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GOVERNMENT RELATIONS LLC

OMB 12866 Meeting on 2/15/08 regarding the Implementing Regulation for Section 707 of Public Law 109-364

TRICARE Talking Points

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November 27, 2007

VIA EMAIL AND FIRST CLASS MAIL

Kathleen Peroff, Deputy Associate Director for National Security
Executive Office of the President
The Office of Management and Budget
725 17th Street, NW
Washington, DC 20503

Dear Ms. Peroff:

We are submitting this letter to you at the request of our client, Mort Perlroth. Its purpose is to provide you with our view of what we believe to be the proper application of the provisions of § 707 of the John Warner Defense Authorization Act of 2007 (the "Act") to employee pre-tax elections under Section 125 of the Internal Revenue Code (the "Code") regulating so-called "cafeteria plans." We understand that you are currently reviewing a proposed regulation issued by the Department of Defense pursuant to the Act § 707. For the reasons explained at length below, we wish to call to your attention an important distinction that will affect the ability of military retirees to access TRICARE supplemental coverage though a cafeteria plan in a way that comports with the intent of Congress.

Background

Act § 707 for the first time imposes upon TRICARE so-called "secondary payer" rules similar to those that have applied to Medicare since the Omnibus Budget Reconciliation Act of 1980.[1] Specifically, Act § 707 establishes rules governing the order of payment where (i) an employee is covered simultaneously under an employer-sponsored group health plan and TRICARE, and (ii) the same medical procedure or service is covered under both plans. The plan that is obligated to pay first is referred to as the "primary payer" and the other plan is referred to as the "secondary payer."

The Act expressly requires that the TRICA secondary payer rules be applied:

> "[I]n the same manner as such section 1862(b)(3)(C) applies to financial or other incentives for an individual entitled to benefits under title XVIII of the Social Security Act [i.e., the Medicare secondary payer rules] not to enroll (or to terminate enrollment) under *a group health plan or a large group health plan*

[1] Pub. L. 96-499, 94 Stat. 2631 (December 5, 1980).

> which would (in the case of enrollment) be a primary plan . . . ." (Emphasis added).

Thus, in developing regulations under the Act, the regulators are directed to look to the Medicare secondary payer rules promulgated by the Centers for Medicare & Medicaid Services ("CMS"). Separately, House Conference Report 109-702 accompanying the Act requests the Secretary of Defense to report to the House and Senate Armed Services Committees on the treatment of cafeteria plans and non-TRICARE exclusive employer-provided incentives under the Department's implementation of Act § 707.

Law and Analysis

The Act governs "group health plans and large group health plans" as those terms are defined under the Medicare secondary payer rules. 42 U.S.C. § 1395y(b)(1)(A)(v) defines these terms with reference to Code § 5000(b)(1), which provides:

> "The term 'group health plan' means a plan (including a self-insured plan) *of, or contributed to by, an employer* (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees, the employer, others associated or formerly associated with the employer in a business relationship, or their families." (Emphasis added).

Cafeteria plan contributions are not limited to group health plans. It is instead possible for an employee to make a contribution under a cafeteria plan to a non-group, voluntary arrangement. In a revenue ruling that predated the adoption of Code § 125,[2] the IRS made clear that pre-tax treatment is available to non-group products. This holding was expanded upon and confirmed in a recently (re)proposed cafeteria plan regulation.[3] The following examples should serve to illustrate the point:

> (1) *Could a TRICARE-eligible employee simply decline employer-sponsored group health plan coverage, and opt instead to (i) enroll in TRICARE and (ii) purchase a TRICARE supplement with his or her after-tax dollars?*
>
> Assuming that the decision is free from any improper employer incentives, the answer is clearly yes. The TRICARE supplement in this instance is not maintained by the employer—i.e., it is not a "group health plan." It is, rather,

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[2] Rev. Rul. 61-146, 1961-2 C.B. 25 (holding that amounts advanced by an employer to enable retirees to purchase medical coverage as reimbursements can get the advantage of pre-tax treatment if properly substantiated).
[3] Prop. Treas. Reg. § 1.125-1(m) (Aug. 6, 2007).

mere individual coverage that is regulated by the various states under laws governing the individual rather than the group insurance market.

(2) *Could the same employee in Example (1) above purchase the same coverage on a pre-tax basis under a Section 125 cafeteria plan?*

Again, we think the correct answer is yes. We based this conclusion upon the IRS's clarification in its proposed cafeteria plan regulation cited above, which recognizes that individual market insurance products can be purchased under a cafeteria plan.

The critical distinction in this instance is between a "group health plan," which the Act regulates, and voluntary or individual coverage, which it does not. "Voluntary benefit" programs are arrangements that are paid for entirely by employees, and with respect to which the employer's role is confined to arranging for the payment of the employee's premiums through payroll deduction. As to what distinguishes group benefits from individual, voluntary benefits, there are two sets of available precedents: one from the U.S. Department of Labor and the other from CMS.

(1) *ERISA/Department of Labor.* For purposes of the Employee Retirement Income Security Act ("ERISA"), U.S. Department of Labor Reg. § 2510.3-1(j) singles out voluntary, employee-pay-all welfare arrangements if—

(i) No contributions are made by an employer or employee organization;

(ii) Participation is completely voluntary;

(iii) The sole involvement of the employer or employee organization is, without endorsing the program, to permit the sponsor to publicize the program and to collect contributions through payroll withholding or dues check-offs and remit them to the sponsor; and

(iv) The employer or employee organization receives no consideration, in cash or otherwise, other than reasonable compensation for services rendered in connection with payroll deductions or dues check-offs.

Where these requirements are satisfied, the underlying welfare benefit is exempt from ERISA by virtue of the lack of employer involvement.

(2) *CMS.* In a similar vein, CMS both in its operations manual and its website bars an employer from making pre-tax contributions to a "group health plan."[4] But voluntary arrangements are not plans "of or contributed by" employers. While CMS has not opined on the matter of what distinguishes group health plans from voluntary arrangements, we think the correct view is that the latter are not group health plans for this purpose.

In the examples set out above, the contribution is not to a "group health plan;" rather, it is to an individual, voluntary benefit. To hold otherwise, in our view, would lead to a result that Congress never intended.

It is also important to recognize that a voluntary, employee-pay-all arrangement might be exempt from regulation as an "employee welfare benefit plan" under ERISA § 3(1) and nevertheless be a "group health plan" merely for purposes of the health care continuation requirements of Code § 4980B and ERISA Title I, Subtitle B, Part 6 (i.e., COBRA). According to Treas. Reg. § 54.4980B-1, Q&A 2, a plan with no employer contributions must still offer health continuation rights where the premium cost to an employee through the employer is less than the premium cost in the individual market. We understand that the TRICARE supplement products offered to employees of some large employers exhibit this characteristic—i.e., that the premium cost, though paid entirely with the employees' funds, is less than the premium cost that would be charged to an unemployed TRICARE eligible individual. That such an arrangement is considered a "group health plan" for COBRA purposes should not change its character as a voluntary benefit for purposes of implementing the TRICARE secondary payer rules.

There is another consequence of failing to properly distinguish between group health plans and voluntary or individual benefits. Many employers offer a cash incentive for employees to accept a cash bonus if they decline employer-sponsored coverage and they can demonstrate that they have coverage elsewhere. The other coverage might be through a spouse (i.e., a group health plan not sponsored by the employer), for example, or through a governmental program (e.g., TRICARE). These so-called "opt-out" arrangements must operate under Code § 125, since they involve a choice between cash and a non-taxable benefit (i.e., health insurance). CMS has expressed the view, admittedly informal, that opt-out arrangements are permissible.

In a May 28, 2002 letter to Roberta C. Watson from Paul J. Olenick (Director, Division of Integrated Delivery Systems, Purchasing Policy Group, Center for Medicare Management of CMS), CMS opined that broad-based credits are not considered financial incentives that would violate the Medicare secondary payer rules. Writing on behalf of the Joint Committee on Employee Benefits of the American Bar Association, Ms. Watson specifically asked CMS whether the MSP rules would be violated if an employer with a cafeteria plan allowed employees to choose between health coverage and a specific cash amount in lieu of electing the health

[4] http://www.cms.hhs.gov/medicaresecondpayerandyou/ (site last visited Aug. 25, 2007).

coverage, provided that the same choice is offered to all employees regardless of age or Medicare status. CMS responded that, as long as any cash payment to an employee is made based upon the employee's election of a benefit offered under the employer's cafeteria plan, the cash payment would not violate the prohibition on financial incentives under the MSP rules.

Based upon the forgoing, we urge you to include in the proposed regulations implementing § 707, language to the following effect:

> "For purposes of determining that health coverage is offered under an employer-sponsored group health plan, these rules will not apply to a 'bona fide voluntary benefits program.' For purposes of these regulations, the phrase 'bona fide voluntary benefits program' means an arrangement that satisfies the requirements for exemption from the requirements of the Employee Retirement Income Security Act of 1974 ('ERISA') set out in Department of Labor Reg. § 2510.3-1(j)."

We further recommend that the following clarifying examples be included in the proposed regulations:

> **Example 1**. Employer X maintains a voluntary benefits program, which includes a TRICARE supplement that is available to TRICARE-eligible employees. The employer periodically deducts premiums for an employee who elects the TRICARE supplement from the employee's paycheck and remits them to the insurance carrier. There are no employer contributions. The employer allows the carrier to promote the supplement among its employees, but it does not hold the arrangement out as its plan, nor does it in any way encourage participation. The employer pays all administrative costs relating to all of its voluntary benefits programs and receives no consideration of any kind from any insurance carrier, broker or other source. The arrangement described in this Example 1 is a bona fide voluntary benefits program.

> **Example 2**. Same facts as Example 1, except that employee premiums are paid under a "cafeteria plan" that satisfies the requirements of Section 125 of the Internal Revenue Code. The arrangement described in this Example 2 is also a bona fide voluntary benefits program.

Conclusion

Our comments and request for clarification set out in this letter are aimed principally at voluntary benefits arrangements, and they are based upon the unambiguous text of § 707, which is directed at actions by employers, not employees. In our view, to say that a TRICARE-eligible employee

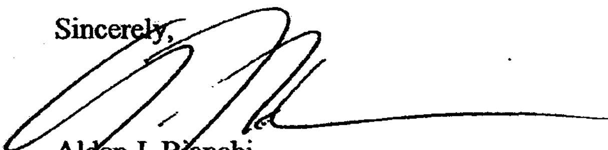
can elect TRICARE coverage and purchase a TRICARE supplement on his or her own but not through a voluntary benefits program is to exalt form over substance. In each case, the dollars go from the employee's pocket to that of the insurance carrier. The only difference is the route traveled.

The availability of pre-tax treatment through a § 125 cafeteria plan does not alter the equation. That an individual purchases a TRICARE supplemental policy with his or her own money should not invoke the Act's proscriptions, for the reasons set out above. By clarifying that individual (as opposed to group) products may be purchased on a pre-tax basis under a cafeteria plan, the IRS has affected the tax-treatment of the premium contribution, but not its character as a non-group product. The difference is only that the employee is being provided a tax benefit that is available with respect to *any* medical benefit. We therefore encourage the proposed regulations to state clearly that voluntary benefits arrangements (including those offered through § 125 cafeteria plans), which include access to individual, employee-pay-all TRICARE supplements, do not run afoul of § 707.

In connection with this submission, we attach a copy of an e-mail message from Senator Saxby Chambliss (R. Ga.) describing his understanding of the coordination of Act § 707 and Code § 125. Though he does not use the same terminology, the Senator's views of how the Act ought to be interpreted are on all fours with ours. But perhaps even more compelling is his understanding of the Act's underlying policy goals. A failure to recognize that voluntary and individual benefits can be accessed under a cafeteria plan puts Military retirees at a disadvantage vis-à-vis other employees. This would happen, by way of example, where a TRICARE eligible employee is barred from using a broad-based opt-out plan. This, we submit, is both inconsistent with the intent of Congress, and it sends entirely the wrong message to (in the Senator's words) "our military retirees who have proudly served our great Nation."

We appreciate this opportunity to offer our views in the matter of the proper scope and application of Act § 707, and we invite you to contact us if we can answer questions, provide clarification, or otherwise assist with your efforts.

Sincerely,



Alden J. Bianchi

AJB/dln
Enclosure

From: Saxby Chambliss
> To:
> Sent: Monday, November 19, 2007 2:19 PM
> Subject: Responding to your message
>
>
>
> Dear Mr.:
>
>
> Thank you for contacting me with your concerns about employer benefits
> to TRICARE beneficiaries. It is good to hear from you.
>
>
> On September 30, 2006, the Senate passed the fiscal year 2007 National
> Defense Authorization Act (P.L. 109-364) which contains a provision
> that prohibits employers from offering incentives to TRICARE eligible
> employees to prevent them from using the employer sponsored health
> plan. While employers should not be able to offer cash incentives to
> encourage employees to remain on TRICARE, employers should not be
> prohibited from allowing TRICARE recipients to participate in company
> sponsored cafeteria plans. These plans allow employers to offer
> employees many options for healthcare which in turn will allow them to
> have the coverage best suited for their needs. Under these plans,
> TRICARE recipients can purchase a supplemental TRICARE policy or other
> policies to increase their overall health coverage. When these plans
> are offered to all employees, it is only fair that TRICARE recipients
> should be allowed to participate.
>
>
> I can think of no higher priority than the responsibility for caring
> for our military retirees who have proudly served our great Nation. I
> am deeply committed to promoting the well -being of those who have
> served our country and preserved our freedoms and way of life. You can
> be assured that I will fight, as I always have, to make certain that
> their concerns are given the highest priority in Congress. America 's
> servicemen and women have earned their benefits through their service
> to the United States . I will do all I can to make sure that our
> military retirees and their families are provided with the best
> healthcare available.
>

> Thank you again for taking the time to contact me. As always, I
> appreciate hearing from you. In the meantime, if you would like to
> receive timely email alerts regarding the latest congressional actions
> and my weekly e-newsletter, please sign up via my web site at:
www.chambliss.senate.gov .
>

REPORT LANGUAGE

Relationship between the TRICARE program and employer-sponsored group health care plans (sec. 707)

The House bill contained a provision (sec. 710) that would extend to TRICARE the same rule that applies to the Medicare program making it unlawful for an employer or other entity to offer any financial or other incentive for a retired TRICARE beneficiary not to enroll under an employer-provided group health plan. The provision would also authorize the Secretary of Defense to discontinue a relationship with a Department of Defense contractor for repeated violations of this provision. The provision would take effect on January 1, 2008.

The Senate amendment contained a similar provision (sec. 722).

The Senate recedes with an amendment that would clarify that TRICARE eligible employees have the opportunity to elect to participate in an employer group health plan in the same manner as other similarly situated employees, and that the provision would not be construed to effect, modify, or terminate the eligibility of a TRICARE eligible employee or spouse for their earned military health care entitlement authorized under chapter 55, title 10, United States Code. The amendment would also delete the authority for the Secretary to terminate Department contractor relationships based on repeated violations of this provision because the Federal Acquisition Regulation already specifies the circumstances under which repeated violations of law may be a basis for suspension or debarment of a Department contractor.

The conferees are aware of concerns that have been expressed regarding the treatment of cafeteria plans authorized under section 125 of the Internal Revenue Code and non-TRICARE exclusive employer-provided health care incentives under this provision. The conferees direct the Secretary to report, not later than April 1, 2007, to the Committees on Armed Services of the Senate and the House of Representatives on the treatment of cafeteria plans and non-TRICARE exclusive employer-provided health care incentives under the Department's implementation of this provision. This report shall assess the treatment of such plans under the Medicare Secondary Payer statute and regulations and such incentives, and include any recommendations the Secretary finds appropriate to ensure fair treatment of all TRICARE beneficiaries under this provision.

PUBLIC LAW 109–364—OCT. 17, 2006 120 STAT. 2283

SEC. 707. RELATIONSHIP BETWEEN THE TRICARE PROGRAM AND EMPLOYER-SPONSORED GROUP HEALTH CARE PLANS.(a) IN GENERAL.—Chapter 55 of title 10, United States Code, is amended by inserting after section 1097b the following new section:

"§ 1097c. TRICARE program: relationship with employer sponsored group health plans

"(a) PROHIBITION ON FINANCIAL INCENTIVES NOT TO ENROLL IN A GROUP HEALTH PLAN.—(1) Except as provided in this subsection, the provisions of section 1862(b)(3)(C) of the Social Security Act shall apply with respect to financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under a health plan which would (in the case of such enrollment) be a primary plan under sections 1079(j)(1) and 1086(g) of this title in the same manner as such section 1862(b)(3)(C) applies to financial or other incentives for an individual entitled to benefits under title XVIII of the Social Security Act not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of enrollment) be a primary plan (as defined in section 1862(b)(2)(A) of such Act).

"(2)(A) The Secretary of Defense may by regulation adopt such additional exceptions to the prohibition referenced and applied under paragraph (1) as the Secretary deems appropriate and such paragraph (1) shall be implemented taking into account the adoption of such exceptions.

"(B) The Secretary of Defense and the Secretary of Health and Human Services are authorized to enter into agreements for carrying out this subsection. Any such agreement shall provide that any expenses incurred by the Secretary of Health and Human Services pertaining to carrying out this subsection shall be reimbursed by the Secretary of Defense.

"(C) Authorities of the Inspector General of the Department of Defense shall be available for oversight and investigations of responsibilities of employers and other entities under this subsection.

"(D) Information obtained under section 1095(k) of this title may be used in carrying out this subsection in the same manner as information obtained under section 1862(b)(5) of the Social Security Act may be used in carrying out section 1862(b) of such Act.

"(E) Any amounts collected in carrying out paragraph (1) shall be handled in accordance with section 1079a of this title.

"(b) ELECTION OF TRICARE-ELIGIBLE EMPLOYEES TO PARTICIPATE IN GROUP HEALTH PLAN.—A TRICARE-eligible employee shall have the opportunity to elect to participate in the group health plan offered by the employer of the employee and receive primary coverage for health care services under the plan in the same manner and to the same extent as similarly situated employees of such employer who are not TRICARE-eligible employees.

"(c) INAPPLICABILITY TO CERTAIN EMPLOYERS.—The provisions of this section do not apply to any employer who has fewer than 20 employees.

"(d) RETENTION OF ELIGIBILITY FOR COVERAGE UNDER TRICARE.—Nothing in this section, including an election made by a TRICARE-eligible employee under subsection (b), shall be construed to affect, modify, or terminate the eligibility of a TRICARE-eligible employee or spouse of such employee for health care or dental services under this chapter in accordance with the other provisions of this chapter.

"(e) OUTREACH.—The Secretary of Defense shall, in coordination with the other administering Secretaries, conduct outreach to inform covered beneficiaries who are entitled to health care benefits under the TRICARE program of the rights and responsibilities of such beneficiaries and employers under this section.

"(f) DEFINITIONS.—In this section:

"(1) The term 'employer' includes a State or unit of local government.

"(2) The term 'group health plan' means a group health plan (as that term is defined in section 5000(b)(1) of the Internal Revenue Code of 1986 without regard to section 5000(d) of the Internal Revenue Code of 1986).

"(3) The term 'TRICARE-eligible employee' means a covered beneficiary under section 1086 of this title entitled to health care benefits under the TRICARE program.

"(g) EFFECTIVE DATE.—This section shall take effect on January 1, 2008.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 55 of such title is amended by inserting after the item relating to section 1097b the following new item:

''1097c. TRICARE program: relationship with employer-sponsored group health plans.''.

REPORT TO CONGRESS ON THE RELATIONSHIP WITH EMPLOYER SPONSORED GROUP HEALTH PLANS

House Conference Report 109-702, accompanying the John Warner National Defense Authorization Act (NDAA) for Fiscal Year 2007, requests the Secretary of Defense to report to the House and Senate Armed Services Committees on the treatment of cafeteria plans and non-TRICARE exclusive employer-provided incentives under the Department's implementation of section 707 of the Act regarding employer sponsored group health care plans. As enacted, section 707 added to title 10, United States Code, section 1097c, which extends to TRICARE the same prohibition on offering financial or other incentives not to enroll in a Group Health Plan (GHP) that currently applies to Medicare under section 1862(b)(3)(C) of the Social Security Act (42 U.S.C. 1395y(b)(3)(C)). That law provides in pertinent part:

> (C) Prohibition of financial incentives not to enroll in a group health plan or a large group health plan
>
> It is unlawful for an employer or other entity to offer any financial or other incentive for an individual entitled to benefits under [Medicare] not to enroll (or to terminate enrollment) under a group health plan or a large group health plan which would (in the case of such enrollment) be a primary plan.... Any entity that violates the previous sentence is subject to a civil money penalty of not to exceed $5,000 for each such violation.

10 U.S.C. 1097c, as added by section 707, becomes effective January 1, 2008.

The Conference Report further requests the Secretary of Defense to assess and report on the treatment of such plans under the Medicare Secondary Payer statute and make recommendations to ensure the fair treatment of all TRICARE beneficiaries.

The Department has reviewed the Medicare prohibition on GHP incentives, and intends to follow closely those rules in applying the comparable prohibition to TRICARE. Medicare law and implementing governance prohibit financial and other incentives to Medicare beneficiaries not to enroll or to terminate enrollment in a GHP that would be primary to Medicare. This is part of the Medicare Secondary Payer (MSP) Program. Under the MSP program, Medicare is the secondary payer to group health insurance provided for employees; in these cases Medicare pays after the employer-sponsored health insurance pays a claim. When an employer-sponsored health insurance plan is covered by the MSP rules and Medicare is the secondary payer, Medicare will generally pay no more than the amount it would have paid if there were no employer group health plan. As described in section 1862(b) of the Social Security Act, MSP applies to:

- Health plans offered by an employer to current employees (where the employer has 20 or more full- or part-time employees) that cover workers and their spouses age 65 and older.
- Large group health plans offered by an employer to current employees (where the employer has 100 or more full- or part-time employees) that cover an employee or family member who is disabled.
- Health plans offered by an employer, which cover an individual with end-stage renal disease (ERSD).

If the MSP rules do not apply, Medicare, not the employer-sponsored health plan, pays first and the private health insurance plan becomes secondary to Medicare. MSP rules do not apply to insurance:

- That covers workers or their spouses on Medicare due to age, when an employer has fewer than 20 employees.
- That covers workers or their spouses on Medicare due to disability, when an employer has fewer than 100 employees.
- Offered by an employer after someone with ESRD has been on Medicare for 30 months.
- Offered by employer that does not cover current employees. This includes retiree health insurance and COBRA insurance.

In all instances where a TRICARE beneficiary is employed by a public or private entity and elects to participate in a GHP, reimbursements for TRICARE claims will be paid as a secondary payer to the TRICARE beneficiary's employer sponsored group health plan. By law, TRICARE is not responsible for paying first as it relates to reimbursements for TRICARE beneficiary's health care and the coordination of benefits with employer-sponsored GHPs.

The reason Medicare law includes the prohibition on incentives not to enroll in employer-sponsored GHPs is to prevent employers from shifting their responsibility for their employees onto the Federal taxpayers. In implementing this law, the Centers for Medicare and Medicaid Services (CMS) has clarified that certain common employer benefits programs do not constitute improper incentives under the law. For example, in general, CMS does not treat cash payments to an employee as an improper incentive, so long as any such cash payment is based on the employee's election as a benefit offered as part of an employer's cafeteria plan which comports with section 125 of the Internal Revenue Code.

A cafeteria plan is defined by the Internal Revenue Code, 26 U.S.C. 125(d), as a written plan under which all participants are employees and the participants may choose among two or more benefits consisting of cash and qualified benefits. DoD will parallel

Medicare's MSP rules relating to section 125 cafeteria plans. Under Medicare law, a cafeteria plan is not considered an unlawful incentive if the requirements of section 125 are followed and all employees are treated the same, to include those without an entitlement to Medicare. Employers who adhere to the requirements of section 125 and offer employees a choice between health insurance and cash payment equivalents are not considered in violation of 42 U.S.C. 1395y(b)(3)(C). Therefore, if a Medicare beneficiary elects the cash payment option as a benefit offered under the employer's cafeteria plan, one which meets section 125 requirements, then the employer would not be in violation of the MSP provisions. TRICARE will adopt an identical rule with respect to TRICARE beneficiaries eligible for an employer's cafeteria plan.

Once implemented, 10 U.S.C. 1097c will prohibit "TRICARE Supplement" plans as an option for health coverage under an employer-sponsored GHP to TRICARE eligible beneficiaries. Such plans could not be included in cafeteria plans because they are not open to all employees, but would constitute an improper incentive targeted only at TRICARE beneficiaries not enrolling in the employer's main health plan option or options. Section 1097c will have no impact on "TRICARE Supplement" plans that are not offered by an employer, but are sold by an insurer and/or beneficiary association working in conjunction with an insurer. Such non-employer-sponsored TRICARE Supplement Plans will continue to be expressly excluded as double coverage under 32 CFR 199.2(b) and 199.8(b)(4)(ii). These plans have been sold by beneficiary associations or insurers.

However, many employers, including state and local governments, have begun to offer their employees who are TRICARE eligible a TRICARE Supplement as an incentive not to enroll in the employer's primary GHP. These actions shift thousands of dollars of annual health costs per employee to the Defense Department, draining resources from higher national security priorities. This is what 10 U.S.C. 1097c is designed to stop.

DoD will soon issue an interim final rule to codify all rules and governing authorities pertinent to effectuating the requirements of 10 U.S.C. 1097c, and will include the treatment of cafeteria plans and other employer provided incentives under the Department's implementation of the provision.

The interim final rule will closely track CMS regulations and associated guidance. Employers will be prohibited from offering TRICARE eligible employees financial or other benefits not to enroll or to disenroll from the employer's group health plan that is or would be primary to TRICARE. Cafeteria plans that comport with section 125 of the Internal Revenue Code will be permissible. Additional requirements of any plan offered by the employer are permissible so long as the plan treats all employees the same and does not illegally take TRICARE eligibility into account. Because Group Health Plans

are defined as plans offered by an employer that has 20 or more employees, small businesses with fewer than 20 employees will be exempt from this prohibition.

The Department expects to enforce this prohibition through the authority provided by section 1097c: civil monetary penalties not to exceed $5000 for each violation, investigative authorities of the Department of Defense Inspector General, recourse under the Debt Collection Improvement Act, 31 USC 3701 *et seq.*, and any other authority provided by law. Procedures for civil monetary penalties will be considered with reference to section 1097c(a)(2)(B), which authorizes agreements between DoD and the Department of Health and Human Services.

The interim final rule will also be consistent with other provisions of section 1097c, including the protection of TRICARE-eligible employees' rights to participate in employer-sponsored GHPs to the same extent as similarly situated employees who are not TRICARE eligible. In addition, the rule will reiterate the command of section 1097c that it does not affect any TRICARE beneficiary's eligibility for services and benefits under the Military Health System. Finally, DoD will conduct outreach, as called for in section 1097c(e), to inform beneficiaries of the rights and responsibilities of beneficiaries and employers under the law.

The Department of Defense is committed to careful implementation of section 1097c in a manner that will stop improper employer incentives aimed at shifting employer responsibilities to DoD, but leave undisturbed proper employer practices in the administration of lawful cafeteria plans that treat all employees equally.

CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

June 9, 2006

S. 2766
National Defense Authorization Act for Fiscal Year 2007

As reported by the Senate Committee on Armed Services on May 9, 2006

SUMMARY

S. 2766 would authorize appropriations totaling $509 billion for fiscal year 2007 for the military functions of the Department of Defense (DoD), for activities of the Department of Energy (DOE), and for other purposes. That total includes $50 billion for military operations in Iraq and Afghanistan. The bill also would authorize an estimated $68 billion in supplemental appropriations for 2006, primarily for the costs of those operations not covered by appropriations provided earlier in the year. (A supplemental appropriations act to provide that amount has been passed by the Senate, but as of this date, that legislation has not yet been enacted into law.)

In addition, S. 2766 would prescribe personnel strengths for each active-duty and selected reserve component of the U.S. armed forces. CBO estimates that appropriation of the authorized amounts would result in additional outlays of $572 billion over the 2006-2011 period. Including outlays from funds previously appropriated, spending for defense programs authorized by the bill would total about $530 billion in 2007, CBO estimates. (By comparison, CBO estimates that such spending will total about $518 billion in 2006, assuming appropriation of pending supplemental appropriations.)

The bill also contains provisions that would both increase and decrease costs of discretionary defense programs over the 2008-2011 period. Most of those provisions would affect DoD force structure or would provide added compensation, benefits, or health care coverage to members of the armed forces. Provisions affecting force structure would lower costs by several billion dollars annually beginning in 2008. Certain other provisions—primarily those related to compensation and health care benefits—would increase costs between $1 billion and $2 billion annually.

TABLE 3. ESTIMATED AUTHORIZATIONS OF APPROPRIATIONS FOR SELECTED PROVISIONS IN S. 2766

Category	By Fiscal Year, in Millions of Dollars				
	2007	2008	2009	2010	2011
FORCE STRUCTURE					
Navy and Air Force Active-Duty Endstrengths	-2,324	-4,783	-4,925	-5,068	-5,218
Army and Marine Corps Active-Duty Endstrengths	39	81	83	86	88
Reserve Component Endstrengths	-105	-216	-223	-231	-238
Reserve Technicians	49	102	106	109	113
COMPENSATION AND BENEFITS					
Pay Raises	196	401	414	428	442
Expiring Bonuses and Allowances	1,527	793	303	287	199
Special Pay for Reserve Health Care Professionals	10	12	12	2	0
Accession Bonuses for Health Specialties	19	5	0	0	0
Voluntary Separation Pay	132	311	514	518	496
Health Professions Scholarships and Financial Assistance	91	93	96	100	103
Loan Repayment for Health Professionals	4	8	12	13	13
Survivor Benefit Plan	23	23	23	24	24
Other Provisions	14	4	2	2	2
DEFENSE HEALTH PROGRAM					
TRICARE Use by Employed Retirees	0	-119	-176	-193	-212
TRICARE Pharmacy Program	49	98	105	104	103
TRICARE Disease Management Programs	10	33	58	79	70
TRICARE Standard Enrollment Fee	20	18	1	1	1
TRICARE Incentive Pay	0	5	8	8	9
OTHER PROVISIONS					
Telecommunications Benefit Program	64	48	39	20	20
Defense Acquisition Challenge Program	0	30	31	32	32
Matters Relating to Other Nations	45	45	5	5	5

NOTES: For every item in this table, the 2007 levels are included in Table 2 within the totals specifically authorized to be appropriated in the bill. Amounts shown in this table for 2008 through 2011 are not included in Table 1.

Numbers in the text may differ from figures shown here because of rounding.

- Section 605 would authorize a second basic allowance for housing for unmarried reserve members activated as part of a contingency operation;

- Section 606 would allow the spouses of members that die on active duty to temporarily receive that member's housing allowance, even if the spouse is a member of a uniformed service;

- Section 617 would increase the maximum amount of the nuclear career accession bonus to $30,000;

- Section 618 would increase the incentive bonus for transfer between armed forces to $10,000; and

- Section 1103 would equalize benefits for civilian personnel on official duty in Iraq and Afghanistan.

Defense Health Program. Title VII contains a number of provisions that would affect DoD health care benefits, with the most significant provision prohibiting private-sector companies and state and local governments from encouraging their employees to use TRICARE instead of the employers' group health insurance plans.

Prohibition on Employers Encouraging Military Retirees to use TRICARE. Section 722 would prohibit employers from encouraging their employees to forgo enrollment in a group health plan and to use TRICARE instead. This ban would take effect on January 1, 2008. Currently, some private-sector companies and state and local governments are encouraging those employees who are also military retirees under age 65 to use TRICARE for health care coverage instead of the insurance plans sponsored by the employer. Most of those employers are offering to purchase a TRICARE supplemental policy for those employees and any eligible family members. Such supplemental insurance generally covers all deductibles, copayments, and other TRICARE cost-sharing amounts. These supplemental insurance policies cost as little as $60 per month for single coverage while it can cost employers more than $5,500 per year to provide full health insurance coverage for an employee. DoD reports that, in 2007, it will cost about $3,000 a person to provide health care under its TRICARE Standard program.

Based on data from DoD about the number of retirees under age 65 and their dependents under age 65 and data from surveys and studies about the percentage of retirees currently being offered incentives to forgo employer-sponsored insurance, CBO estimates that about 50,000 people a year are being diverted from employer-sponsored plans to TRICARE. Thus, under section 722, CBO estimates that 50,000 retirees and their dependents would stop using

TRICARE in favor of an employer-sponsored plan, for a savings to DoD of about $119 million in 2008 and $700 million over the 2008-2011 period.

TRICARE Pharmacy Copayments. Section 702 would eliminate copayments for prescriptions obtained through the TRICARE mail-order program (TMOP) and require that most refills of maintenance medications be filled through TMOP. Currently, TRICARE participants can choose to have prescriptions filled in one of three ways: through the TMOP, at military treatment facilities (MTFs), or at retail pharmacies. In 2007, beneficiaries will be charged copayments of $5 for generic drugs and $15 for brand-name drugs at retail pharmacies and $9 for brand-name drugs obtained through the TMOP. There would be no copayment for generic drugs obtained through the TMOP, nor for drugs obtained at MTFs. Those copayment amounts apply to active-duty dependents and all retirees and their dependents. Health care costs for active-duty dependents and retirees and dependents under age 65 are discretionary costs and are covered in this part of the estimate. Retirees and their dependents age 65 and older are covered under TRICARE For Life, which is classified in the budget as a mandatory (i.e., direct spending) program. CBO's evaluation of the pharmacy costs for that group of beneficiaries is discussed later in the "Direct Spending" section.

Based on data provided by DoD, CBO estimates that in 2007 almost 60 million prescriptions for a one-month supply of a drug will be filled through the three outlets for active-duty dependents and retirees and their dependents under age 65. Active-duty dependents have the vast majority of their prescriptions filled at MTFs. Retirees and their dependents under age 65 have about half of their prescriptions filled at MTFs and more than one-third filled at retail pharmacies. Based on analysis by DoD, CBO estimates that 65 percent of all prescriptions obtained at retail pharmacies and MTFs are refills of maintenance medications that will have to be filled through the TMOP beginning April 1, 2007. By eliminating TMOP copayments, CBO estimates that DoD collections would be reduced by about $34 million in 2007 and $349 million over the 2007-2011 period.

Transferring prescriptions from the other two outlets to the TMOP would also result in cost changes for DoD in addition to the changes in collections from the copayments. While it costs DoD about $20 to fill each generic prescription at MTFs, at retail pharmacies, and through the TMOP, the average cost for DoD to provide brand-name drugs varies, depending on the population and how the drug is dispensed. Though retirees and their dependents use more expensive drugs than do active-duty dependents, it is cheaper for DoD to fill the prescription for both groups through the TMOP than through a retail pharmacy and cheaper still to do it through an MTF, which dispenses the drugs directly to beneficiaries. Thus, the cost to DoD decreases when beneficiaries switch from retail pharmacies to the mail-order program but the cost increases when they switch from MTFs to mail order. CBO estimates that the savings from transferring prescriptions from retail pharmacies to the TMOP would

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PERSONNEL AND
READINESS

NOV 1 6 2007

The Honorable Lindsey O. Graham
Ranking Member
Subcommittee on Personnel
United States Senate
Washington, DC 20510

Dear Senator Graham:

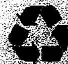
Thank you for your letter of August 1, concerning Department of Defense (DoD) implementation of section 707 of the John Warner National Defense Authorization Act (NDAA) for fiscal year 2007. Please excuse the delay in responding.

As enacted, Section 707 of the NDAA extends to TRICARE the same rule that currently applies to the Medicare program prohibiting most employers from offering any financial incentive for current employees also covered by a Government health program not to enroll in the employer's group health plan that would, by law, be the primary payer to the Government plan. This section takes effect January 1, 2008.

Conference Report 109-702, accompanying the NDAA, included the following statement of Congressional intent with respect to the treatment of cafeteria plans under section 717:

> The conferees are aware of concerns that have been expressed regarding the treatment of cafeteria plans authorized under section 125 of the Internal Revenue Code and *non-TRICARE exclusive* employer-provided health care incentives under this provision. The conferees direct the Secretary to report, not later than April 1, 2007, to the Committees on Armed Services of the Senate and the House of Representatives on the treatment of cafeteria plans and *non-TRICARE exclusive* employer-provided health care incentives under the Department's implementation of this provision. This report shall assess the treatment of such plans under the Medicare Secondary Payer statute and regulations and such incentives, and include any recommendations the Secretary finds appropriate to ensure fair treatment of all TRICARE beneficiaries under this provision. (Emphasis added.)

Consistent with the Conference Report statement, we assessed the treatment of such plans under the Medicare Secondary Payer (MSP) program, and noted the following provision of the MSP Manual (Chapter 1, Section 70.1):



> An employer or other entity is prohibited from offering Medicare beneficiaries financial or other benefits as incentives not to enroll in or to terminate enrollment in a GHP [Group Health Plan]...that is or would be primary to Medicare. This prohibition precludes the offering of benefits to Medicare beneficiaries that are alternatives to the employer's primary plan (e.g. prescription drugs) unless the beneficiary has primary coverage other than Medicare.... *This rule applies even if the payments or benefits are offered to all other individuals who are eligible for coverage under the plan.* (Emphasis added.)

DoD's report to Congress indicated the understanding that TRICARE Supplemental Insurance plans would only benefit TRICARE eligible beneficiaries. Thus, they would not be within the scope of the Conference Report's concern regarding *non*-TRICARE exclusive employer-provided health plans. Further, the offering of a plan specifically established as a TRICARE supplement, not only does not qualify as a non-TRICARE exclusive plan, it cannot, consistent with the MSP Manual, become permissible by being nominally offered to all employees. If the plan only benefits TRICARE beneficiaries, it is not within the cafeteria plan guidance provided by the Conference Report or the scope of permissible employer sponsorship under the MSP program.

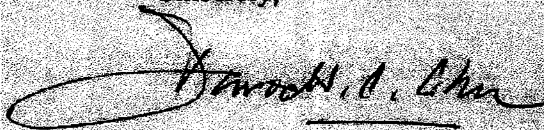
Per your request, we consulted with Internal Revenue Service personnel to insure the Department correctly understands cafeteria plans under section 125 of the Internal Revenue Code. Cafeteria plans are written plans under which participants may choose from among permitted benefits, to include taxable cash benefits and different types of healthcare coverage. There are very few restrictions on what may be offered under a cafeteria plan for purposes of the employer's Federal tax liability. A TRICARE Supplemental Insurance Policy offered to all employees could qualify as a proper option under an employer's cafeteria plan for purposes of the employer's tax liability. However, such an option still runs afoul of Section 707 because the benefit of a TRICARE Supplemental Plan only accrues to a TRICARE eligible beneficiary, regardless of whether the option is offered to other employees. It also squarely conflicts with the Conference Report expression of Congressional intent behind section 707.

The Department of Defense (DoD) will soon issue a regulation to implement Section 707. The regulation will closely track Centers for Medicare and Medicaid Services regulations and associated guidance to include the handling of benefits offered under a proper cafeteria plan. The IFR will also be consistent with other provisions of the law, including the protection of TRICARE-eligible employees' rights to participate in employer-sponsored Group Health Plans to the same extent as similarly situated employees who are not TRICARE eligible. In addition, the rule will reiterate the command of the statute that it does not affect any TRICARE beneficiary's eligibility for

services and benefits under the Military Health System. Finally, DoD will conduct outreach, as called for in the Act, to inform beneficiaries of the rights and responsibilities of beneficiaries and employers under the law.

I hope you find this information helpful. A similar reply is being sent to Senator Nelson. Thank you for your interest in the Military Health System and its beneficiaries.

Sincerely,



David S. C. Chu

Recommended Language

We suggest you include in the proposed regulations, implementing §707 language to the following effect:

> "For purposes of determining that health coverage is offered under an employer-sponsored group health plan, these rules will not apply to a 'bona fide voluntary benefits program.' For purposes of these regulations, the phrase 'bona fide voluntary benefits program; means an arrangement that satisfies the requirements for exemption from the requirements of the Employee Retirement Income Security Act of 1974 (ERISA) set out in Department of Labor Reg. §2510.3-1(j)."

We further suggest that the following clarifying examples be included in the proposed regulations:

Example 1. Employer X maintains a voluntary benefits program, which includes a TRICARE supplement that is available to TRICARE-eligible employees. The employer periodically deducts premiums for an employee who elects the TRICARE supplement from the employee's paycheck and remits them to the insurance carrier. There are no employer contributions. The employer allows the carrier to promote the supplement among its employees, but it does not hold the arrangement out as its plan, nor does it in any way encourage participation. The employer pays all administrative costs relating to all of its voluntary benefits programs and receives no consideration of any kind from any insurance carrier, broker or other source. The arrangement described in this Example 1 is a bona fide voluntary benefits program.

Example 2. Same facts as Example 1, except that employee premiums are paid under a "cafeteria plan" that satisfies the requirements of Section 125 of the Internal Revenue Code. The arrangement described in this Example 2 is also a bona fide voluntary benefits program.