospital discharge. A benefit period ends when a beneficiary has not been an inpatient of a hospital or a skilled nursing facility for at least 60 consecutive days.

**Figure 4: Examples of Medicare Benefits Categories**

Medicare Part A	Medicare Part B	Medicare Part D
<ul style="list-style-type: none"> <li>• Inpatient hospital services</li> <li>• Posthospital skilled nursing facility services</li> <li>• Hospice care</li> <li>• Some home health services</li> </ul>	<ul style="list-style-type: none"> <li>• Outpatient hospital services</li> <li>• Physicians' and nursing services</li> <li>• X-rays, laboratory and diagnostic tests</li> <li>• Durable medical equipment</li> <li>• Some preventative care services</li> <li>• Limited coverage of certain outpatient drugs</li> </ul>	<ul style="list-style-type: none"> <li>• Outpatient prescription drugs</li> </ul>

Source: GAO analysis of the Centers for Medicare & Medicaid Services (CMS) information. | GAO-15-4

Note: Medicare Part C—Medicare Advantage—covers all the benefits that are included in Parts A and B, except for hospice care. However, Medicare Part A covers hospice care for individuals covered by a Medicare Advantage plan. Most Medicare Advantage plans also include prescription drug coverage (Part D), and plans may cover additional benefits not covered by Medicare Parts A or B.

State Medicaid programs offer a package of benefits to individuals—including dependents of servicemembers and former servicemembers and their dependents. State Medicaid programs may design their own benefits packages, provided they fall within federal parameters. As a result, Medicaid benefits may vary by state. State Medicaid programs generally must cover certain categories of mandatory benefits, as defined under federal law (see fig. 5). Additionally, states may also cover a range of optional benefits, such as prescription drugs, physical therapy, hospice, and preventive and dental services for adults.<sup>37</sup> State Medicaid programs may also cover benefits that are not covered through other major federal programs, such as long-term services and supports for individuals who have limited ability to care for themselves because of physical, cognitive, or mental disabilities or conditions that are delivered in institutional (e.g., nursing facilities) and community-based (e.g., private homes) settings.

<sup>37</sup> Additionally, states may receive CMS approval of demonstrations or waivers under which the state may cover additional benefits or tailor benefit packages to specified groups of Medicaid beneficiaries. For example, states may cover a broad range of home and community-based services for targeted populations under an approved waiver.



**Figure 5: Medicaid Mandatory Benefits**

<ul style="list-style-type: none"> <li>• Inpatient and outpatient hospital services</li> <li>• Physician services</li> <li>• Certified pediatric and family nurse practitioner services</li> <li>• Home health services</li> <li>• Laboratory and X-ray services</li> </ul>	<ul style="list-style-type: none"> <li>• Rural health clinic services</li> <li>• Family planning services</li> <li>• Federally qualified health center services</li> <li>• Nurse midwife services</li> <li>• Tobacco cessation counseling and pharmacotherapy for pregnant women</li> </ul>	<ul style="list-style-type: none"> <li>• Nonemergency transportation</li> <li>• Early and Periodic Screening, Diagnostic, and Treatment services for individuals under the age of 21</li> <li>• Nursing facility services for individuals aged 21 and over</li> </ul>
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Source: GAO analysis of the Centers for Medicare & Medicaid Services (CMS) information. | GAO-15-4

Note: Rehabilitative services and devices are provided to help a person regain, maintain, or prevent deterioration of a skill that has been acquired but then lost or impaired due to illness, injury, or disabling condition. Habilitative services and devices, as defined by several advocacy groups, are provided to help a person attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition.

Exchange plans offer benefits to individuals—including servicemembers, former servicemembers, and their dependents—who purchase this coverage. Beginning in 2014, health plans offered through the exchanges are required to cover 10 categories of benefits, referred to as essential health benefits (see fig. 6). For example, these health plans cover certain preventive health services, which include a variety of screenings, such as blood pressure and cholesterol screening, and certain vaccinations.<sup>38</sup> Exchange plans may cover additional health care benefits beyond the essential health benefits, such as health club memberships, hearing aids for children, adult dental services, and infertility treatments.

**Figure 6: Categories of Essential Health Benefits Covered by Exchange Plans**

<ul style="list-style-type: none"> <li>• Ambulatory patient services (outpatient care without being admitted to a hospital)</li> <li>• Emergency services</li> <li>• Hospitalization</li> <li>• Maternity and newborn care</li> </ul>	<ul style="list-style-type: none"> <li>• Laboratory services</li> <li>• Mental health and substance use disorder services</li> <li>• Prescription drugs</li> <li>• Rehabilitative and habilitative services and devices</li> </ul>	<ul style="list-style-type: none"> <li>• Preventive services and chronic disease management</li> <li>• Pediatric services, including oral and vision care</li> </ul>
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Source: GAO analysis of the Centers for Medicare & Medicaid Services (CMS) information. | GAO-15-4

<sup>38</sup>Centers for Medicare & Medicaid Services, *Preventive Care Benefits*, accessed September 24, 2014, <https://www.healthcare.gov/what-are-my-preventive-care-benefits/#part=1>.

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## DOD, VA, Medicare, Medicaid, and Exchange-Purchased Coverage May Have Premiums or Cost-Sharing Subject to Certain Limits

DOD, VA, Medicare, Medicaid, or exchange plans may have premiums or cost-sharing for their respective beneficiaries, including servicemembers, former servicemembers, and their dependents, but the costs for each are subject to certain limits. Cost-sharing includes copayments, coinsurance, or deductibles.<sup>39</sup> DOD's TRICARE plans may require servicemembers, former servicemembers, and their dependents to pay a premium—referred to as an enrollment fee—or to participate in certain cost-sharing. The amount of the premium or copayment is based on individuals' military status, which TRICARE plan they use, and where they choose to receive their care. For example, servicemembers and their dependents covered by TRICARE's Prime plan do not pay an enrollment fee, although former servicemembers who retired from military service and their dependents are required to pay an annual enrollment fee of \$273.84 for an individual and \$547.68 for a family for fiscal year 2014. Conversely, there are no enrollment fees for TRICARE Standard or Extra. Additionally, former servicemembers who retired from military service, dependents of servicemembers, and dependents of retired servicemembers may have to pay copayments or meet deductibles.

VA's health care program generally does not require former servicemembers to pay premiums and generally does not require cost-sharing for certain groups of former servicemembers, such as those with certain service-connected disabilities or who are low income. Other former servicemembers, such as those seeking care for non-service-connected disabilities or who have higher incomes, may be required to participate in cost-sharing that is subject to certain limits. The average, annual out-of-pocket costs for those required to participate in cost-sharing was \$322 for fiscal year 2013.

VA's health care programs for eligible dependents of former servicemembers generally require individuals to meet an annual deductible and pay coinsurance for health care services that were not provided at a VA facility. For example, in 2014, dependents of former servicemembers enrolled in the Civilian Health and Medical Program of

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<sup>39</sup>A copayment is a fixed dollar amount that a consumer must pay at the time a covered service is provided, such as a \$25 payment for a physician visit. Coinsurance is a fixed percentage of the total cost of covered services that a consumer must pay. A deductible is a specified amount that must be paid by the consumer before the health plan will begin paying for covered services. Health plans may also have an annual limit on the maximum out-of-pocket costs a consumer could incur.

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the Department of Veterans Affairs pay an annual deductible of \$50 for outpatient care. After this deductible is paid, VA's health care program pays for 75 percent of covered health care expenses, and the individual is responsible for the remaining 25 percent of expenses until the catastrophic cap—\$3,000 per family per calendar year—is reached.<sup>40</sup>

Medicare may require beneficiaries—including former servicemembers and their dependents—to pay premiums and other cost-sharing, depending on their income and other factors. For example, Medicare Part A coverage does not generally require payment of premiums, but beneficiaries who did not pay Medicare taxes while working may be required to pay a monthly premium (of up to \$426 in 2014).<sup>41</sup> Additionally, Part A beneficiaries—including former servicemembers and their dependents—may be responsible for a deductible, coinsurance, or a copayment for services. Medicare Parts B and D coverage generally requires individuals to pay a monthly premium. The monthly premium for Medicare Part B in 2014 ranges from \$104.90 to \$335.70, depending on the beneficiary's income. Additionally, Medicare Part B generally requires individuals to pay 20 percent of the cost of the medical service received. Medicare Parts A and B have a per service limit on cost-sharing, but no annual limit on these out-of-pocket costs. The costs, including premiums and copayments, for Medicare Part C vary by health plan though there are certain, established cost limits. For example, Medicare Advantage plans are not able to charge more in cost-sharing than Original Medicare for certain services, such as chemotherapy, renal dialysis, and skilled nursing facility care. Specifically, Medicare Advantage plans cannot require beneficiaries to share in the cost of the services beyond what is allowed for Medicare Part B for services, which generally requires beneficiaries to pay 20 percent of the Medicare-approved amount. Additionally, Medicare Advantage plans have a yearly limit, which varies by plan, on an individual's out-of-pocket costs for medical services. There are no such annual out-of-pocket cost limits in the Original Medicare program.

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<sup>40</sup>The catastrophic cap is the annual limit of how much a beneficiary can be charged in a calendar year for covered services and supplies.

<sup>41</sup>A beneficiary generally pays no premium for this coverage unless the beneficiary or spouse has worked fewer than 40 quarters in his or her lifetime, but the beneficiary is responsible for required deductibles, coinsurance, and copayment amounts.

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Certain servicemembers and former servicemembers and their dependents who have Medicare Parts A and B are also automatically covered by TRICARE for Life. Because TRICARE for Life serves as supplemental coverage that may minimize out-of-pocket expenses, such as copayments and deductibles, these individuals may have lower out-of-pocket expenses than an individual who does not have this additional coverage.

State Medicaid programs may not impose premiums or cost-sharing on certain populations or services. Specifically, states are prohibited from imposing premiums on Medicaid beneficiaries—including dependents of servicemembers and former servicemembers—with incomes below 150 percent of the federal poverty level. Additionally, states may not impose cost sharing on services provided to certain populations, such as children under the age of 18 or pregnant women. Further, states may not charge cost-sharing for certain services, including emergency and family planning services.<sup>42</sup> States can choose to impose premiums or cost-sharing for other Medicaid beneficiaries, but these costs are subject to certain limits. For example, total premiums and cost-sharing amounts cannot exceed 5 percent of a family's income.<sup>43</sup>

Exchange-purchased coverage provided by participating health insurance issuers may require beneficiaries—including servicemembers, former servicemembers, and their dependents—to pay premiums and cost-sharing, such as deductibles and copayments. Individual premium and cost-sharing amounts depend on the type of plan purchased, and exchange plans are categorized according to the costs expected to be paid by the plan—designated as bronze, silver, gold, or platinum. For example, a bronze plan will typically have lower premiums and higher cost-sharing when services are delivered, while a gold or platinum plan will have higher premiums and lower cost-sharing.<sup>44</sup> Additionally, PPACA established an annual limit on cost-sharing for exchange plan

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<sup>42</sup>States have the option to extend this exemption to children under the age of 21.

<sup>43</sup>States have the option to apply this limit on a quarterly or monthly basis.

<sup>44</sup>Each level has an assigned actuarial value, which is defined as the estimated amount an average enrollee will have to pay out of pocket (excluding premiums). For example, a silver plan has an average value of 70 percent, which means that an enrollee will be responsible for 30 percent of the cost of services.

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beneficiaries, which in 2014, was \$6,350 for self-only coverage and \$12,700 for other coverage.<sup>45</sup>

PPACA established two forms of federal subsidies for exchange-purchased coverage—premium tax credits and cost-sharing reductions—which reduce costs of the coverage to individuals who qualify. To qualify for federal subsidies, individuals must be eligible to enroll in an exchange plan, meet income criteria, and not have MEC, including coverage through government-sponsored programs, such as DOD or VA, Medicare, or Medicaid. Individuals who purchase health care coverage through the exchanges may qualify for premium tax credits if they have an income between 100 and 400 percent of the federal poverty level.<sup>46</sup> Cost-sharing reductions, available to individuals with incomes from 100 to 250 percent of the federal poverty limit, are only available to individuals who purchase a silver plan through an exchange. In addition, the amounts of cost-sharing assistance vary by income. For example, in the case of one state plan, individuals with incomes at 150 percent of the federal poverty level and with a silver plan would have their primary care visit copayment reduced from \$45 to \$3 and their specialty care visit copayment reduced from \$65 to \$5.<sup>47</sup>

Federal subsidies for exchange-purchased coverage may be available to certain former servicemembers and certain dependents of servicemembers and former servicemembers who are not covered by DOD or VA health care, if they meet applicable income and other requirements.<sup>48</sup> Most servicemembers and former servicemembers and their dependents have MEC and therefore are ineligible for premium tax

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<sup>45</sup>This limit does not include premiums, but does include deductibles.

<sup>46</sup>PPACA provides for a federal tax credit to lower the premium cost for eligible individuals to between 2 and 9.5 percent of income for individuals whose incomes are from 100 to 400 percent of the federal poverty level. This assistance is based on the premiums for the second-lowest-cost silver plan. Accordingly, if an individual chooses to enroll in a gold or platinum plan, their premium costs may exceed these levels.

<sup>47</sup>See GAO, *Retirement Security: Challenges for Those Claiming Social Security Benefits Early and New Health Coverage Options*, [GAO-14-311](#) (Washington, D.C.: Apr. 23, 2014).

<sup>48</sup>For example, these individuals cannot be incarcerated or have another form of MEC.

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credits and cost-sharing reductions, regardless of their income.<sup>49</sup>

Therefore, in order to qualify for federal subsidies, these individuals would first need to cancel their government-sponsored coverage. This is an option for certain individuals, but not for others. Specifically, former servicemembers and their dependents who have the option to enroll in VA coverage and certain TRICARE beneficiaries who are not statutorily entitled to TRICARE coverage—such as certain reservists and dependents eligible for TRICARE Young Adult—may choose not to enroll or may cancel their existing VA or TRICARE coverage. However, the majority of servicemembers and former servicemembers who retired from military service and their dependents are statutorily entitled to TRICARE coverage and, therefore, do not have the option to disenroll from TRICARE in order to potentially qualify for federal subsidies.

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## DOD and VA Provide Information on Eligibility for Exchange-Purchased Coverage, but DOD Provides Limited Information on Qualifying for Federal Subsidies

Both DOD and VA provide information to servicemembers, former servicemembers, and their dependents on how DOD and VA coverage is affected by PPACA requirements, as well as information on eligibility for exchange-purchased coverage. DOD and VA disseminate this information using a variety of mechanisms, including dedicated websites (e.g., [www.tricare.mil/aca](http://www.tricare.mil/aca) and [www.va.gov/health/aca](http://www.va.gov/health/aca)) and program materials available on their websites (e.g., fact sheets). The information provided generally focuses on PPACA's impact on their programs. For example, as of September 2014, both DOD and VA provided the following information through their websites:

- DOD and VA health care are considered MEC, with certain exceptions.<sup>50</sup> As a result, servicemembers, former servicemembers, and their dependents who have coverage through DOD or VA do not need to take additional steps or obtain other coverage to satisfy PPACA's requirement that individuals have MEC in order to avoid paying a tax penalty.

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<sup>49</sup>Certain types of DOD coverage may not qualify as MEC. For example, under a proposed regulation, DOD care that is limited to those services provided in the line of duty or as space is available at a military treatment facility would not qualify as MEC. 79 Fed. Reg. 4305, 4307-8 (Jan. 27, 2014).

<sup>50</sup>For example, special TRICARE programs, such as TRICARE Plus, which only provide certain limited services at a military treatment facility, are not considered to be MEC.

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- PPACA does not change servicemembers', former servicemembers', and their dependents' existing TRICARE and VA benefits or individuals' out-of-pocket costs for benefits offered through TRICARE or VA's health care program.

Additionally, both DOD's and VA's websites provide information to servicemembers, former servicemembers, and their dependents on how eligible individuals may get health care coverage through their respective programs, if they are not currently covered. For example, DOD's website provides a link to update its eligibility database and VA provides links to its application process. Further, agencies' websites or program materials suggest individuals who either do not have, or are ineligible for, coverage through their programs consider purchasing coverage from an exchange.

VA's website also provides information to former servicemembers and their dependents on qualifying for federal subsidies on exchange-purchased coverage. Specifically, VA provides information on its website that informs its users that VA coverage meets the standard for MEC under PPACA and, as a result, individuals covered by VA do not qualify for federal subsidies on exchange-purchased coverage. VA's website also provides information on how former servicemembers and their dependents who are enrolled in VA coverage may cancel this coverage, if they so choose. This type of information may be useful for former servicemembers and their dependents to compare the costs and other factors associated with VA coverage with the costs of exchange plans. For example, in some circumstances, former servicemembers and their dependents who do not live near a VA medical center may wish to consider whether federal subsidies may make exchange-purchased coverage affordable and whether that coverage may enable them to receive care closer to home.

However, unlike VA's website, DOD's website does not provide information on circumstances under which servicemembers or former servicemembers who retired from military service, or their dependents might qualify for federal subsidies, which could be useful in understanding their health care choices. Specifically, DOD's website does not inform servicemembers and former servicemembers that retired from military service that they and their dependents are statutorily entitled to TRICARE coverage and, as a result, they may not opt out of this coverage in order to potentially qualify for federal subsidies. Nor does DOD's website inform those individuals who may opt in to TRICARE coverage—including reservists, retired reservists, and dependent children under the age of 26 eligible for the young adult program—that they may choose not to enroll

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or cancel their TRICARE coverage in order to potentially qualify for federal subsidies.<sup>51</sup> Not providing such information is inconsistent with federal internal control standards.<sup>52</sup>

DOD officials stated that their focus has been on ensuring that servicemembers, former servicemembers who retired from military service, and their dependents understand that TRICARE coverage meets the standard for MEC and is not adversely affected by the enactment of PPACA. DOD officials also stated that to avoid confusion, they direct servicemembers and their dependents who are no longer eligible for TRICARE, such as those who have separated from military service or young adults over the age of 26, to obtain information on other coverage options from the [healthcare.gov](http://healthcare.gov) website. However, [healthcare.gov](http://healthcare.gov) does not inform servicemembers, former servicemembers that retired from military service, and their dependents who may qualify for federal subsidies that these subsidies are not available to individuals who have coverage through TRICARE. As a result, these individuals may not have complete information to make choices on the form of coverage that best meets their individual financial and health care needs. DOD officials acknowledged that changes could be made to DOD's program materials in order to clarify that when servicemembers, former servicemembers who retired from military service, and their dependents are eligible for TRICARE, they do not qualify for federal subsidies on exchange-purchased coverage.

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<sup>51</sup>The TRICARE Young Adult plan provides coverage to eligible adult children aged 21 to 26 who are not otherwise eligible for employer-sponsored health care coverage or another TRICARE plan.

<sup>52</sup>Federal internal control standards require agencies to use effective and timely communications—including communications with external stakeholders—in order to meet their mission and goals. See [GAO/AIMD-00-21.3.1](#).



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## More Than 27 Million Servicemembers, Former Servicemembers, and Their Dependents Had Coverage through Federal Programs in 2012

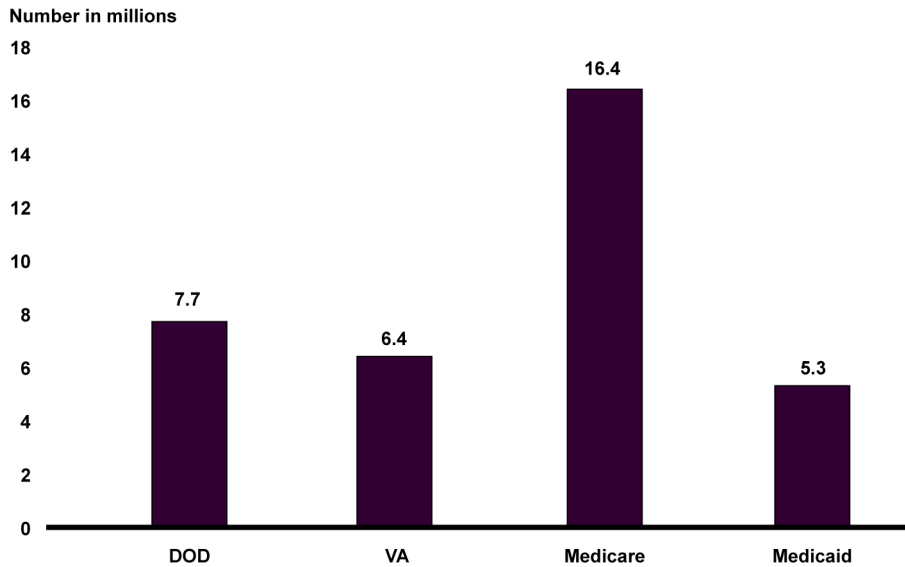
More than 27 million servicemembers, former servicemembers, and their dependents reported that they had health care coverage through DOD, VA, Medicare, Medicaid, or a combination of these in 2012, according to data we reviewed from the ACS. Of these, about 20 million reported they had coverage through a single program and 7 million reported they had coverage through a combination of two or more of these programs. Additionally, about 22 million servicemembers, former servicemembers, and their dependents reported that they did not have coverage through any of these federal programs in 2012. Of these, about 18 million reported they had coverage through another source, such as employer-sponsored coverage, and 4 million reported they were uninsured.<sup>53</sup>

We found that the number of servicemembers, former servicemembers, and their dependents covered by DOD, VA, Medicare, and Medicaid varies by program (see fig. 7). The number of individuals with coverage through each of these programs includes those who have coverage through a single program and those covered through that program and one or more other federal programs. For example, an individual with coverage through DOD and Medicare is counted in the DOD count and the Medicare count. As a result, the total number of those with coverage across all four programs is greater than the 27 million total unique servicemembers, former servicemembers, and their dependents who reported that they had health care coverage through these programs.

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<sup>53</sup>We used ACS data to estimate the number of servicemembers, former servicemembers, and dependents that had health care coverage under these programs because it is the only source that provides, for this population, information regarding coverage through all of these programs. ACS data, which are self-reported survey data, underestimates certain populations, including the servicemember, former servicemember, and dependent population. According to VA officials, the data reported on the ACS may reflect numbers lower than what is contained in DOD's and VA's administrative data because the ACS data does not include responses from individuals residing in the Virgin Islands, Pacific Islands, or other overseas locations (such as the Philippines). Additional factors, such as ACS survey respondents confusing their training for active duty with actually being activated for service, may account for other differences.

**Figure 7: Number of Servicemembers, Former Servicemembers, and Their Dependents Who Had Health Care Coverage through DOD, VA, Medicare, or Medicaid in 2012**



Source: GAO analysis of 2012 American Community Survey (ACS) data provided to us by the Department of Veterans Affairs (VA) | GAO-15-4

Note: Servicemembers, former servicemembers, and their dependents may have health care coverage through more than one federal program. Individuals covered by two or more programs are included in the count of each program through which they have coverage. As a result, the total number of those with coverage across all four programs is greater than the 27 million total unique servicemembers, former servicemembers, and their dependents who reported that they had health care coverage through these programs.

ACS survey respondents reported coverage through DOD's TRICARE and VA health care programs. About 7.7 million servicemembers, former servicemembers who retired from military service, and their dependents reported that they had health care coverage through DOD's TRICARE program in 2012, according to data we reviewed from the ACS.<sup>54</sup> About

<sup>54</sup>DOD has administrative records that provide the number of individuals covered by its program, but do not include information on health care coverage for individuals not covered by its program, such as former servicemembers who left the military for reasons other than retirement and their dependents. DOD's administrative records for individuals covered by its program showed that an average of 8.1 million servicemembers, former servicemembers who retired from military service, and their dependents used their TRICARE coverage to access health care services in fiscal year 2012. In fiscal year 2013, an average of 8.0 million servicemembers, former servicemembers who retired from military service, and their dependents (of the 9.6 million eligible beneficiaries) used their TRICARE coverage.

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6.4 million former servicemembers and their dependents reported that they had health care coverage through VA according to the 2012 ACS data.<sup>55</sup>

ACS survey respondents also reported coverage through Medicare and Medicaid. About 16 million servicemembers, former servicemembers, and their dependents reported that they had coverage through Medicare in 2012, according to the ACS data we reviewed. Former servicemembers may be 65 years of age or older, as may be their spouses, and therefore would qualify for Medicare. In fiscal year 2012, there were approximately 2.0 million individuals aged 65 and older who were covered through DOD's health care program and 3.6 million who were covered through VA's health care program. Additionally, servicemembers, former servicemembers, and their dependents may qualify for Medicare due to disability or illness. About 5.3 million servicemembers, former servicemembers, or their dependents reported that they had health care coverage through Medicaid according to the 2012 ACS data we reviewed. These 5.3 million individuals may include former servicemembers with low incomes, or dependents of servicemembers or former servicemembers with special-needs children.

About 7 million servicemembers, former servicemembers, and their dependents had health care coverage through two or more programs in 2012. Of these, most—nearly 6 million—had coverage through two programs; far fewer were covered by three or four programs (see table 1).

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<sup>55</sup>While many individuals who leave military service for reasons other than retirement are eligible for health care coverage through VA, many choose not to enroll for reasons that include distance between the former servicemembers' homes and VA facilities or perceptions about VA care.

VA has administrative records that provide the number of individuals covered by its program, but the records do not include information on health care coverage for individuals not covered by its program, such as servicemembers, their dependents, former servicemembers not enrolled in VA health care, and dependents of former servicemembers not eligible for VA health care. VA's administrative records for individuals covered by its program showed that about 6.3 million individuals used their VA coverage to access health care services in fiscal year 2012. In fiscal year 2013, approximately 6.5 million individuals (of the 9.3 million eligible beneficiaries) used their VA coverage. Of these 9.3 million enrolled beneficiaries, 8.9 million were servicemembers or former servicemembers and, according to VA officials, 378,000 were dependents, caregivers, or survivors enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs or the Spina Bifida Program.

**Table 1: Number of Servicemembers, Former Servicemembers, and Their Dependents with Multiple Forms of Coverage through DOD, VA, Medicare, or Medicaid in 2012**

Types of coverage	Number of servicemembers, former servicemembers, and their dependents (reported in millions)
<b>Two forms of coverage</b>	<b>5.9</b>
VA and Medicare	2.4
Medicaid and Medicare	1.3
TRICARE and Medicare	1.2
TRICARE and VA	0.6
VA and Medicaid	0.2
TRICARE and Medicaid	0.1
<b>Three forms of coverage</b>	<b>1.2</b>
TRICARE, VA, and Medicare	0.7
VA, Medicaid, and Medicare	0.4
TRICARE, Medicaid, and Medicare	0.1
TRICARE, VA, and Medicaid	0.04
<b>Four forms of coverage</b>	
TRICARE, VA, Medicaid, and Medicare	<b>0.1</b>
<b>Total</b>	<b>7.2</b>

Source: GAO analysis of 2012 American Community Survey (ACS) data provided to us by the Department of Veterans Affairs (VA).  
| GAO-15-4

Note: Certain dependents of servicemembers and former servicemembers who retired from military service, reservists, and retired reservists may choose not to be covered by TRICARE even if they are eligible to purchase this coverage, according to Department of Defense (DOD) officials. Similarly, former servicemembers and their dependents may choose not to be covered by VA health care even if they are eligible.

According to the ACS data we reviewed, approximately 2.4 million former servicemembers and their dependents were covered by VA and Medicare. Generally, those covered through both VA and Original Medicare may choose which form of coverage they would like to use for a particular episode of care. For example, former servicemembers may elect to use their VA coverage to obtain regular preventive care visits at a nearby VA community-based outpatient clinic and their Medicare coverage to obtain certain specialty services, such as surgery, from a non-VA community-based provider. In general, if an individual chooses to receive care from a VA provider, VA pays in full if the care is for a service-connected disability and, for a non-service-connected disability, may assess any copayments that an individual may owe through VA rules. Conversely, if the individual chooses a Medicare participating provider,

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Medicare would cover the cost of the services and assess any cost-sharing charges owed through the Original Medicare program rules.

According to the ACS data we reviewed, approximately 1.3 million former servicemembers and their dependents are covered by both Medicare and Medicaid. This type of coverage may occur when former servicemembers and their dependents, who are not covered through DOD or VA, meet the requirements for coverage through both Medicare and Medicaid. For these individuals, Medicare generally covers most of the cost of services, and Medicaid may cover some or all of the cost-sharing. Additionally, Medicaid may cover certain services that Medicare does not.<sup>56</sup> For example, a former servicemember who is 65 years of age or older who requires long-term nursing home care may receive coverage of this service through his or her state Medicaid program, as that service is not covered through Medicare.<sup>57</sup>

According to the ACS data we reviewed, approximately 1.2 million servicemembers, former servicemembers, and their dependents are covered by both TRICARE and Medicare, and which program provides the benefits depends on where the individuals receive the services. While these individuals are eligible to receive care directly from a military treatment facility, DOD rules allow these individuals to receive care only if space is available. When an individual uses this option, DOD generally covers the full cost of that episode of care. However, if these individuals choose to receive care from a Medicare participating provider, Medicare generally is the primary payer, with TRICARE paying the out-of-pocket expenses for services it covers that are owed by the individuals, such as any copayments or deductibles.

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<sup>56</sup>Individuals covered by both Medicare and Medicaid may be categorized as full-benefit or partial-benefit. Those with full benefits generally receive coverage of their Medicare premiums and cost-sharing as well as the entire range of Medicaid benefits. Those with partial benefits do not receive Medicaid-covered services, but Medicaid covers their Medicare premiums and/or cost-sharing, or both. Partial-benefit beneficiaries have limited income and assets, but their income and assets are not low enough to qualify them for full Medicaid benefits in their states.

<sup>57</sup>State Medicaid programs are required to cover nursing facility service, subject to certain limitations. Examples of these limitations include medical necessity and utilization control procedures.

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## Conclusions

Servicemembers, former servicemembers, and their dependents may face complex choices in considering which forms of coverage best meet their health care needs and financial situations given that DOD, VA, Medicare, Medicaid, and the exchanges offer a range of benefits and cost-sharing requirements depending on individuals' eligibility for these programs. In 2014, the initiation of exchange-purchased coverage, and the expansion of Medicaid in states choosing to participate, added to the choices and complexity these individuals face in making choices for health care coverage. Moreover, changes in servicemembers', former servicemembers', and their dependents' military status, age, disabilities, and other factors over time can result in the need to reconsider complex choices in coverage through different federal programs.

For servicemembers and former servicemembers to make well-informed decisions for themselves and their dependents, it is important that federal agencies provide complete information about individuals' health care coverage choices, including the range of benefits offered, and the potential cost-sharing associated with each program. In particular, servicemembers, former servicemembers, and their dependents need complete information on the complex health care coverage choices offered by DOD, VA, and the recently implemented exchanges in order to select the coverage that best meets their needs. This includes information on how they may qualify for federal subsidies that may reduce the cost of exchange-purchased coverage. While DOD and VA both provide information on their eligibility for coverage through the exchanges, only VA provides information on how individuals may qualify for federal subsidies. Consequently, certain servicemembers, former servicemembers, and their dependents may not have adequate information to compare costs efficiently and choose the coverage that best meets their health care needs and their available financial resources.

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## Recommendation for Executive Action

To help ensure that servicemembers, former servicemembers, and their dependents have complete information for considering their choices for their health care coverage, we recommend that the Secretary of Defense disseminate information on how DOD health care coverage may affect servicemembers', former servicemembers', and their dependents' ability to qualify for federal subsidies that reduce the costs of exchange-purchased coverage.

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## Agency Comments

We provided a draft of this report to DOD, VA and HHS for comment. In its written comments—reproduced in appendix I—DOD concurred with our recommendation. DOD stated that it will continue to assess and implement strategies that strengthen the dissemination of information on how TRICARE eligibility affects its beneficiaries’ ability to qualify for subsidies on exchange-purchased coverage. In its written comments—reproduced in appendix II—VA generally agreed with our conclusions. VA also provided technical comments that were incorporated, as appropriate. HHS had no comments.

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We are sending copies of this report to the Secretary of the Department of Defense, the Secretary of the Department of Health and Human Services, the Secretary of the Department of Veterans Affairs, the Administrator of CMS, and the appropriate congressional committees. In addition, the report will be available at no charge on the GAO website at <http://www.gao.gov>.

If you or your staffs have any questions about this report, please contact me at (202) 512-7114 or at [iritanik@gao.gov](mailto:iritanik@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 who made key contributions to this report are listed in appendix III.



Katherine Iritani  
Director, Health Care

# Appendix I: Department of Defense Comments



## THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON  
WASHINGTON, DC 20301-1200

### HEALTH AFFAIRS

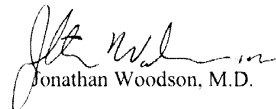
Ms. Katherine Iritani  
Director, Defense Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Iritani:

This is the Department of Defense's (DoD) response to the attached Government Accountability Office (GAO) Draft Report titled, "HEALTH CARE: Information on Coverage Choices for Service members, Former Service members, and Their Dependents," (GAO-15-4) dated October 10, 2014. Thank you for the opportunity to review and comment on the Draft Report. My comment on the recommendation is included in the attached document.

My points of contact on this matter are Captain (CAPT) Kimberly Elenberg (Functional) and Mr. Gunther Zimmerman (Audit Liaison). CAPT Elenberg may be reached at (703) 681-6219, or [Kimberly.Elenberg@dha.mil](mailto:Kimberly.Elenberg@dha.mil). Mr. Zimmerman may be reached at (703) 681-4360, or [Gunther.Zimmerman@dha.mil](mailto:Gunther.Zimmerman@dha.mil).

Sincerely,

  
Jonathan Woodson, M.D.

Attachment:  
As stated



GAO DRAFT REPORT – DATED OCTOBER 10, 2014  
GAO CODE 291167/GAO-15-4

“HEALTH CARE: Information on Coverage Choices for Service members,  
Former Service members, and Their Dependents”

DEPARTMENT OF DEFENSE COMMENTS  
TO THE RECOMMENDATION

**RECOMMENDATION:** To help ensure that service members, former service members, and their dependents have complete information for considering their choices for their health care coverage, we recommend that the Secretary of DoD disseminate information on how DoD health care coverage may affect service members', former service members', and their dependents' ability to qualify for federal subsidies that reduce the costs of exchange purchased coverage.

**DOD RESPONSE:** The DoD concurs with the GAO recommendation and will continue to assess and implement strategies that strengthen the dissemination of information on how TRICARE eligibility affects our beneficiaries' ability to qualify for the Affordable Care Act subsidies.

# Appendix II: Department of Veterans Affairs Comments



DEPARTMENT OF VETERANS AFFAIRS  
WASHINGTON DC 20420

October 30, 2014

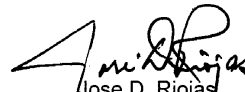
Ms. Katherine Iritani  
Director, Health Care  
U.S. Government Accountability Office  
441 G Street, NW  
Washington, DC 20548

Dear Ms. Iritani:

The Department of Veterans Affairs (VA) has reviewed the Government Accountability Office's (GAO) draft report, ***"HEALTH CARE: Information on Coverage Choices for Servicemembers, Former Servicemembers, and Their Dependents"*** (GAO-15-4). VA generally agrees with GAO's conclusions.

The enclosure provides technical comments to the draft report. VA appreciates the opportunity to comment on your draft report.

Sincerely,

  
Jose D. Riojas  
Chief of Staff

Enclosure

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# Appendix III: GAO Contact and Staff Acknowledgments

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## GAO Contact

Katherine Iritani, (202) 512-7114 or [iritanik@gao.gov](mailto:iritanik@gao.gov)

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## Staff Acknowledgments

In addition to the named above, key contributors to this report were James C. Musselwhite, Jr., Assistant Director; Kathryn Black; Sarah Harvey; Laurie Pachter; Vikki Porter; and Hemi Tewarson.

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# Related GAO Products

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*VA Nursing Homes: Reporting More Complete Data on Workload and Expenditures Could Enhance Oversight.* [GAO-14-89](#). Washington, D.C.: December 20, 2013.

*Patient Protection and Affordable Care Act: Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges.* [GAO-13-601](#). Washington, D.C.: June 19, 2013.

*Patient Protection and Affordable Care Act: Status of Federal and State Efforts to Establish Health Insurance Exchanges for Small Businesses.* [GAO-13-614](#). Washington, D.C.: June 19, 2013.

*Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance.* [GAO-13-55](#). Washington, D.C.: November 15, 2012.

*Medicare Advantage: Enrollment Increased from 2010 to 2011 while Premiums Decreased and Benefit Packages Were Stable.* [GAO-12-93](#). Washington, D.C.: October 31, 2011.

*VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access.* [GAO-12-12](#). Washington, D.C.: October 14, 2011.

*DOD Health Care: Cost Impact of Health Care Reform and the Extension of Dependent Coverage.* [GAO-11-837R](#). Washington, D.C.: September 26, 2011.

*Health Care Price Transparency: Meaningful Price Information Is Difficult for Consumers to Obtain Prior to Receiving Care.* [GAO-11-791](#). Washington, D.C.: September 23, 2011.

*Medicaid and CHIP: Given the Association between Parent and Child Insurance Status, New Expansions May Benefit Families.* [GAO-11-264](#). Washington, D.C.: February 4, 2011.

*VA Health Care: VA Has Taken Steps to Make Services Available to Women Veterans, but Needs to Revise Key Policies and Improve Oversight Processes.* [GAO-10-287](#). Washington, D.C.: March 31, 2010.

*Medicare Part D: Spending, Beneficiary Out-of-Pocket Costs, and Efforts to Obtain Price Concessions for Certain High-Cost Drugs.* [GAO-10-529T](#). Washington, D.C.: March 17, 2010.

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*VA Faces Challenges in Providing Substance Use Disorder Services and Is Taking Steps to Improve These Services for Veteran.* [GAO-10-242R](#). Washington, D.C.: March 10, 2010.

*Medicare Part D: Spending, Beneficiary Cost Sharing, and Cost-Containment Efforts for High-Cost Drugs Eligible for a Specialty Tier.* [GAO-10-294R](#). Washington, D.C.: January 29, 2010.

*Medicaid: States Reported That Citizenship Documentation Requirement Resulted in Enrollment Declines for Eligible Citizens and Posed Administrative Burdens.* [GAO-07-889](#). Washington, D.C.: June 28, 2007.

*Medicare Part D: Challenges in Enrolling New Dual-Eligible Beneficiaries.* [GAO-07-272](#). Washington, D.C.: May 4, 2007.

*TRICARE: Enrollment of the Department of Defense's TRICARE Beneficiaries in Medicare Part B.* [GAO-06-489R](#). Washington, D.C.: June 20, 2006.

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