STATEMENT ON

FUTURE OF THE MILITARY HEALTH SYSTEM

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ON THE FUTURE OF MILITARY HEALTH CARE

BEFORE THE

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Madam Chairwoman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System (MHS) and appear here on behalf of the Department of Defense Task Force on the Future of Military Health Care.

During this past year, I had the opportunity to serve alongside General John Corley as the Co-Chair of the Task Force. The Task Force was established pursuant to the John Warner National Defense Authorization Act for Fiscal Year 2007 (Section 711). We provided you, the Congress, an interim report in May, and we submitted our final report to the Secretary of Defense on December 20, 2007. While I have given considerable thought and time to the study of the military health care system during the year, as did the other Task Force members with whom I served, my "day job" is as a Senior Fellow with Project HOPE. I am not here to provide my individual views, however, but rather to discuss the work of the Task Force as its representative.

As an overview, I will first describe some general aspects of the Task Force: a short chronology, its Congressional charge, its approach, its composition, and its activities. Early in the life of the Task Force, we adopted some guiding principles that I want to share with you because they were instrumental in guiding us through this endeavor over the last year. Then, I will focus on our recommendations. I will discuss our general approach to the recommendations, and then provide some specifics on the recommendations themselves.

In the interim report, we provided you with preliminary findings and recommendations relative to military health care costs and cost-sharing in general and on the pharmacy benefit program in particular.

In the final report we addressed a broader array of issues that you, the Congress, asked us to examine, such as the Department of Defense's wellness initiatives, disease management programs, ability to account for the true and accurate costs of the military health care system, the adequacy of health care procurement and contracting practices, and we took the opportunity to more fully develop assessments and recommendations on the cost-sharing issue--cost-sharing between the Government and beneficiaries of the Military Health System, a growing concern because of the rapid and continual rate of increase in health care costs of the Department of Defense.

As you well know, the availability and affordability of health care is a significant national concern. While we concentrated on the Military Health System, it is in many ways a microcosm of health care in the rest of the country, with its costs largely driven by factors and trends beyond the control of the Department of Defense. We have made specific recommendations, which we believe will make the health care provided by the military more efficient and effective and also put the system in a more fiscally sustainable position for the future. We hope these recommendations will receive timely attention and action. We recognize, however, the challenge associated with legislating changes that may be controversial during an election period and while the country is still at war. We also recognize that that the Department of Defense and the Congress will continue to face many challenges concerning the impact of health care costs that rise faster than the rest of the defense budget or the rest of the economy, even if our recommendations are adopted.

Early during our Task Force deliberations, we adopted a set of guiding principles to help focus our activities and to guide us in our data collection, analysis, deliberations, assessments, and ultimately, our recommendations and associated action items. We sought to maintain the best aspects of the current system and to identify ways military health care can be enhanced and maintained for the long term.

We shared a belief that members of our Armed Forces, and their families, who have made, or continue to make, tremendous sacrifices for our nation deserve a quality health care system. As an overarching principle, we determined that all of our recommendations must focus on the health and well-being of beneficiaries and be cost-effective, taking into account not just budgetary concerns, but the effects on the specific guiding principles summarized as follows:

1) maintain or improve the health readiness of U.S. military forces and preserve the capability of military medical personnel to provide operational health care globally

2) maintain or improve the quality of care provided to beneficiaries, taking into account health outcomes as well as access to and productivity of care

3) result in improvements in the efficiency of military health care, to include approaches reflected by best practices

4) avoid any significant adverse effects on the ability of the military compensation system (which includes health benefits) to attract and retain personnel needed to carry out military missions effectively

5) balance the need to maintain generous health care benefits in recognition of the demanding service required of the military and their families with the need to set and maintain a fair and reasonable cost-sharing arrangement between the Government and the beneficiaries, and

6) align cost-sharing measures in a manner that promotes accountability and judicious use of resources

Stated another way, we believe that the Department of Defense must maintain a health care system that meets military readiness, is appropriately sized and resourced, and able to withstand and support the long war on terror as well as the support of conventional war, and equally important, that quality, accessible, cost-effective health care is available and provided for the long-term.

During the year that we had to accomplish our work, we held more than a dozen public meetings. We heard from many experts, those from both inside and outside of the Department of Defense. We had testimony from almost all categories of beneficiaries, and many of the advocacy groups representing them--members of all the Services, officer and enlisted, active duty, National Guard, the Reserves, retirees (both Medicare-eligible

and non-eligible), family members, men and women recently deployed and actually deployed, and medical personnel (military and civilian), including those participating in direct care and managed care aspects of the Military Health System. Several of us had the opportunity to see deployed medicine firsthand—Qatar, Iraq, and Germany. We had panel discussions and town hall meetings in San Antonio, Texas, and Virginia Beach.

We also reviewed many studies and reports, relating to both the private and public sector, GAO and Inspector General reports included, and gathered as much evidence as we reasonably could and analyzed it as best we could so that any recommendations would be data-driven and evidence-based.

Half of the 14 Task Force members were from the Department of Defense and half were from outside of the Department. We operated independently of the Department of Defense, as a federal advisory committee (under the Defense Health Board), without a predetermined course of action or conception of what recommendations would be made. With a couple of minor exceptions, our recommendations (including specific action items related to recommendations), were adopted unanimously by the Task Force members.

The recommendations that we are making, to the extent that they involve changes in cost, will not affect active- duty personnel or their families. We thought this was an important principle. The greatest impact of proposed cost changes, if accepted, would affect retirees and their families, and to a far lesser extent, those who are Medicare-eligible, i.e., the ones who are eligible for TRICARE for Life (for them we recommended a very modest enrollment fee that could be waived under specified conditions). Some cost-sharing in pharmacy benefits, if accepted, would affect active duty military families,

We consciously decided to limit the number of recommendations. We came to a set of 12 recommendations (excluding related action items), but the last two are of a different level of magnitude. For example, on the subject of coordinating TRICARE with private health insurance, namely the situation where a military retiree has access to other employer-based health insurance, we recommended as our 11th recommendation a study, and then possibly a pilot program, aimed at better coordinating insurance plans. Our 12th recommendation, responding to the Congressional charge to address the appropriate command and control structure for management of the Military Health System, recommended DoD develop metrics by which to measure the success of any planned transformation of the command and control structure, taking into consideration its costs and benefits. We considered that a relatively short period of time had elapsed since the debate within the Department of Defense and the recent recommendation for a Defense Health Agency.

In framing our recommendations and action items, we also tried to distinguish between actions DoD could do administratively, from actions that require legislative action by the Congress.

Our first recommendation is an overarching one: develop a strategy for integrating direct and purchased care, particularly at the level where care is actually

provided. The objective is to maintain and enhance the mission of the direct care system to the military mission while optimizing the delivery of health care to all DoD beneficiaries. The strategy should provide incentives to use best practices of direct care and private sector care and to hold managers of integrated care accountable. It requires that metrics be developed to measure whether desired outcomes are produced. As part of this recommendation, we have asked Congress to facilitate improved integration with a fiscal policy—one that provides flexibility —for prompt and adequate funding of purchased and direct care as circumstances require. In other words, to reduce or remove some of the fiscal constraints that separate the funding of direct care and purchased care systems, so that it will be easier at the local or operational level to make the most cost-effective and beneficial health care delivery decisions for beneficiaries. This overall recommendation rests upon our finding that the Military Health System does not function as a fully integrated health care system. Not only is there the separation between direct care and purchased care, but within the direct care system, there are separate Service systems.

The second recommendation directs the DoD to charter an advisory group to enhance collaboration with the private sector and other federal agencies in order to share, adopt, and promote best practices. While the Military Health System is unique in some ways, the acts of purchasing and delivering health care are common across health care systems. The increasing costs of health care, as well as the challenges of access, measurement, clinical quality, and overall satisfaction, have been areas of significant attention and impressive innovation over the last decade. The MHS leadership needs to be more outward-looking and actively engaged in broad-based discussions in these areas. We recommend alignment with Health and Human Services, Veterans Affairs, the Office of Personnel Management (that oversees the Federal Employees Health Benefit Program) and private sector organizations to make health care quality and costs more transparent and easily accessible by all beneficiaries. Another action item is to implement a systematic strategy of pilot and demonstration projects to evaluate changes in practices for the military health system. Once successful practices are identified, the strategy should provide for more widespread implementation.

Our third recommendation also deals with best practices—financial and management controls. We have advised DoD to request an external audit to determine the adequacy of processes by which the military ensures 1) that only those who are eligible for health benefit coverage receive such coverage, and 2) that compliance with law and policy regarding TRICARE as a second payer is uniform. This is not intended as any kind of an indictment of current practices. Private companies that have performed audits of their health plans often find coverage is provided to persons not eligible for such coverage. The Military Health System is large, including over 9 million beneficiaries. Many events affect eligibility such as births, deaths, retirements, separations, divorces, mobilizations, and demobilizations. Given the size of the system, its complexities, and the frequency of events affecting eligibility for coverage, even small improvements in controllership can have a significant fiscal impact. In an associated action item, we recommend that DoD establish a common cost accounting system that would provide true and accurate accounting for management and also that supports compliance with the law that TRICARE be a second payer when there is other health insurance.

As part of its charge, the Task Force was asked to assess wellness initiatives and disease management programs and education programs focused on prevention awareness and patient-initiated health care. Our fourth recommendation is that DoD should follow national wellness and prevention guidelines and promote the appropriate use of health care resources through standardized case management and disease management programs. These guidelines should be applied across the Military Health System. This recommendation is not intended to imply the Department does not have disease management programs and wellness initiatives but rather that they are not state of the art programs and also that they need to be applied uniformly throughout the military.

Recommendations five, six, and seven address procurement and contracting. The Task Force was charged to assess: 1) the adequacy of the military health care procurement system, including methods to streamline existing procurement activities, and 2) efficient and cost-effective contracts for health care support and staff services, including performance-based requirements for health care provider reimbursement.

The focus of our recommendation on acquisition processes is at the TRICARE Management Activity (TMA) level rather than at the Service specific level. Our fifth recommendation is that DoD should restructure TMA to place greater emphasis on its acquisition role. We recommended that head of the contracting activity be elevated within TMA. Acquisition personnel should be certified according to the Defense Acquisition Workforce Improvement Act. In addition, strong competencies in health care procurement are needed. The system must have checks and balances through separation of the distinct functions of 1) acquisition, 2) requirements and operations, and 3) budget and finance.

The sixth recommendation is for DoD to aggressively seek out and incorporate best practices from the public and private sectors in the area of health care purchasing. This recommendation encompasses strategies to promote value-driven health care consistent with Executive Order 13410, "Promoting Quality and Efficient Health Care Programs." Generally, these strategies are designed to promote interoperable health information technology systems and better transparency in quality measurements and of pricing information.

Recommendation seven calls for DoD to reassess requirements for purchased care contracts to determine whether more effective strategies can be implemented to obtain those services and capabilities. The objective in making this recommendation is to enhance competition, efficiency, cost-effectiveness, and innovation. For example, as an action item, we ask DoD to examine current requirements for the delivery of health care services, including the contractor's role in accomplishing referrals, the need for authorizations, and whether enrollment could be accomplished by DoD with registration performed by managed care support contractors. Another action item is to test and evaluate, through pilot or demonstration projects, the effectiveness of carved out chronic disease management programs.

Our eighth recommendation is that DoD should improve medical readiness for the Reserve Component, recognizing that its readiness is a critical aspect of overall Total

Force readiness. Although this subject was not specifically addressed in the charge given to the Task Force, we considered it appropriate to make a recommendation in view of the increasingly frequent and heavy use of the Reserve Component, and the importance of health care for its readiness and health care as a valued part of the compensation system for the Reserve Component. The Task Force realizes it is premature to assess the impact of recent changes in TRICARE Reserve Select, but included an action item for DoD to conduct such an assessment of recent eligibility changes on readiness.

Our ninth recommendation is that Congress and DoD should revise the pharmacy tier and copayment structures based on clinical and cost-effectiveness standards to promote greater incentive to use preferred medications and cost-effective points of service. [There are four outpatient pharmacy points of service: Military Treatment Facility pharmacies, TRICARE-network retail pharmacies, non-network retail pharmacies, and the TRICARE Mail Order Pharmacy. There currently is a three-tiered Uniform Formulary: generic (tier 1), brand name (tier 2), and nonformulary (tier 3)] The Task Force proposes a new tier of special category medications—very expensive, specialty, and/or biotechnology drugs with a mandated point of service. It also proposes a change of tier one that would allow it to be more inclusive, i.e., preferred drugs, not just generic drugs. Also, it proposes to allow DoD to include, selectively, over-the-counter drugs in the formulary. Proposed changes in the copayment structure would create larger cost-differentials for the different tiers and points of service, thereby increasing incentives to use preferred drugs and more cost-effective points of service, for example, maintenance drugs through the mail order program. If accepted, the proposal to change the copayment structure would be the first change in copayments since inception of the TRICARE Senior Pharmacy Program in 2001.

As a related action item, the Task Force stated that DoD should conduct a pilot program integrating the Pharmacy Benefit Management function within the managed care support contract in one of the three service regions to assess and evaluate the impact on total spend and outcomes. The goal of such a program would be to achieve better total financial and health outcomes.

Our tenth recommendation addresses cost-sharing between the Government and beneficiaries. It is a multiple-part recommendation.

Please note that the Task Force proposes no changes in health care benefits for active duty personnel, and no significant changes for families of active duty personnel. The major impact is on retirees and their families who are not Medicare-eligible.

For the Medicare-eligible group, generally those over age 65, we propose what we view as a modest change. That is, we recommend a small enrollment fee of $10 per month for TRICARE for Life. We recognize that this is inconsistent with the intent of Congress when it established the program without any enrollment fee. TRICARE for Life is quite similar to a Medigap plan: TRICARE is a second payer; Medicare is the first payer. No Medigap plans are free. TRICARE for Life is still a generous plan. We did recommend that DoD be allowed to waive the fee for participants to take part in activities designed to improve medical care and health or reduce costs.

The Task Force recommends a phased-in increase in costs borne by under-65 retirees. For the largest program used by this group (TRICARE Prime), this increase would restore the relationships between beneficiary and government costs that existed in 1996 when TRICARE was being established. Cost-sharing changes for the other major program, TRICARE Standard, are designed to be comparable to those for Prime in dollar terms.

Even more important than the phased-in increase in costs to restore the financial relationship between retiree and government that existed in 1996 is the use of indexing in annual enrollment fees going forward. Indexing so that relative shares are maintained is the single most important step that can be taken if DoD and Congress wish to reverse the current trend where the beneficiary pays a smaller and smaller share of the total health care cost. Without indexing, any one-time changes will quickly be eroded.

The Task Force, as part of this recommendation, also proposes a tiering of fees (for TRICARE Prime) and of deductibles (for TRICARE Standard) based on military retired pay. The intent is to mitigate the effect of proposed increases on those with less retired pay.

The fees presently are applied toward the catastrophic cap ($3,000 for retirees). The Task Force recommends that fees not be applied toward the cap, and that the cap be reduced to $2,500. It also recommends some changes on the interaction of the cap and copayments for some drugs.

The Task Force recommends a modest enrollment fee for Standard Family of $10 a month (and half that amount for Standard Single). The enrollment is new for TRICARE Standard. This fee is not intended to save money. Rather it would improve health care for Standard participants, because through this mechanism, DoD will know who they are and be better able to communicate health care information to them.

We worked to find the right balance between a cost-effective, efficient, and high quality health care system for military beneficiaries and managing a system of spiraling costs. We are suggesting a focus on strategy integration, preserving the best aspects of the current system, creating efficiencies by streamlining operations, improving effectiveness and the accessibility of quality care, borrowing where appropriate the best practices from both the public and private sectors, and changing ways that will not diminish the high quality of health care or the trust of military members and their families.

The Task Force recognizes that its proposals, if accepted, will not resolve the future budgetary problems produced by health care costs that are likely to be growing substantially faster than the rest of the Defense Department budget. However, we urge Congress to act. We believe that given the current and likely future military commitments, the Military Health System needs to be changed so as to be as efficient and effective as possible and to be in a financially stable position. These conditions do not presently exist.

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