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HEARING
ON
NATIONAL DEFENSE AUTHORIZATION ACT
FOR FISCAL YEAR 2009
AND
OVERSIGHT OF PREVIOUSLY AUTHORIZED
PROGRAMS
BEFORE THE
COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES
ONE HUNDRED TENTH CONGRESS
SECOND SESSION

MILITARY PERSONNEL SUBCOMMITTEE HEARING
ON
**BUDGET REQUEST ON THE FUTURE OF
THE MILITARY HEALTHCARE SYSTEM**

HEARING HELD
MARCH 12, 2008



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FISCAL YEAR 2009 NATIONAL DEFENSE AUTHORIZATION ACT—BUDGET REQUEST ON THE FUTURE OF THE MILITARY HEALTHCARE SYSTEM

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
Washington, DC, Wednesday, March 12, 2008.

The subcommittee met, pursuant to call, at 9:02 a.m., in room 2118, Rayburn House Office Building, Hon. Susan Davis (chairwoman of the subcommittee) presiding.

OPENING STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, CHAIRWOMAN, MILITARY PERSONNEL SUBCOMMITTEE

Mrs. DAVIS OF CALIFORNIA. The meeting will come to order. Good morning everybody. Thank you all for being here.

The purpose of today's hearing is to look at the short-and long-term challenges facing the Defense Health Program. In 2007, total health expenditures of approximately \$33 billion accounted for just under 8 percent of the overall Department of Defense (DOD) budget.

By 2015, the Department projects that total health expenditures will rise to over \$64 billion accounting for just over 11 percent of the total Defense budget. All of this assumes a steady, modest and potentially optimistic annual rate of inflation in healthcare expenses.

Without controlling the growth in healthcare costs, both the Department of Defense and Congress will face some very difficult choices: Do we fully fund healthcare or operations; maintain medical readiness or procure all of the new equipment the services will require; keep our promises to retirees, or resource all of the research and development needed to keep our technological edge? Tough questions.

The Department's 2009 budget submission marks the third straight year that the Department has proposed their Sustain the Benefit program. In basic terms, Sustain the Benefit proposes to raise beneficiaries' co-payments, deductibles and enrollment fees to both offset and avoid costs.

The increase in fees will result in modest sums returned to the Department. Beneficiaries will be discouraged from seeking care both necessary and unnecessary, again, due to higher co-payments for visits. And the Department's own budget materials clearly state that they intend to realize savings by raising the costs of TRICARE so much that family members and retirees will seek health insurance coverage outside the DOD system because it will be cheaper.

These steps are likely to reduce costs over the short term. People are simply less likely to seek the same amount of care that they receive today. However, what are the long-term implications of these actions? What will the costs be if beneficiaries wait too long to seek care and the underlying conditions worsen or become untreatable?

Now is not the time to exacerbate existing long-term problems or create new ones with programs that provide only short-term relief. When TRICARE was envisioned in its current form back in the 1990's, assumptions were made without clear evidence that private sector care was cheaper than the care provided in military treatment facilities.

Risk was taken by dramatically shrinking the size, staffing, and number of military treatment facilities to save both money and end-strength personnel authorizations, and as a result, we now have great difficulty fully supporting our combat forces as the medical practitioners that support them are pulled from the very military treatment facilities that we downsized.

Some military hospitals and clinics have had to close down entire departments for months at a time due to deployed providers, and consequently, many beneficiaries who received their care in military facilities now must receive their care in the civilian sector.

With most of our beneficiary care, in terms of dollars, now provided in the civilian system, we are at the mercy of inflationary pressures affecting the Nation's healthcare system. Our beneficiary pool is simply not big enough to move the market in a positive direction. These are the problems we face with a military at war supported by a healthcare system designed with just barely enough capacity to function during peacetime. Again, we must not repeat such shortsighted thinking. So what is the way forward?

To help us answer these questions today—we have a great burden that we have put on you—we have before us today Dr. Ward Casscells, the Assistant Secretary of Defense for Health Affairs. We also have Dr. Gail Wilensky, co-chair of the Defense Task Force on the Future of Military Healthcare.

And finally, Dr. Ron Goetzel of Emory University's Institute for Health and Productivity Studies, who is also a Vice President for Consulting and Applied Research with Thomson Healthcare. Dr. Goetzel is a leading voice on the issues of wellness and prevention having authored or co-authored numerous studies on the subject not to mention advising many of our Nation's top companies.

Welcome to you all. We are delighted to have you with us.

And we will begin with Dr. Casscells.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 39.]

Dr. CASSCELLS. Thank you Madam Chairwoman, Ranking Member McHugh, Dr. Snyder, Semper Fi, Mr. Kline. On behalf of—

Mrs. DAVIS OF CALIFORNIA. I am so sorry, Dr. Casscells—

Dr. CASSCELLS. Sorry.

Mrs. DAVIS OF CALIFORNIA [continuing]. If I can interrupt you. I was so anxious to hear what you had to say, that I forgot to turn to my colleague, Mr. McHugh, on my side.

Mr. McHugh, I am so sorry. You see what happened—

**STATEMENT OF HON. JOHN M. MCHUGH, A REPRESENTATIVE
FROM NEW YORK, RANKING MEMBER, MILITARY PER-
SONNEL SUBCOMMITTEE**

Mr. MCHUGH. No, it is all right. I am anxious to hear Dr. Casscells, as well, and that is probably the more important part of it. Thank you, Madam Chair. I will just submit my comments for the record in their entirety.

I want to welcome our guests here this morning.

Dr. Casscells, you have been very open and quite willing to engage us in discussion as to the way forward. We appreciate that leadership.

And Dr. Goetzl, I certainly think that your perspective holds some very positive tabs for us as to how we can better contain costs than just relying upon burdening further the beneficiaries with that.

And last, but certainly not least, Dr. Wilensky, thank you for your great service as co-chair on the Defense Task Force on the Future of Military Healthcare. I had—as did the chair—a chance to chat with you previously, and your reputation precedes you. And certainly, your work on this task force only adds to that illustrious reputation, and we are greatly enriched by your participation, and we appreciate it.

That having been said, as the chair noted, the third year in a row we are discussing significant increases to the costs to the beneficiaries of the TRICARE system. And quite frankly, I remain concerned—as I have in the past—that the place we start, particularly in time of war, in trying to put the healthcare system on a better path is on the backs of the beneficiaries.

I am not sure that is either the most effective or certainly the most equitable way to approach it, and in fact, I am pretty convinced it is not, but this is a very important hearing and a very serious challenge.

The Department, I think, has very fairly described the effects of the increased costs, and the chair, I think, equally fairly described the tradeoffs that we are already having to make. And as time goes forward, without some kind of action to contain these costs or certainly to accommodate them more effectively, we are going to have to face more of those choices.

So your input today is going to be very, very important to us as we continue to try to find a way to ensure that we continue to provide the best possible healthcare for those in uniform, their families, and of course, equally important, the retirees that have served this Nation so honorably.

So welcome, and I look forward to your comments.

And thank you, Madam Chair.

[The prepared statement of Mr. McHugh can be found in the Appendix on page 41.]

Mrs. DAVIS OF CALIFORNIA. Dr. Casscells, please.

**STATEMENT OF HON. S. WARD CASSCELLS, M.D., ASSISTANT
SECRETARY OF DEFENSE FOR HEALTH AFFAIRS**

Dr. CASSCELLS. Thank you, Mr. McHugh.

We appreciate this opportunity to come before you and tell you what help we need and where we are in this one-year progress re-

port, and I want to say how helpful the members of the committee and the staff have been as we have had a challenging year.

I think you know I am not an Master of Business Administration (MBA) or a professional manager, and my military career is short and recent. So I don't have the great Pentagon experience that many do. So I have needed, more than most, the advice that we have gotten from the committee members and staff, and from the task forces—seven in number—particularly, General Corley and Dr. Wilensky and former Secretary Shalala and former Senator Dole.

These task forces have been great beacons for us, and we have embraced them, and we have already begun to implement the vast majority of those recommendations. There are a few that may need some help from this committee.

We had a challenging year. We have made progress in almost every aspect of the things that we talked about when I came before you—not in the oversight hearing but in a hearing about combat casualty care and combat stress—some 9 or 10 months ago. So I won't brag about the progress—just to say that in almost all of these areas, we still have work to do—combat care; preventive medicine; safety issues in theater—making progress. Got more to do; Post-Traumatic Stress Disorder (PTSD); concussions or traumatic brain injury (TBI)—a lot of progress. We could talk about that at great length, and we have more to do. We have got a good clear roadmap on that as well.

The frustrating disability system: We have a pilot, which we are beginning to evaluate. We hope that—as the Government Accountability Office (GAO) pointed out two weeks ago—that we are on the right track with that and getting a disability system that is faster, fairer or at least as fair, but certainly simpler and faster. And those returns are just coming in. The GAO has reminded us we need more metrics before we roll it out. So that is the interim report on that.

We have had a lot of people working on patient advocacy and family support—kind of programs. And the Army and we at Health Affairs and the Navy have put a lot of people in place to care for injured soldiers and Marines and their families, and we have created some mechanisms in parallel to the chain of command by which they can get help.

DOD-Veterans' Administration (VA) relations: night and day compared to a year ago; clear roadmap on that. I don't think we need help from you on that, but we would be glad to talk about that in some detail.

Information technology: We appeared before you about six months ago. Mr. Kline had plenty of advice for us at that time, and we have taken that to heart. And I am really pleased to say that we are scoring runs in information technology now, and this is being recognized increasingly around the country. We are really pleased with that, but we have got a ways to go.

There are a number of issues in the theater, which relate to combat care, particularly stress and long deployments. We would be willing to talk about these. These are areas of ongoing discussion in the Pentagon, and we hope that we can make progress on those.

Humanitarian assistance: You all know that this has been a big focus for us, for the Navy, for Admiral Mullen, and we, of course, plan to continue this in this vain—African command (AFRICOM), pandemic flu, these kinds of services, which we consider will be bridges to peace. We don't plan to belabor that this morning, but would be glad to answer any questions.

We hope that our Uniformed Services University will increasingly become a global educator, a force for peace, a force to bring people together through healthcare, through telemedicine, distance learning and the like. And we are making a lot of plans in this regard. We would be glad to share them with you.

TRICARE and cost: Let me talk about them since that was the main focus of the opening remarks. Very briefly—and Dr. Wilensky will talk about it more—we have expanded the benefits in this long war on our own and with congressional guidance—reservists, Guard, family members—increasing benefits and increasing duration of benefits, so the number of eligible beneficiaries has increased.

The usage of these services has increased, because they are increasingly high quality. TRICARE is the most popular health plan. It has the highest satisfaction of any health plan in the country. Now, service members increasingly, particularly reservists, for example, will drop their private coverage and exclusively use TRICARE. It is cheaper, and they like the quality. So this, of course, is increasing the costs.

We have retirees who fortunately are doing well, living a long time, liking their TRICARE for Life. We have doctors who are coming up with new ways of treating things, so the intensity of care continues to ramp up. That is a factor, as Dr. Snyder can tell you, in healthcare inflation broadly.

So there are lots of factors here, and we are hopeful that, in a general sense, competition and choices will drive innovation; innovation will drive quality; people will compete on the basis of quality, satisfaction, and eventually cost.

But that is sort of a long-term mantra. In the meantime, I would say I personally feel it is critical that we begin to endorse the findings of this Corley-Wilensky task force. And I believe that the veterans I have spoken to, including the leaders of the Veterans Service Organizations (VSOs), are willing to see a gradual increase in fees, co-pays and deductibles as long as it is not more expensive than the private sector, because they don't want to rob theater care for garrison care or retiree care, so I would endorse that.

At the same time though, we are moving away from the more simplistic and draconian discussions of things like efficiency wedges and Military to Civilian (MILCIV) conversions in favor of agreed upon metrics between our surgeons, our TRICARE people and using pay for performance techniques—and Dr. Goetzl can probably talk about those, because he has studied this a lot—to incentivize prevention and to reward units and reward individuals, both clinicians and patients, who are taking good care of themselves and taking good care of each other.

And this sort of pay for prevention is, in the long run, the best way to reduce costs, but there are other things we are working on too. And I am proud to say that, you know, we invited inspectors

general to come in, and they have lived with us and gone over these plans like hawks. And I am proud about the ethical performance of our caregivers and our administrators.

So, you know, we have got a great team. As Dr. Wilensky says, “you got a great bench,” and it is true, I do. We are going to be ready for the transition next winter in January, because we do have a good bench, and we get a lot of help from you all.

So with that, let me stop and say, thanks again for this opportunity and this year of advice and the coming year of advice. We look forward to working with you. Thank you.

[The prepared statement of Dr. Casscells can be found in the Appendix on page 43.]

Mrs. DAVIS OF CALIFORNIA. Dr. Wilensky.

STATEMENT OF DR. GAIL R. WILENSKY, CO-CHAIRMAN, DEFENSE TASK FORCE ON THE FUTURE OF MILITARY HEALTHCARE

Dr. WILENSKY. Thank you, Madam Chair and distinguished members of the committee. I am pleased to have this opportunity to appear before you representing the Department of Defense Task Force on the Future of Military Healthcare.

During this past year, I have had the opportunity to work with my very able co-chair, General John Corley of the Air Force and 12 other members, half from the Department of Defense and half from the outside, so to speak.

During that same time, I had the privilege of serving as a commissioner on the Dole-Shalala Commission and thus spent a good portion of my last year trying to help focus on how to improve healthcare in both the military and the Veterans’ Administration. I am a health economist by day—Project HOPE sometimes wonders if I am still a senior fellow with them—but I am here not to represent my own views as a health economist but rather to represent the views of our task force.

What I would like to do is to very briefly review what it is that we have recommended in our task force. And while I understand and appreciate that much of your concern has been with regard to changes in the financing arrangements—and I am pleased to discuss that in whatever detail you would like—I think it is very important to understand that of the 12 recommendations—10 and then two follow on recommendations—two of them deal with changes in fees, and eight of them deal with how to make military healthcare more effective and efficient in its delivery. And we think that is a very important signal as to how we approached our duties.

We want to help make the military healthcare system more fiscally sustainable. We think that means making it a more efficient and effective healthcare system, and in addition, making some changes in the fiscal arrangements. But it is not only changing in the fiscal arrangements, and we are going to do as much as we can to dissuade people from looking at our recommendations only in that light. I think it misses what we spent a lot of time thinking about, and it will miss the point of the changes that we believe need to occur.

We recognize that you have a difficult task, and that we had a difficult task, which is attempting to balance the needs for military medical readiness—the most important single function of healthcare in the military—recognizing that there has been commitments to those in the military and to their families for the sacrifices they have made. And we want to make sure that there is a healthcare system in the future that will be sustainable for them and for their families.

We also recognize that military healthcare system—as you said Madam Chair—operates within a much broader healthcare environment. You are big, but you are not that big. There are approximately nine million people on the TRICARE system, broadly defined. There are 44 million in Medicare, and there are 300 million in the country. So, while you are significant, it is not easy for military healthcare to influence the healthcare system at large, and some of the difficulties that military healthcare is facing is broadly reflective of the challenges of healthcare in the country today.

I am going to review quickly these recommendations. And I have said, while I am more than happy to discuss the financial ones in any detail you wish, I do think it is important to consider the other recommendations we are making, because it will make, we believe, the military healthcare system more efficient and effective.

The first and the most overarching recommendation has to do with developing strategies to better integrate the direct and purchased care, particularly at the level where the care is actually provided—that means at the local level.

You mentioned, Madam Chair, that early on there had been a decision to blend purchased care in the private sector with direct care provided in the Military Treatment Facility (MTF). I personally believe that is a great strength of the military healthcare system, not so much as to whether one provides more efficient or less efficient healthcare, but because it allows the military to respond better to surges and demand, to the effects of deploying large numbers of people in theater and to shifts in geography.

However, it represents a challenge and that is to integrate the purchased care and direct care, and we think that is not yet occurring in an optimum way. People who are running these systems need to be empowered, and they need to be held accountable. Metrics need to be developed so it is clear how they are progressing.

We have several recommendations that focus on implementing best practices both in a business and in a clinical sense. We don't say this to suggest that there is something fundamentally wrong with the military healthcare system. We have found no indication that it does not run generally well or with high quality. We just think there are several areas where it is not necessarily following the best of what exists in the private sector, and it could. And those are the sense in which we have made recommendations.

We think there needs to be more collaboration with other payors on best practices, both in the private sector and in the government—the VA, Department of Health & Human Services (HHS), et cetera. There needs to be more of an attempt to have cost and quality more transparent. There needs to be a strengthening of incentives. Dr. Goetzel, I am sure, will cover some of these issues with

regard to pay for results and other strategies being used in the private sector.

We would like to see more systematic use of pilots and demos with the results being evaluated. Interesting pilots aren't helpful if you don't have a clear set of expectations at the front and well-developed metrics at the back. We think that the Department needs to have an audit of the financial controls done by an outside group.

We would like to see the processes with regard to eligibility, second payor, et cetera, examined with changes being suggested as needed. We would like to see more in the way of wellness and prevention guidelines. It is not that none of this is done, but we think that it is not done at the state of the art, and it is not done in a uniform way across the military.

We think there are ways that there can be efficiencies in the procurement system. We think it is important that the acquisition in terms of TRICARE management be elevated in terms of the characteristics of the individuals who are running these processes making sure that they are certified, and that best practices be used in procurement, which is not always occurring.

And also, in this area, we think that there needs to be an examination of existing requirements. We heard from contractors and from family members that there are some of the areas that are stipulated in the contracting language that do not allow for the best use of disease management or of other strategies, and that they need to be examined to see whether or not more flexibility can be provided in the system.

We would like to see an assessment as to how the changes with regard to Reserves, particularly the TRICARE Reserve Select program works. We think it is too soon to have such an assessment, but we encourage the department to do that over the course of the next two or three years and to make any changes that are necessary.

In the two areas where we have suggested changes with regard to fees, one has to do with modifying the pharmacy benefit to use more cost-effective care. We have suggested different types of tiering and co-payments to use so that there is more of an incentive to use preferred meds and also the more cost-effective points of service.

And we have also suggested that there be a pilot where the pharmacy function itself is integrated into the direct delivery of care. There is some debate both within the military and outside the military whether you get the best care by integrating pharmacy services directly within the provision of the rest of healthcare or whether you can get the best cost efficiency by keeping it outside, separate and having direct contracting. This is an area that we think can best be settled by having a serious pilot in one of the three TRICARE areas evaluating the results and then using that information going forward.

We have, as you have referenced, suggested that there be a revision to the cost sharing that occurs. I think you are aware that we have focused on the retiree. We do not suggest increasing the fees with regard to active duty or their families. We have primarily focused on the under 65 retirees, the majority of whom—but not all of whom—are working. And that is to phase in over a four-year pe-

riod—changes in enrollment fees and deductibles that go back to the cost sharing arrangements that existed when the Congress introduced the TRICARE program in the mid 1990's.

Even more importantly than going back to what that was is how you go forward. And that is to continue indexing the relationship between what is paid by the beneficiary and what is paid by the military, so that this relationship—which is approximately 91:9 on the part of the military versus the beneficiary—is maintained going forward. Changes need to occur in a predictable way—small changes in each year rather than attempting to make large changes in any type of a make up arrangement.

Finally, we have two recommendations that go toward monitoring in the way going forward. We think that it would be better for the beneficiary and better for the military if individuals who have multiple choices, particularly employer-sponsored insurance and TRICARE, would choose one or the other of those two systems, whichever they prefer, and bring some of the other money with them to have a unified benefit.

Having individuals use healthcare in multiple settings without any communication between those multiple settings is very expensive care and very poor care, medically. We have suggested that a pilot be demonstrated to see whether or not it is possible to have such an arrangement, again, at the choice of the beneficiary as to whether it is the TRICARE program that is chosen or the employer-sponsored program that is chosen with a contribution being made by the other payor.

And, finally, we were asked to look at command and control issues with regard to the military health system. We think it is too early to do so given the changes that are being put in place. We think it is important that metrics be developed so that it is clear what the Department and the Congress is expecting from these changes, and that several years hence in the future, it will be possible to assess whether or not the changes that are already on the books have occurred as anticipated.

Thank you for allowing me to participate. We recognize that even if all of our proposals are introduced, it will not resolve the future budgetary problems that will be produced by healthcare costs that are increasing faster than the Department of Defense budget, whatever that will be, and faster than the economy as a whole. We understand that that is a problem to be addressed by the Congress, broadly speaking. But we think that it is still important that changes that can be introduced, be introduced, that will allow the healthcare system in the military to be as efficient and effective as possible and to be in a financially stable position. These conditions do not presently exist.

Thank you.

[The prepared statement of Dr. Wilensky can be found in the Appendix on page 69.]

Mrs. DAVIS OF CALIFORNIA. Thank you, Dr. Wilensky.
Dr. Goetzl.

**STATEMENT OF DR. RON Z. GOETZEL, RESEARCH PROFESSOR
AND DIRECTOR, INSTITUTE FOR HEALTH AND PRODUC-
TIVITY STUDIES, EMORY UNIVERSITY ROLLINS SCHOOL OF
PUBLIC HEALTH, VICE PRESIDENT, CONSULTING AND AP-
PLIED RESEARCH, THOMSON HEALTHCARE**

Dr. GOETZEL. Yes. Good morning. Thank you, Madam Chairwoman and distinguished members of the subcommittee. I would like to thank you for inviting me to testify this morning on the subject of the health and financial benefits of health promotion programs, and I have some prepared statements, but I won't read them directly. I will just summarize and synthesize some of the main points.

My background and my work over the last 20 years has been in the private sector. So I have not done work with the military. My work has involved doing large scale evaluations of corporate health promotion, disease demand programs, and the companies that I have worked with include Dow Chemical and Johnson & Johnson and Motorola, Chevron, IBM—a long list of Fortune 500 companies.

I have also, in the last five or six years, been a principle investigator on federally funded health promotion programs for Centers for Medicare & Medicaid Services (CMS), for Medicare and for the Centers for Disease Control and Prevention (CDC) and for the National Institute for Occupational Safety and Health (NIOSH). So, my experience bridges the gap between the public and private sector, and my main emphasis is on looking at—from a research perspective—the benefits of providing prevention programs to workers, to employees—in this case the military being the workers of the government.

First though I want to, very quickly, make a distinction between different categories of prevention, because oftentimes that is confused. Prevention is primary, secondary and tertiary prevention. And primary prevention is essentially focused on keeping healthy people healthy. So getting people not to start smoking, being physically fit, maintaining a healthy weight, eating healthy, managing their stress, managing their blood pressures, cholesterol, glucose levels, and essentially remaining well, remaining healthy. And that is primary prevention, and there is very little being done in that arena in general, not just in the military.

Secondary prevention essentially involves screening programs to detect diseases or detect risk factors before they get out of hand, before people become patients, and those involve screenings for blood pressure, cholesterol, glucose levels, but also people who are overweight, people who smoke and getting them to manage those risk factors.

And tertiary prevention is what we typically consider disease management—people already have disease. They already have cardiovascular disease, diabetes, depression, asthma and so forth. And the intent there is to prevent further exacerbation of those conditions.

Now, that can be done medically, but there is also a very important behavioral component associated with that. As you can imagine, people with diabetes need to manage their weight; they need to exercise; they need to eat healthy and get preventive screenings on a regular basis.

Fundamentally, if you think about health promotion, disease prevention and the logic flow behind it, it can be boiled down to the following points. Many of the diseases and disorders from which people suffer are preventable. In fact, if you look at the deaths in the United States over past many decades, it is really heart disease and cancers that constitute over 50 percent of all deaths in the United States.

And if you flip it around and ask what causes heart disease and cancer, it is tobacco, overweight, sedentary behavior and not eating right. Those are really the main factors contributing to the chief deaths in the United States—preventable deaths in many cases.

Many modifiable health risk factors have been associated with increased healthcare costs and reductions in productivity. Now, we have done a series of studies in the private sector where we have looked at the relationship between 10 modifiable health risk factors and subsequent healthcare expenditures and productivity impacts and found a clear relationship, short term, between having these risk factors and increased costs and reduced productivity.

There is also strong evidence that you can actually change the risk profile of a population. Even though it is very, very hard to get people to quit smoking, start exercising, eat healthy, manage stress and so forth, there is growing evidence—in fact, the CDC's Community Guide Task Force has just done a literature review of worksite health promotion programs and came to the conclusion that there is strong, sufficient, and in many cases strong evidence to support the notion that you can actually reduce risks in many of the risk factors and also have a positive impact on healthcare utilization and worker productivity.

And then, finally, our research over the past 20 years has focused on the notion of return on investment. We have been funded by companies and other sources to look at whether these programs actually save money above and beyond what they cost.

And our analyses done in private sector with increasingly proved methods overtime have shown that many of these programs due actually produce a positive return on investment—medium value, somewhere around 3:1, but if you use better methods, more rigorous methods, the ratios are closer to 1.5:1 to 2:1. And what that means is that for every dollar you invest, you get somewhere around \$1.50 to \$2 back on that investment over a two-to four-year period.

In fact, we just published a study in last month's issue of the *Journal of Occupational and Environmental Medicine* using better methods to evaluate the return on investment in a worksite program—this is with Highmark, a health plan in Pennsylvania—and our conclusions were that that program achieved a \$1.65 return on investment for every dollar that Highmark invested in the program.

So to summarize, I think there is a growing body of evidence that prevention and health promotion in all three categories—primary, secondary and tertiary prevention—more so though in primary and secondary—can not only improve the health and well-being of the population, in your case the military, but also have a positive financial impact on healthcare utilization, healthcare costs—in our terms, productivity, but in your terms, readiness.

And again, I want to thank you very much for giving me the opportunity to testify this morning.

[The prepared statement of Dr. Goetzel can be found in the Appendix on page 77.]

Mrs. DAVIS OF CALIFORNIA. Thank you very much. We appreciate your being here.

Dr. Casscells, let me just start with you. We talked about the fact—and you mentioned as well—that in the 1990's we began moving beneficiaries out of the military treatment facilities and into a TRICARE program.

I am wondering if you were to build that program today—if we were to just try and erase the slate and think of how you would do that today, things being different than they are—what would you do? How would you build that? Is that the direction that you would go? Or is there something quite different, if you can think out of the box, if you will, about how we would go about doing that?

Dr. CASSCELLS. Madam Chairwoman, thank you for the opportunity. We, in fact, have taken a white sheet of paper—clean sheet of paper and, with support from Dr. David Chu, the Under Secretary for Personnel and Readiness, our TRICARE director, Elder Granger, has gathered a number of experts and the first meeting to redesign the system is, in fact, coming in a few weeks. And we appreciate Mr. Kildee's coming to that and giving us his thoughts about it, but the opportunities there are to do many of the things that Dr. Wilensky addressed.

For example, information sharing: We all know that there are many mistakes in medicine. There are, you know, maybe close to 100,000 preventable deaths. The military is not perfect, and while we have people working hard and trying diligently to use ATA—a not very responsive health informatics system—we need to do better in that, and we need better remote decision support in our routine care.

In the prevention aspects, you know, we are pleased that we exceed the civilian sector now in colonoscopy and pneumonia vaccine and influenza, but influenza—we had to order people to take it. And pneumonia vaccine—the Army is paying people cash to take the pneumonia vaccine, because there was resistance to it.

So, we are seeing some flexibility and some innovation. This is the kind of thing we call “pay for prevention,” which we hope to get in a redesigned system. Pay for performance, of which pay for prevention would be a part, as we redesign this, should have incentives for the commander, for the team, for the patient, for the nurse and doctor so that everyone has the same goals and everyone has some extra reason to perform besides the sense of duty, which drives so much of what, you know, military personnel do.

Mrs. DAVIS OF CALIFORNIA. Can I interrupt for a second? Are you seeing that it is more in the military treatment facilities or something that integrates more with TRICARE? I mean is it, because there are things we can't control—

Dr. CASSCELLS. Yes, ma'am.

Mrs. DAVIS OF CALIFORNIA [continuing]. In that arena.

Dr. CASSCELLS. Starting with the local issues and backing up just the way Dr. Wilensky's saying, we need an integrated system where at least there is bi-directional information exchanged that is

transparent between our purchased care and our military treatment facilities, and we know that that has to occur locally. Central guidance is awfully important, and a nudge from this committee in this direction would have a significant impact in accelerating this work.

Because we in the military tend to be cautious—when we are not sure, we become cautious. So this is a hallmark of the way we do things, so a nudge would be helpful. But I think I will not get into details such as whether we should make people choose between the MTFs and purchased care and whether they can go back and forth. My hope would be that once the incentives are aligned and the metrics are aligned—the outcome measures, as Dr. Wilensky mentioned—that, in fact, people could go back and forth between private care and military treatment facility care with their portable records with a clear sense that they are the owner of their care; that they have some responsibility for their care; that they have choices in their care.

This kind of opportunity is possible in this system where 97 percent of our enlisted have a high school degree or equivalent degree now. All of our people are computer literate. They have a great sense of responsibility, and so I believe we can be in the lead in patient accountability, doctor accountability, nurse accountability, alignment of incentives, but your guidance on this would accelerate this.

Mrs. DAVIS OF CALIFORNIA. Thank you. I am going to go ahead and move on.

Mr. McHugh? I know we have a number of members here, and I want to be sure that they all have a chance to ask some questions.

And Dr. Wilensky? I know I have a number for you and also for Dr. Goetzl.

We will move on and, hopefully, come back and have a few rounds. Thank you.

Mr. McHugh.

Mr. MCHUGH. Thank you, Madam Chairman.

Dr. Casscells? I heard you reference the VSOs. I want to make sure I understood what you said. Are you telling this panel that the VSOs support the fee increases that are contained in the DOD budget proposal?

Dr. CASSCELLS. Sir, the VSO leaders I have spoken with are not in favor of an abrupt increase of fees, co-pays or deductibles, cost sharing of any kind that would catch up to the past 12 years where they have been flat or that would make military care more expensive than the private sector. But all the ones I have spoken with have said they recognize that you can't go for another 10 years without some increase in fees and co-pays and deductibles, because they know at some point this will eat into theater care, combat casualty care and force readiness.

So they are in favor of a cost-of-living—what they tell me, sir, is they would accept a cost-of-living index, gradual increase in co-pays and deductibles—

Mr. MCHUGH. If you could get any of that in writing, I would love to see it. And I am not questioning. I didn't mean it quite the

way it sounded. I am not questioning that, but I think they are an important part of this equation—

Dr. CASSCELLS. Sure.

[The information referred to can be found in the Appendix beginning on page 99.]

Mr. MCHUGH [continuing]. And you understand that, and I think it is important to go forward with a precise understanding of what their tolerances are and what they believe is correct—not to say they are absolutely correct one way or another—but that is an important part of the discussion.

So, to the extent we can have that formalized, that would be helpful.

Dr. Wilensky? As I read your report, and as we had discussions, the fee increases for the under 65 retirees does not really demonstrably add to the bottom line of the defense healthcare system. In other words, it is not the revenues that is the factor here, it is the avoidance of utilization. Is that correct?

Dr. WILENSKY. There are two purposes: One is if you do not start having gradual increases in the enrollment fees and some changes in the deductibles, because of the growth in healthcare spending, you will gradually approach the point that the military pays everything. Period.

So you have frozen in an absolute dollar sense all of these contributions since the program was—I don't mean you the Congress—

Mr. MCHUGH. I understand.

Dr. WILENSKY [continuing]. But these have been frozen since 1995 when the program was introduced. Because of the growth in healthcare spending, the contribution by the individual will approach zero over time if you don't start that clock.

Mr. MCHUGH. But the net positive in terms of a budgetary perspective is not the income that is received through the increased costs, it is the cost avoidance and nonutilization of the program. That is the Department's assumption. I am just trying to—

Dr. WILENSKY. I want to make very clear, the Department does what the Department is doing, and we—

Mr. MCHUGH. Do you agree with the Department's assumption?

Dr. WILENSKY. We agree with some of the issues they have raised. We have not mimicked their proposals. What we are looking at is partly to restructure the benefit. The reason I am hesitating is enrollment fees do not affect utilization. Co-payments affect utilization and deductibles. Only when you get within the range of where you are crossing the deductible affect utilization.

Enrollment fees, like premiums paid in the private sector, affect the relative shares of who pays the bill. It doesn't affect behavior. When you want to affect behavior, you do it by affecting co-payments or co-insurance rates or the pharmacy tiering that we talked about.

So we are recommending two different types of changes in the financial arena: one is to try to bring back some of the original share between the military and the beneficiary as to how this benefit should be financed—overwhelmingly by the military, but not 100 percent by the military. We are also trying to use financial incentives to change behavior.

Part of that is why we have introduced changes in the pharmacy benefit where we are incenting by spreading the differential costs between using preferred drugs then other drugs and between using the lowest cost place to get them, which is mail order and other places to get drugs and also co-pays.

So we are both changing the financial arrangements to try to put the military health program in a little better financial state. Otherwise, what is going to happen is this benefit will basically be funded entirely by the military. It is largely funded by the military. It will always be largely funded but it is going to be 100 percent effectively funded if you don't start having the beneficiaries' contribution increase.

That is not to change behavior. With all due respect to the Department, there is nothing they are going to do which is going to make TRICARE more expensive than what goes on in the private sector. So I know they have used that argument. I don't know what they are thinking. I don't agree with it.

Mr. MCHUGH. Well, that is—okay.

Dr. WILENSKY. Okay. And I have—

Mr. MCHUGH [continuing]. Don't agree with it.

Dr. WILENSKY. I don't agree that it will make TRICARE more expensive and, therefore, less attractive than what goes on in the private sector. Nothing that I see being talked about begins to approach that. I do think you can make the TRICARE benefit more financially sustainable, which is what we have suggested doing and also incent better behavior in the sense of how you would like to see the beneficiaries choose the pharmaceuticals or, in general, engage in the use of healthcare. That is generally why you have co-insurance and co-payments.

Mr. MCHUGH. I thank the chair for her patience, because that was the crux of the question, because that is a fundamental assumption of the Department's proposal, and if it is valid, it is important to know. If it is, in your opinion, not valid, it is important to know, and I appreciate your comments.

Thank you, Madam Chair.

Mrs. DAVIS OF CALIFORNIA. Thank you. Mr. Kline has left.

Ms. Drake, you are next.

Mrs. DRAKE. Thank you, Madam Chairman.

Well, first of all, thank you all for being here. And I just want to get a few things straight in my mind, because I think the population we are having this discussion about and the people that approach us and are so emotional about this issue, are our retirees who aren't able to get in TRICARE for Life yet—in that age bracket.

First of all, everyone agrees that military offers wonderful medical care. People I talk to love TRICARE for Life. They think that is an excellent program. So just a couple questions that I have, because the time I have been in Congress we have this discussion year in and year out on this committee about the cost and how we deal with the cost.

So, and I have asked before, what are we telling new enlistees? Because I think the real problem here are the people in that middle bracket not old enough for TRICARE for Life who believe they went into the service with the understanding their benefits would

be taken care of, and that is why they are such a key component. This is really, really emotional for them, because they feel like the rules are being changed.

So, is there a cutoff point where people who came in after that were told something different and were told to expect these types of fees, deductibles and co-pays, because it is really a matter of expectations and what people thought they were doing and what they thought they were getting.

And I know we are treating everybody the same, but my question revolves around is there a way to separate them into two categories: people who truly had the expectation their healthcare would be paid for and newer people coming in who don't have that expectation? So that is one question.

I thought it was great when we went to the reservists being able to be in TRICARE, because this idea of going in and out of a healthcare system based on whether you are activated or not made no sense to me.

My second question would deal with is what they are paying for TRICARE when they are not activated—when this is optional for them—is that an appropriate amount, or are we looking at that amount—and there again not to make it more than or even the same as healthcare in the private sector. And then just the last issue that hits me, and it sort of backs up the chairwoman's question, is about the military treatment facilities. Because I also hear from people that they are very offended they have to go into the private sector.

They would like to be able to be treated at Portsmouth Naval Hospital, and they aren't able to do that. So, going back to 1995 and looking at what was done then, would it have been better to have given people the option of remaining in military health treatment facilities or making a choice to go into the private sector and paying for that, you know, for that option if they want to use a civilian doctor? Because I can't imagine that the costs are less by going into the civilian population with what our doctors are paying for today in liability costs and all the fees that are associated with even being reimbursed by TRICARE.

I mean, as a former realtor, when I walk in any medical facility, I say, I cannot believe the square footage and number of people just to get reimbursed and so much of that is government reimbursement that we don't have an easier way to do it.

So I know that is a lot of questions, but I will stop there.

But Dr. Casscells? I haven't been talking to the people you have been talking to who want their premiums raised.

Dr. CASSCELLS. Congresswoman, thank you. A couple general points and then more specifically—first, thanks for the kind words about the military treatment facilities. Not everyone realizes, as you do, that the inpatient care has generally been superb despite the demands of the longest war in our Nation's history and the frequent deployment of one's favorite doctor overseas, and your appreciation of that—like the patience of our service members and their families—is very appreciated.

There are still areas where we are not able to provide adequate care. A small facility may have their only psychologist and psychiatrist deployed, and they may have to drive, you know, 40 miles to

see someone if they are in need of counseling. So there are issues about, you know, understaffed, skeleton-staffed facilities, which we are struggling with.

Certainly, you, from your constituents, will hear from a different subset than we hear from. We are actively canvassing asking for complaints of all kinds. We hear relatively few. We post every one on our Web site, and I am out there walking the deck, trooping the line every day trying to solicit more, because of this tradition in the military where people tend not to complain until they just can't take it any longer.

And you see a different part of the elephant. You are going to get the constituent complaints, and that is important, so we need to hear them from your staff, and thank you for when you have sent those over. We appreciate those. We follow up every one. And if you don't hear back from us, let me know right away.

As regards to the cost issue, overall, you know, the chairwoman alluded to the 7.8 percent of the DOD budget, which is healthcare. This compares favorably to the 17 percent of Gross Domestic Product (GDP), which is healthcare in the U.S. But we are trying to prevent this from becoming a runaway train here, and so, we are trying to be careful with these costs.

Certainly, the people—to get more specific with your question—the guys and gals who served 20 and 25 years ago, 30 years ago for a much lower salary and far inferior benefits—many of them, you know, on a draftee basis—certainly feel that they got a promise, explicit or implicit, that they would get care for life. And many of them will say this promise is not being kept. You can refer them to the fine print, and they don't appreciate that.

So if there is a way that we can do more for them in this valley between active duty service or Reserve service—as a reservist, I know exactly the issue, and before you get TRICARE for Life, we would like to hear about that. It is a weak spot and some assistance in this area would be appreciated.

So the answer is yes.

Mrs. DAVIS OF CALIFORNIA. Thank you.

Dr. Snyder.

Dr. SNYDER. Thank you all for being here.

Is it Dr. Goetzel?

Dr. GOETZEL. Yes.

Dr. SNYDER. I think you are all here today as primarily talking about health promotion, and I appreciate your perspective, but I thought you might be a good person to ask—do you think investing in medical research through military medicine, through the Pentagon—is that a good investment of taxpayer dollars?

Dr. GOETZEL. I am a proponent of research—

Dr. SNYDER. I am too.

Dr. GOETZEL [continuing]. Because I am a researcher myself, and I am a proponent of conducting research in applied settings—in real life settings. So I agree with Dr. Wilensky when she talks about doing pilots and demonstrations to test out some of these ideas in real world settings. So, yes, I would be a proponent of doing that kind of research with the military—

Dr. SNYDER. Now, I took Dr. Wilensky to be pilots kind of in healthcare delivery, not necessarily basic science research, al-

though I think we underfund healthcare delivery models too, but I agree with her on that.

I wanted to ask—and this will be your softball question for today, and maybe I will start with you Dr. Wilensky.

We always like to hear from you, because you have such a long history of experience and a varied background. But, am I wrong—it seems to me that Dr. Casscells' job is really one of the toughest ones with regard to healthcare. When you look at other things—the Medicare program—right away we all have a sense of mind, what is the typical Medicare patient? Well, they are generally older. You think about, okay, Medicaid, we have a sense most of it is poor children or nursing home people, but Dr. Casscells literally has to run a worldwide program dealing with all ages. I mean, he has to come here prepared today for me to say, "I have an 87-year-old military retiree that this happened to. I have a young couple just enlisted and they have a five-year-old child with autism." I mean, just this huge perspective, and yet, we want the system to be almost perfect because we care so much about our military families and retirees.

Am I correct to say—and it is not much of a question, but I mean it really is a challenge that we are laying on Dr. Casscells here because of the breadth and quality that we expect out of the system. Is that a fair statement?

Dr. WILENSKY. It is, and you have used some good examples. If you think about the VA, the VA tends to concentrate on certain age groups. It has been heavily male in its focus—it will be less so in the future, but still—and it has tended to be heavily focused with populations that have certain kinds of service-connected disabilities and now an aging population at that.

The military, because it is both active duty and retiree, does cross the age span. For the over 65—most of the TRICARE for Life is primarily driven by what goes on in Medicare. The military becomes a wraparound, a very generous wraparound, but a wraparound to Medicare. So it is mostly—as I look at it—in the under 65 population, but it includes active duty and retirees.

Dr. SNYDER. This was—

Dr. WILENSKY. It is one of the reasons why this integration is such a good idea, in my mind, between direct care and purchased care, because you have so many varied experiences. People shift where they live, bases change, et cetera.

Dr. SNYDER. You can't do it without having some kind of blend like that. I think this has really brought home to me—I was talking some years ago now with a family who had a child with some fairly severe psychiatric problems—a fairly major diagnosis—and so Dr. Casscells and his folks can set up this perfect healthcare system for that family and patient and then two years later, they are transferred, or the next year one of the parents is mobilized for 18 months, and then you have the whole issue of the family dynamic.

And I think it is a challenge for us sometimes, I think, to get a handle on all the specific issues. Maybe a lot of Members of Congress—we get a feel for it because we hear from families about what happens, but I think it is hard to judge this program with

how we do other programs because there is not the typical military patient.

I wanted to ask one specific question, Dr. Casscells. What is the status of military-to-civilian conversions now in the different branches?

Dr. CASSCELLS. Dr. Snyder, as you know we are trying to get everybody over there who hasn't had a chance to serve, and this does require to backfill at the military treatment facilities. To this end, there has been a multi-year effort to shift some positions to be permanent civilian positions, you know, radiation therapy for cancer, for example—or to purchase that downtown in the private sector.

Having said that, our surgeons feel that has gone far enough—the military-to-civilian conversion of billets. In going through the detailed analysis with them, I feel we are about at the point where we have done what we should be doing in that, and there is not a lot of savings to be got by pushing that much harder.

We are trying to get some of that done this year. We may be at about the right balance now, this year.

Mrs. DAVIS OF CALIFORNIA. Ms. Tsongas.

Ms. TSONGAS. Thank you very much.

Secretary Casscells? I have a question. This committee recently traveled to Camp Lejeune, and I had an opportunity to visit the Marine Corps Wounded War Battalion along with many others and sat with a young Marine who had been hit by an improvised explosive device and was going to be medically retired from the Marine Corps.

This young man had been classified 85 percent disabled, and he was still suffering from his injury. He was about 20 years old. So, my question is, in considering the future of our military healthcare system, what long-term strategy is beginning to evolve for the care of these young medical retirees.

We can imagine that his needs may go well into his adulthood and beyond. The cost could be tremendous, and I think particularly in light of the discussion we have been having about preventive care—how do we anticipate and plan for and prevent sort of worst case scenario around these kinds of situations?

Dr. CASSCELLS. Congresswoman Tsongas, thank you. You know, the Marines have borne an extraordinary burden in this war, and it is to their everlasting credit that the Marine family has embraced them and nurtured them to recovery, and they feel like—even as they retire medically—they are Marines for life.

But esprit de corps doesn't help you get to the lavatory or hold a job. So we are watching this very closely, making sure that all of our medically retired personnel have had all of the vocational rehabilitation opportunities they can have, because the most important single thing is to have a job.

It is better than having an inheritance. It gives you a reason to get up in the morning, and it keeps families together. It keeps people from drinking, and so this is the key. And of course, they get healthcare; their family gets healthcare when they are 85 percent disabled, but the main thing is to have a mission still.

And while they are recovering, their mission is to recover, and they stay in, and they put the uniform on. They go to formation. They have their disciplined routine, and they have their standards.

And it is when they transition to the civilian sector we have a special obligation—I think that is what you are alluding to—to follow up on them, and we have new procedures in place to do that so that we don't have any lost sheep.

An example on the Army side, which I am, is the people who go home as an Army Reservist, even without an injury but with, you know, combat stress, and they are not close to a VA, and there is no TRICARE provider in their neighborhood or their TRICARE runs out, and some of those people are lost sheep.

There are a lot of them out there. So we are actively looking to bring them home and to make sure that they are getting the counseling and particularly the job assistance that they need so that—as Secretary Gates said, we owe them the best facilities, the best care and the help they need to move on to the next step in their life if that is what they choose to do.

So we have no higher priority. We can't give great inpatient healthcare and then say, you know, send me a postcard. You have an obligation to follow up. So we certainly intend that, and I know you will hold us to it.

Ms. TSONGAS. I would like to ask Dr. Goetzl the same question, because I can imagine that the cost will be great if we don't engage and seriously think through how to provide preventive care. This young man, for example, had lost his sense of balance. He had to walk with a cane. Long term it is hard to know. It is hard to know how quickly, if ever, he will fully recover, so a job alone may not—obviously, it is very important, but as a country, we really don't know yet the long-term medical costs of this. And I don't know if you have any thoughts about how we should be thinking about this for our medical retirees as we go forward given how very young they are.

Dr. GOETZEL. I agree with Dr. Casscells that the disability management and rehabilitation services that are being provided are essential and especially in terms of providing purpose and mission. And one of the most important things psychologically is to give people, soldiers in particular, who have been hurt the sense of the duty that they have to fulfill, and that they have to continue working, and that they are complete citizens and complete contributors to society.

So the work that is being done in rehabilitation is essential. My focus is much more upstream in terms of just basic day-to-day health habits that people have even before they enter the military. Things that, in the long term, may have very detrimental effects on their health and well-being. Things like smoking, being sedentary, not eating properly, being overweight—doing many things, drinking too much and so forth—many things that potentially may harm them whether or not they are affected by combat directly.

And in many ways that is a significant burden. It is kind of a silent burden on the military that is not as apparent as somebody who is injured in battle.

Ms. TSONGAS. Thank you.

Mrs. DAVIS OF CALIFORNIA. Ms. Boyda.

Mrs. BOYDA. All right. Thank you.

Thank you so much. This is just the number one issue whether it is private healthcare, military healthcare, so I have a number of questions, and I am going to try to go quickly.

Just for the record, I would like to just know what the satisfaction levels are for TRICARE, and I would like to see a comparison among the three regions. I will just ask that for the record, please.

Real quickly, because I have another—when you say we are 7.8 percent of—we spend on healthcare, what does General Motors (GM) spend? Not GM, bad example. What does Motorola spend on healthcare? What is their percentage, generally?

Dr. GOETZEL. I am not sure I can translate it directly as a percent, because there are many other benefits, but I can give you a dollar value for that. Today, the average American company is spending roughly \$9,000 for every employee in healthcare benefits, and—

Mrs. BOYDA [continuing]. Seventeen percent GDP, and that just didn't seem like an apples-to-apples. If you have something for the record—if you could just get back, I would be curious about that. It is not a have to do, just more curiosity.

The real question that I have is very specific, and if I have another chance, I would love to come back and talk about broader issues, but the issue of mail order pharmacy has been something—my background is coming from the pharmaceutical industry from a research and development standpoint, and just mail order pharmacy is something that has always kind of concerned me.

When I look at your recommendations here, you have got a 30-day retail supply up against a 90-day mail order supply, and I wondered from an economic standpoint, have you evaluated—people tell me that mail order is cheaper. You know, and I am going, wait a minute, you have got apples-to-kumquats or apples-to-something else, but why do we think that 90-day mail order—you know, we are losing—I represent a rural, rural district, and of course, I am coming from we are losing that person who is part of our healthcare team.

What data do you have to suggest that this is cheaper?

Dr. WILENSKY. We can provide or have the task force staff give you the information that is available, but in a more intuitive, common sense way, the reason it is cheaper is because what you need for mail order is basically a big warehouse facility with minimal staffing—

Mrs. BOYDA. And minimal interaction with human beings as well.

Dr. WILENSKY [continuing]. As opposed to what you need for a retail distribution site. This is an issue, and I am going to encourage you because you are rural—one of my many other hats is that I am a trustee for the United Mine Workers Health and Retirement Fund, and they are quite substantial users of mail order for maintenance drugs.

Mail order does not make sense for all drugs, but for maintenance drugs where either once you are on you are on for life or you are on for three or five years until your healthcare professional wants to try to some other combination, really are drugs that you need to have on a regularized basis. Chronic disease being the issue it is, those are really where you have just the savings, but

again, the savings come from not having the support structure you need—

Mrs. BOYDA. My question is if you had a chronic drug that was filled at a retail pharmacy, do you have the data to—how much does that cost? Because we have got 30 days—clearly you are filling a prescription three times as often. But for chronic drugs—obviously, we are talking chronic drugs—do you know that it is that much cheaper?

Dr. WILENSKY. The cost, again, is cheaper because of the support structure that it takes will have provided what it is. We did not try to assess the cost as a task force. We used the information that was available elsewhere.

Mrs. BOYDA. Right, and I would suggest that there may be a great deal at stake for the person—for the one or two mail order facilities that are around. I would very, very, very much like to see an analysis of how that actually works. And again, we are also talking about, you know—as you well know, if my pharmacy from Chanutte actually talks to my pharmacy from Parsons to get a better price, that is considered anti-trust. So we are, in fact, trying to do something about that to say that our small community pharmacies can, in fact, come together to get better pricing as well.

So you are kind of doubly at a disadvantage. Your retail has to fill every 30 days, and then they clearly don't get a—the other question that I would have too is when we are looking at mail order—and I have seen degradation curves of what happens at high temperature in literally 24 and 48 hours. Do we take that into consideration?

Dr. WILENSKY. I will, in addition to have the staff, see whether I can have the executive director from the UMWA Fund provide the information—because again, as I have indicated, they are, because of where their retirees are, primarily rural and come up with some of the same questions where, for their populations, you have the tradeoff between a social visit as well as a medical need being filled and the mail order—but provide you with the information that they have in terms of why they are encouraging on a fixed budget the use of mail order where appropriate, which is maintenance.

Mrs. BOYDA. I think we are out of time, but yes. And I would also appreciate anything that DOD has regarding that, actually that is my bigger concern. Thank you very much.

Dr. WILENSKY. I will ask them.

[The information referred to can be found in the Appendix beginning on page 99.]

Mrs. BOYDA. All right. Thank you.

Mrs. DAVIS OF CALIFORNIA. Thank you. We have an adjournment vote coming up. I think we can get in one more question.

Mr. Jones? If you could ask a question quickly. We have about 11 minutes left to go.

Mr. JONES. Just two or three points. First of all, Dr. Casscells, I appreciate you and your associates being here, and I couldn't help to remember three or four years ago when Dr. Winkenwerder came to my office and said, "Congressman, we have got a balloon that is about to explode. We can't continue this process as it is," as it relates to the issues we are talking about today.

And I said to him—the somewhat of a line that Mr. McHugh was talking on—I told him, I said, “Let me tell you, I hope you have got a great public relations staff, because once the word gets out,”—in fact, two years ago, it was Congressman Chet Edwards and myself put in the bill, and we had over 300 people to join us in the House to say, “No increase in fees.”

This is a huge problem. Our Nation is in very bad financial shape. We all know that. We know you have answered my colleagues, and I listened very intently that the problem is growing and you have got to somehow deal with it. But I will tell you truthfully—Mr. McHugh was so right—you have got to reach out to these VSOs.

They have the contacts that we don’t have, even though we go in our district and we know our veteran’s groups; we meet with them; we listen to them, but when you really come down to it, if there is going to be any movement one way or the other, I am telling you, you have just got to really reach out.

And, Dr. Wilensky, this issue that Congresswoman Boyda was talking about, I hear from pharmacists all the time. I have a rural district. I have Camp Lejeune down in my district, Cherry Point Marine Air Station, and from time to time, they will call me or I might go into the drug store, and they will say, you know, “What in the world is the Federal Government doing? Are they trying to put me, the local pharmacist, out of business?”

I want to work with you. I am not trying to be against you. I want to make that clear, but this is going to be a tremendous job of convincing those men and women who wore the uniform that this is not a Washington, D.C. game. This is reality. And I will tell you that I have them say to me all the time, “How in the world—you can do nothing about this, but how in the world do you all find the money to send overseas? And yet you can’t take care of my medical needs.”

And I really, as this moves forward—and I know we will have more hearings, and I thank the ranking member, and I thank the chairman, but I really think that this country—the White House down to the Congress—better understand when you increase foreign aid three or four percent every year, send it overseas, and then you tell the retirees you are going to have an increase in your fees, it just doesn’t wash. It just does not wash.

Now you can’t do anything about what this Congress votes on, at least I know that part, but I am just saying that this is going to be extremely important that you inform that this is a critical situation. I don’t mind telling you I have spent much of my time in my district recently telling people that when you have to borrow money from foreign governments to keep your doors open as a government, it won’t last long.

And I think that with this issue that those who wore the uniform for this country—they want to be patriots just like they were when they went overseas for America—but they have got to be told the true story. And they don’t need to be seeing in 2005 where we sent money to Switzerland—you can’t do anything about it, but how in the world does this country send money to countries who have a surplus and we have a debt. It doesn’t make any sense, but we are

in the minority—can't do anything about it, but maybe the majority can.

But again, I really can't add anymore than what my colleagues have said more articulate than I have, but I can just tell you that we know it is a problem. We know there has got to be a fix to the problem, but you better bring in the VSOs to sit down with your people before you even come back to Congress and say, "This is where we are. What can you do to help us sell the American retiree and the veterans on the fact that we don't have the luxury of time to take care of their needs," and they deserve to be taken care of.

Thank you for letting me preach for just about three minutes. I appreciate it.

Thank you, Madam Chairman. Thank you.

Mrs. DAVIS OF CALIFORNIA. Thank you, Mr. Jones.

We are going to go vote and come back. There is only one vote, so it shouldn't take too long. I would ask people to please come back. We would like you to come back with questions. And staff can help out if you need phones or any place to go, please. We should be back shortly. Thank you.

[Recess.]

Mrs. DAVIS OF CALIFORNIA. Thank you, everybody, for being back. We will resume.

Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you very much. I just have two short questions here. I know that is what we all say, but it really will be short.

And this one is for Dr. Casscells, please. I want to know why Wal-Mart and other companies can offer prescriptions for \$4 co-pay and the proposed co-pay is \$15 here, and what are they doing that we could do differently?

Dr. CASSCELLS. Mrs. Shea-Porter, thanks for that. We have got to learn more about that. It is as big a surprise to me as it is to you. Obviously though they are talking about generics. Obviously, they are talking about a program that they are rolling out, and they may be able to sustain a loss on that for a while.

I am not sure that they can sustain that. We do, thanks to the Congress, have Federal pricing now. And this ought to enable us to reduce our pharmacy costs, and in combination with incentives for mail order pharmacy, we may be able to compete with Wal-Mart.

Whether we can compete with \$4, even on a generic, that is a real challenge. I am still not sure—

Ms. SHEA-PORTER. Well, do you think we should be asking them or at least looking to see if it is a model that we could use considering the cost that we incur yearly in prescriptions?

Dr. CASSCELLS. Yes. I think that is very reasonable. And I think the other thing is I hope they will invite us to go over there and learn from some of the things they are doing well. They obviously have found some efficiencies, and you know, this business they have now with ready clinics and minute clinics in the Wal-Marts and the Walgreens, this is very popular with people.

So there are things we can learn, and we intend to try to learn from them.

Ms. SHEA-PORTER. Yes. I would say instead of hoping they invite us, I hope that we call up and check, because this is difficult, and every dollar that we can save a retiree or anybody related to the military, I think we have to make the effort.

The other question I wanted to ask you was, I am aware of a case because it is a relative of mine actually who had to leave one state to go to another state because she needed some surgery, and the hospitals around her were not either accepting TRICARE or would not reimburse in full, and so, she was forced to travel, not the 40 miles that you talked about earlier for a psychologist, but literally hundreds of miles for medical care.

And I know that you have heard these stories before, and I wondered what you were doing to address that, because basically what happened was she found a hospital that was a teaching hospital, and the taxpayers of another state picked up the cost. How much of that cost for our military veterans and their families are we shifting onto, you know, other taxpayers?

Dr. CASSCELLS. Mrs. Shea-Porter, I don't have the answer to the last part. We will have to get back to you about that if we can. I am sure we can. As regards to this commonly encountered problem where there is no care locally—and everyone wants top quality care around the corner, naturally, and they want it covered as a military health benefit.

And what I can say is that thanks to the efforts of General Granger and the governors who have been very good about urging their doctors to take TRICARE, we now have—in most states about 90 percent of doctors are willing to take TRICARE or at least they are signed up.

Now, they may not be actively recruiting TRICARE patients. They may not be doing cartwheels when a TRICARE patient comes in the door, but most of them have enough patriotism, that they are willing to surmount the paperwork. TRICARE is a bit onerous still. We are working to reduce the paperwork burdens, and General Granger has authority, thanks to you all, to go above Medicare by 5 or 10 percent if that is what is needed to persuade people to sign up for TRICARE.

So all these have to be done locally, and every one of these situations, we follow up. So, ma'am, if you will give me the patient's name, we will follow that up today, and we usually can get that resolved.

[The information referred to can be found in the Appendix beginning on page 100.]

Ms. SHEA-PORTER. Yes. It was resolved, because she was willing to travel, and her husband was willing to travel and stay with her and people in the next state were willing to take care of her, but it was onerous obviously, and a lot of steps involved—childcare—everything was too much of a strain, I think, to ask for somebody who has cancer.

So, I do want to thank you for the work that you are all doing and for paying such attention to this and for coming today, and I think that if we work together and we hear these stories and we concentrate on them, we can improve the level of care. So thank you.

Mrs. DAVIS OF CALIFORNIA. Thank you, Ms. Shea-Porter. And we are going to go back to our rounds. I wanted to go back to an issue to clarify, because I think that it has certainly been touched on.

But looking at the structural implications of raising fees: Will the additional fees that are generated or the funds that are generated by raising fees go back into the military health system, or will they go someplace else?

If the fees have some of the effect of reducing demand—which I am not sure that that basic assumption necessarily holds water—for care in the military treatment facilities and driving beneficiaries out of TRICARE toward other insurance, is this then going to reduce the funding and the resource allocation that is going to our military treatment facilities?

And if the beneficiaries are as fond of TRICARE as your survey suggests, then what makes you think that they would leave TRICARE even if the costs increase? If they like it that is a calculus that they have to entertain.

So what happens to this money? And it seems like we are going to enter into a spiral here in terms of being able to actually do what is appropriate by the military treatment facilities.

Dr. CASSCELLS. Madam Chairwoman, we see eye-to-eye on this. I think it is critical that savings that are realized stay in the system. More particularly, we need to guarantee that the people who achieve these savings on a local level—which is the commander, the doctor or nurse practitioner and the patient—are beneficiaries either in cash or some other recognition of what they have done.

Because, you know, for example, one of the things we learned in TRICARE is that when we asked commanders to collect the third party payments from patients who had that, no monies were collected until it became, you know, clearly believed that these would come back to the facility that collected those third party payments, and now that is actually working. So it is a local issue that needs central support from you.

As regards the last part of your question, I agree with you that we are not going to have people leaving TRICARE for civilian care. That should not be a goal. The goal should be that people get high quality, cost-effective care that is convenient for them, and that they have some sense of choice and control because then they are more likely—you know, like they say in Texas, no one washes a rent car, you know. You take ownership of something where you have a stake in it.

So if it just stays where it is now, without driving patients to private sector, I would be delighted, because we have to have a volume of care, particularly in the MTFs, to maintain excellence.

Mrs. DAVIS OF CALIFORNIA. Right, to justify those facilities as well.

Dr. CASSCELLS. Yes, ma'am. If a cardiac surgeon does one case a week, he or she is not going to be as good. Same with a pediatric endocrinologist or whatever, that is why we put Walter Reed and Bethesda together—not to save money, but to have a critical mass to be excellent.

Mrs. DAVIS OF CALIFORNIA. Dr. Wilensky? Can I ask you too then, whether that is consistent with the idea put forth in the task force report it said, "military healthcare benefit must be reasonably

consistent with broad trends in the U.S. healthcare system.” Is that really our goal to have it reasonably consistent? Or is there something else that we are trying to achieve in the military healthcare system?

Dr. WILENSKY. Well, it needs to be reasonably consistent in the sense that individuals are providing services frequently in both settings the military and the private sector. Individuals are moving back and forth between the military and the private sector, and unless you think there is something fundamentally wrong with the trends that are going on in the private sector, you would want to have some kind of consistency.

The attention in the private sector has been in trying to focus on clinical outcomes, quality improvements, improving patient safety measures, moving to pay for results—all of these being driven by the same factors that make our current position unsustainable in the broad sense both in terms of financial pressures and in terms of the value that we are getting. So it is within that kind of context that you want them consistent.

I have already stated quite forcefully that with my knowledge of the Medicare benefits, my knowledge of the private sector benefits and my knowledge of the military healthcare benefits, there is no way that the TRICARE system on average is going to look less attractive than what is available in the private sector. So I don’t think that is really a relevant issue. What I do worry about is whether or not it is going to be sustainable in the sense of not having major spillover affects on the rest of the Department of Defense.

I have used the term—which I believe is that because of the differential growth rates that we see in healthcare versus everything else—that the same way the Medicare budget is going to become the PacMan of the Federal budget unless we can find a way to moderate healthcare spending growth, the health benefit is going to become the PacMan of the Department of Defense not because of gross inefficiencies going on in Defense relative to anywhere else, but because the rate of growth in healthcare spending for the Department of Defense is much greater than I foresee the growth in any other part of the Defense budget. It is just going to put a huge pressure.

We are trying to help find ways to get as an efficient and effective system and a somewhat more sustaining financial system, but we can’t solve that other broader problem that I just laid out, which is signaling; we recognize that it is there.

Mrs. DAVIS OF CALIFORNIA. Yes. I appreciate that. I certainly appreciate the goals, but I think what we would all feel is that it does respond to a higher system in the sense of making certain that the care is there for the people who have served and perhaps does take a different mindset in some way.

Dr. WILENSKY. And we agree and we recognize and we try to be very clear in the report. We recognize the commitment and the sacrifice that people have made. The kinds of benefits that are being provided—we estimate, that we are talking in the 90th percentile of the largest employers in the country. So, you know, you could say, well, it ought to be better than the best that exists anywhere,

and if that is what the Congress and the American public want to fund, they can have it that way.

It is already among the very best benefits that we were able to find described among the large employers who traditionally provide the best benefits, so we think that is appropriate. We just didn't think Congress meant to have zero or very close to zero beneficiary contributions to the program, which is why we made some of the changes, but again—

Mrs. DAVIS OF CALIFORNIA. Can I ask you—just very quickly, Dr. Casscells mentioned trying to keep that local so that we don't bring the costs down to such an extent that a few years even henceforth that we would be in the same position that we are in today, essentially—that we brought the cost down, but we don't have the system to respond.

Is that reasonable to bring those costs back locally, because then you are not being able to respond to other concerns in the DOD budget at all?

Dr. WILENSKY. I do think to bring it back locally makes sense. It is why we wanted to see the local commander medically empowered—to bring the purchased care and the direct care together in a more integrated way. Empower the local commander, give the person incentives and hold them accountable for showing what they have produced.

Mrs. DAVIS OF CALIFORNIA. Thank you very much. We have about eight minutes left—another vote—Motion to Table Resolution, and so we should be back, barring another vote, immediately thereafter. We should be back in about 15 minutes.

Mrs. BOYDA. [OFF MIKE]

Mrs. DAVIS OF CALIFORNIA. Sure.

Mrs. BOYDA. Thank you. I don't want to sound like a broken record but back to the pharmacy. How long do you think it would take to get that sort of an analysis done?

Dr. WILENSKY. I spoke to Colonel Bader, who is the executive director. We think the information exists, and you should have it within the week. I will call the executive director of the UMWA Fund and ask her to send the information. It is an issue, as you can imagine, as a former Medicare head and as a trustee, I have heard raised by the local pharmacy community of "show me."

Mrs. BOYDA. Right. Let me just add too, in our last National Defense Authorization Act (NDAA), we also said that retail pharmacies can get the same pricing as the mail order too. So, I certainly am hoping that that is going to be taken into a scenario that says with the current pricing, but the NDAA said retail gets the same benefit.

Dr. WILENSKY. Obviously, none of the analysis will have done that because of the timing.

Mrs. BOYDA. Well, I would like to then—that is what I would like to look at.

Dr. WILENSKY. Okay, if you are going to ask someone to do additional analysis, I can't commit to when that will be.

Mrs. BOYDA. Okay. I would like to ask, for the record, that that analysis be done, and I would be interested seeing in the short term what the current one is. All right. Thank you very, very much. I appreciate it.

[The information referred to can be found in the Appendix beginning on page 96.]

Mrs. DAVIS OF CALIFORNIA. We are going to come back after this next vote, but then we certainly are very aware of your time restraints, and after that, if there is another vote, we won't do this again. But we would like to have a few more minutes with you. Thank you.

[Recess.]

Mrs. DAVIS OF CALIFORNIA. Thank you all for staying with us today. We are very sorry for the interruptions. I wanted to go back a little bit to some of the recommendations and the ideas that you expressed in terms of some pilots that we might look at in terms of the integration.

And I wondered, Dr. Wilensky, especially, could you be a little more specific? What would that look like? If we were to try and begin to really assess how this better system can work, where would you go first? What kind of a community would you go to? What would that look like?

Dr. WILENSKY. I will speak off the top of my head, but I would be glad to also give it some more thought and get back to you with some more specifics. At least three or four different areas we have suggested pilots.

And, we have done this—I was both, as a researcher promoting the idea, but also from the experience of running Medicare of not wanting to introduce change everywhere until you have had a chance to see that it does what it think you will do and not raise other problems that you haven't focused on. So I think it is wise when you have a program as spread as TRICARE in the military direct system, that you try some of these so you know what you are doing.

There are three different areas that come to mind right away: one of them has to do with this issue about should you integrate the provision of pharmacy care with the direct provision of care? I happen to think it is likely that you will have a better clinical outcome and better use of resources if these are part of the same strategy.

Now at some level it is easier in the MTF—in the direct care system, it is easier to have that be regarded as part of an integrated delivery system with the people practicing in the facility right there. It is much less obvious how that happens in the purchased care part of TRICARE when you have the separate contracts as to how you have physicians prescribing in the smartest way in terms of the pharmaceuticals and therapeutics they are using.

So what we had suggested is in one of the three TRICARE areas, there ought to be a portion—you don't have to do the whole contract—where there is an integration so you have much more of a real integrated delivery system, the way the Kaisers or other delivery systems would operate. That is one kind of pilot.

There is a second pilot that I referenced, And I mentioned it, and it is a little more complicated, so I want to try to explain it, and it had to do with the layering of insurance or the multiple insurance holdings. General Corley and I had heard very clearly from the Congress that the Congress had strong negative feelings about

the notion of pushing people out of TRICARE. So we took that into account.

But we are concerned that in the current world, too often people have both employer-sponsored insurance and TRICARE, but they don't know about each other or, in some cases, they can have all of that and Medicare as well or access to the VA as a priority.

The pilot we are suggesting there is to allow somebody who is eligible for multiple insurance plans, particularly employer-sponsored and TRICARE, to choose one of those, whatever they think gives them the best benefits, and to drag some of the other financial contribution over to the plan that is chosen.

So if it is going to TRICARE, it is having the employer pay a portion of what they would otherwise pay to TRICARE to have an augmented benefit, or—I recommended this being able to go either direction—if the person chooses the employer-sponsored plan, to be able to take some of the money TRICARE would have spent on their behalf and pull it over to paying some of the premiums or the co-pays for the employer-sponsored.

Right now, the world we are in is expensive because people don't know what the other is doing. Sometimes you get tests re-done because people don't know. So that is a different kind of pilot. So we had—some of the pilots had to do with doing better disease management; doing better preventive health like Dr. Goetzel had recommended.

We were surprised that in a place like the military, there isn't more proactive work routinely going on in terms of obesity prevention, smoking cessation, other types of preventive care—again, not that it is not going on at all, just not state-of-the-art some of the work he is recommending.

Those kinds of pilots you can pick and choose a few areas, try to have—the biggest problem you get is self-selection. So trying to either have it in a large enough place that you can have a sample that you can match to the people that you do or you have a treatment facility nearby.

Mrs. DAVIS OF CALIFORNIA. I wondered, Dr. Casscells, do you think there is anything inherent within the military system that would make it difficult to do that kind of a pilot where, in fact, you are sending the military benefits elsewhere?

Dr. CASSCELLS. Mrs. Davis, it would be doable once we have shared metrics, measures of process and measures of outcomes including patient satisfaction that we have agreed upon those with the services and health affairs, and we are now going to be asking the purchased care bidders to abide by that same standard and then begin to share this data transparently.

Now in such a system—and a nudge from your committee would help in that regard—pilots like this would be feasible across the system. Right now—as Dr. Wilensky says correctly—this would only be possible really in the MTFs. But with some further standardization of the outcomes and some requirements that the data be shared in real time or nearly real time, we could certainly do that.

Mrs. DAVIS OF CALIFORNIA. But today, that sharing of data continues to be problematic?

Dr. CASSCELLS. Yes, ma'am.

Mrs. DAVIS OF CALIFORNIA. We would probably need an entire hearing just to try and sift that through, so I appreciate that.

Mr. McHugh.

Mr. MCHUGH. Thank you, Madam Chair. I want to apologize for my late return to this dais. The governor of the state of New York was just resigning, and as someone from New York, I thought I should listen to his words—not that your words are any less important to us today, they are not, and hopefully, in a more positive way.

Dr. Goetzel? You heard Dr. Casscells talk about some of the prevention programs that the military has instituted. I would tend to agree that certainly within the active component, there are strong efforts for smoking cessation programs and responsible consumption of alcohol, et cetera, et cetera, et cetera—maybe you have a different perspective.

I am not so sure that we can see the same kind of achievement amongst the retired community on a programwide basis. Have you had a chance to look at that? And just generically, what kind of opportunities do you see we have within the military setting to implement some of the programs you have spoken about and hopefully contain costs?

Dr. GOETZEL. First, let me address the retiree community. There is very strong evidence that it is never too late; that you can improve health and lifestyle habits even for the elderly population—those 65 and older.

In fact, I was telling Dr. Wilensky that Medicare is starting a 3 1/2-year demonstration right now, actually in the next month, to test out private sector programs and services that have been effective in the corporate world—trying those out with the Medicare beneficiary population—doing a demonstration—a very rigorously implemented experiment in which people will be randomized into different treatment and control conditions to test the notion that you can improve health and also at the same time save money and produce a positive return on investment.

And so there is a lot of literature out there to support that it is not only a possibility to improve health and well-being but also to have a very significant cost impact. For example, in the Medicare system, approximately 5 percent of beneficiaries generate close to 50 percent of the dollars, but 50 percent of the beneficiaries only generate only 2 percent of the dollars.

So there is a huge opportunity not only to go after people who have disease and chronic-disease conditions, which a large proportion do, but actually a large segment of the population are still fairly well and to keep them well, because it is a lot cheaper to keep people well than it is to bring them back from illness back to wellness.

In terms of the kinds of programs that might be put into place. There is a lot of science out there that has been developed over the past 20 years on better ways to get people to change their behavior because it is very, very, very hard to get people to change their behaviors, but there is a lot of social behavioral psychological theories out there put together by Bandura, by Straker, by Kate Lorig, by Prochaska and others that have shown that their methods are ac-

tually a lot more effective than handing someone a brochure saying, you know, “Be healthy.” Those really don’t work very well.

But there are new advances in behavior-change technology and theory and application that may not be tried and applied as broadly as you might think in the military.

Mr. MCHUGH. Would you view the potential—for lack of a better phrase—return on investment that you spoke about earlier—I guess about \$1.50 to \$2—would that be your expectation within the military health system—

Dr. GOETZEL. I think that is a reasonable expectation. I mean there are two sides to a cost-benefit analysis. The benefit, of course, is what you save, and the saving is in medical, but you also, I think, can save it in disability and readiness to monetize those. But the other side is how much you spend on the program.

And you have got to be very efficient and evidence based in the spending so that you don’t go overboard.

Mr. MCHUGH. Dr. Wilensky? Would you like to comment on that?

Dr. WILENSKY. We had been having sidebar conversations while you were off voting, and I am very pleased at the additional work that has been done since, Dr. Goetzel and I have had earlier conversations at the CDC, about the ability to try to be sure you are comparing relevant populations. And the kind of numbers that he has talked about in the timeframe he is talking about are at least intuitively credible.

The area I think the military has a substantial potential savings on is not just the retiree, although certainly the retiree population, but it is the dependent population because of the nature of the military’s being able to reach out to the active duty—although weight control is a problem even in the active duty—although there are a variety of ways in terms of promotion to try to pressure people to be responsive.

So even in the active duty, there may be more that can be done in savings in terms of readiness as well as future disability expenses, but there is a lot of potential with regard to the dependent population that is not being achieved, and they are, as you know, the responsibility of the military in any case.

So, I would encourage you to set your sights higher than only the retiree population, and especially because of the additional work that is been done in the last three to five years to work with behavior modification in areas where, if you go after obesity and smoking, you hit a huge amount of the preventable illness.

Mr. MCHUGH. I would imagine just intuitively the dependent population families would be a lot easier to get to than many of the retirees, because they tend to disburse more widely.

Dr. WILENSKY. Right. Harder than the active duty, but definitely easier than the retiree.

Dr. GOETZEL. There is also one more segment—civilian workforce—that also is affected by your program, and they have not been at all targeted or involved in these kinds of prevention programs.

Mr. MCHUGH. Just, if I might, Madam Chair, one quick question to Dr. Wilensky, and she may not choose to respond, but when the question was posed about Wal-Mart—and I would note other corporations like Wegmans and Hannaford Markets in the northeast

have instituted similar generic \$4 prescription policies—I thought I detected a reaction of some sort on your face.

Dr. WILENSKY. You did.

Mr. MCHUGH. Would you like to add to that?

Dr. WILENSKY. Yes. I have been told never to play poker. [Laughter.]

Dr. WILENSKY. There is something called loss leaders. We have no idea whether Wal-Mart is able to provide the generic for \$4 or not. And, in fact, I have heard it referenced that the most important thing for a company like Wal-Mart to do, is to get people in the store, and I assume for Wegmans as well.

So, I would regard—I mean, the answer is, I really don't know whether they are able to provide it at \$4. I would think that the positive publicity that Wal-Mart has received as a result of the \$4 generic after two or three years of being beaten up in every place imaginable and subject to legislation in the state of Maryland, et cetera, combined with the loss leader notion may be as much an explanation as to the \$4 generic as to their being able to actually have a \$4 generic, although there probably are some generics that are sufficiently low cost that you can at least break even or do a low-margin business with a \$4 generic.

So, I wouldn't dismiss it. I would just caution you to assume they are actually able to cover their costs. Businesses only need to cover their costs on average—plus a return to equity—not on every single item.

Mrs. DAVIS OF CALIFORNIA. Thank you, Mr. McHugh, and I really appreciate your being here. I wonder if there are just a few questions, and we will have a chance to get together again, but I continue to be concerned about the physician bench, essentially, in the military, and how we will develop that.

Now that we are where we have said in law, that there can no longer be these military-civilian conversions, that means there has to be a lot of planning about how that corps is developed, and how are we going to get there, I think is—I would think, a big concern to the services.

You have raised the issue that about 90 percent of doctors will take TRICARE patients, but I know in the community that I serve, physicians are not too eager to do that any longer, and so I think there are gaps in that service. As we move forward, it would be interesting to see—as we really try to focus on how we integrate these systems better—the role that our providers are going to play, because we know that in a number of specialties today—not just in the military system, but in the system as a whole—that is a concern and plays a role in how we are able to move forward.

Did you want to comment just very briefly, Dr. Casscells, because I know we need to finish up? I wanted to express those concerns.

Dr. CASSCELLS. Just to say thank you for that guidance and for the fact that your staff have been so proactive, and Jeanette James and Dave Kildee have consistently seen this not as a contest of wills here but as a year-long dialogue. I particularly appreciate their coaching. The fact that they have, on your behalf—they are not only holding us accountable, but they also are helping us innovate.

And so you asked about a clean sheet approach, how we would redesign the system. We are just starting out on that process now, and so having the committees active engagement in that is very much appreciated.

Dr. WILENSKY. This is also an area where we as a task force recognized we were not able to spend time to try to develop recommendations. We think it is a very serious issue in terms of recruitment and retention of the appropriate number of medical personnel, and the best use of Reserve and active duty medical personnel going in the future, particularly in the time of future military engagement.

So we most definitely recognize that it was not an issue we were able to deal with, but it is a serious one.

Mrs. DAVIS OF CALIFORNIA. Thank you very much.

And Dr. Goetzel? I know a lot of my colleagues asked questions. I didn't have a chance to ask specifically, but the areas of prevention, of course, are very critical. And the extent to which we can really document those cost savings is helpful, because I happen to believe they are there, but ordinarily, we don't plan long term as well as we plan on the short term, and so it is an ongoing concern.

Thank you all so much for being here. Appreciate it. We look forward to seeing you again.

Meeting is adjourned.

[Whereupon, at 12:02 p.m., the subcommittee was adjourned.]

A P P E N D I X

MARCH 12, 2008

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 12, 2008

Opening Statement of Chairwoman Susan A. Davis
Military Personnel Subcommittee
Hearing on the Future of Military Health Care
March 12, 2008

The purpose of today's hearing is to look at the short and long-term challenges facing the Defense Health Program.

In 2007, total health expenditures of approximately 33 billion dollars accounted for just under 8% of the overall Department of Defense budget. By 2015, the Department projects that total health expenditures will rise to over 64 billion dollars, accounting for just over 11% of the total defense budget. All of this assumes a steady, modest, and potentially optimistic 6% annual rate of inflation in health care expenses. Without controlling the growth in health care costs, both the Department of Defense and Congress will face some very difficult choices: do we fully fund health care or operations; maintain medical readiness or procure all of the new equipment the services will require; keep our promise to retirees or resource all of the research & development needed to keep our technological edge.

The Department's 2009 budget submission marks the third straight year that the department has proposed their "Sustain the Benefit" program. In basic terms, Sustain the Benefit proposes to raise beneficiaries' co-payments, deductibles, and enrollment fees to both offset and avoid costs. The increase in fees will result in modest sums returned to the department. Beneficiaries will be discouraged from seeking care, both necessary and unnecessary, again due to higher copayments for visits. The department's own budget materials clearly state that they intend to realize savings by raising the cost of TRICARE so much that family members and retirees will seek health insurance coverage outside of the DoD system because it will be cheaper.

These steps *are* likely to reduce costs over the short-term: people are simply less likely to seek the same amount of care they receive today. However, what are the long-term implications of these actions? What will the costs be if beneficiaries wait too long to seek care and the underlying condition worsens or becomes untreatable?

Now is not the time to exacerbate existing long-term problems or create new ones with programs that provide only short-term relief.

When TRICARE was envisioned in its current form back in the 1990s, assumptions were made, *without* clear evidence, that private sector care was cheaper than the care provided in military treatment facilities. Risk was taken by dramatically shrinking the size, staffing, and number of military treatment facilities to save both money and end-strength personnel authorizations. As a result, we now have great difficulty fully supporting our combat forces, as the medical practitioners that support them are pulled from the very military treatment facilities that were downsized. Some military hospitals and clinics have had to close down entire departments for months at a time due to deployed providers. Consequently, many beneficiaries who received their care in military facilities now must receive their care in the civilian sector. With most of our beneficiary care, in terms of dollars, now provided in the civilian system, we are at the mercy of inflationary pressures affecting the nation's health care system. Our beneficiary pool is simply not big enough to move the market in a positive direction. These are the problems we face with a military at war supported by a health care system designed with just barely enough capacity to function during peacetime.

Again, we must not repeat such short-sighted thinking.

What, then, is the way forward?

To help us find answers to that question we have before us today Dr. S. Ward Casscells, the Assistant Secretary of Defense for Health Affairs.

We also have Dr. Gail Wilensky, Co-chair of the Defense Task Force on the Future of Military Health Care.

And finally, we have Dr. Ron Goetzel of Emory University's Institute for Health and Productivity Studies, who is also a Vice President for Consulting and Applied Research with Thomson Healthcare. Dr. Goetzel is a leading voice on the issues of wellness and prevention, having authored or co-authored numerous studies on the subject, not to mention advising many of our nation's top companies.

Welcome to you all.

Opening Statement of Congressman John M. McHugh
Military Personnel Subcommittee
Hearing on the Future of the Military Health System

“Thank you Ms. Davis. For several years the Department of Defense (DOD) has raised concerns about the rising cost of health care and the challenge of maintaining the viability of the military health system over the long term. I share those concerns. We must seek reasonable solutions for ensuring the availability of world class military health care, not only to our returning wounded and injured and their families, but to future generations of brave young men and women who answer the call to serve our nation.

“I am disappointed, however, that for the third year in a row the budget request proposes TRICARE fee increases and significantly reduces the budget for the Defense Health Program in the hope of Congressional support for the increased fees. The Fiscal Year 2009 budget reduction is \$1.2 billion. Let me make clear my intention to once again oppose the proposed TRICARE fee increases. How this committee will find the means to restore that \$1.2 billion cut will be an especially difficult challenge because the House Budget resolution, which opposes the TRICARE fee increases, does not add funding to restore DOD’s assumed savings.

“Two years ago I expressed my concern about the Department’s over-reliance on fee increases to solve the military health system’s fiscal challenges. The John Warner National Defense Act for Fiscal Year 2007 established a task force to study the military health system and develop recommendations for additional options and a coordinated approach for delivering health care that will solidify the future of the military health system.

“Today we have the opportunity to discuss the recommendations from the Defense Task Force on the Future of Military Health Care. I am interested to hear from the witnesses how these recommendations will ensure the Department’s ability to provide care to our beneficiaries. Given the strong opposition by Congress and military beneficiaries to the DOD-proposed TRICARE fee increases, I must say that I am surprised that the task force not only recommended similar fee increases but added an enrollment fee of \$120.00 for TRICARE for Life beneficiaries. I am interested to hear the task force’s rationale for these additional fees.

“I would like to express my deep appreciation to Dr. Wilensky for her leadership as co-chair of the task force and for the work she and the task force members have done to help inform the discussion on delivering the highest quality healthcare to such a deserving group of people.

"I'd also like to thank Dr. Cacsells for his leadership and his willingness to engage in open and thoughtful dialog with us as we look for reasonable solutions that will support the goal of continuing to provide world class health care to future military beneficiaries.

"I'd like to extend my welcome to Dr. Goetzel and thank him for sharing his expertise on worksite health promotion programs with us today.

"I look forward to your testimony on these issues."

STATEMENT ON
FUTURE OF THE MILITARY HEALTH SYSTEM
BY THE HONORABLE S. WARD CASSCELLS, MD
ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS
BEFORE THE
SUBCOMMITTEE ON MILITARY PERSONNEL
ARMED SERVICES COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES
MARCH 12, 2008

NOT FOR PUBLIC RELEASE UNTIL

RELEASED BY COMMITTEE

Madam Chairwoman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System (MHS). The MHS serves more than 2.2 million members of the Active, Reserve, and National Guard components with more than 272,000 Service members deployed overseas.

Nearly a year ago, the Secretary of Defense charged me with being the guarantor of quality health care for Service members and their families. Quality health care is one of the Secretary's top goals. In the past year, we have reexamined our mission, vision and core competencies and made important steps to prepare the MHS to better support U.S. strategic objectives as we prepare our military forces and our military medical forces for a future in which the U.S. champions aspirations for human dignity.

We are pleased to share the following data just one year after the *Washington Post* addressed important issues in rehabilitative services for transitioning Service members. According to an independent telephone survey conducted by Zogby International, more than 75% of Service members who served in Operation Iraqi Freedom or Operation Enduring Freedom agree that the MHS is doing all it can and should do to meet their health care needs. Fifty-eight percent agree that their trust and confidence in the MHS has increased since their care began. Approximately 54% say their expectations for health care recovery have increased since they returned from deployment (that is, they insist on more service and better care than they previously did). Finally, 70% say the MHS is on the right track with regard to providing medical care to ill and injured military personnel.

We are also pleased that the Government Accountability Office recognized in its February 27, 2008, testimony that "Over the past year, the Army significantly increased support for Service members undergoing medical treatment and disability evaluations, but challenges remain." We are working on the challenges of hiring enough staff to help Service members earlier in the process of transition.

Seven years ago, the MHS had more of a peacetime focus. Military commanders, defense leaders and our elected officials rightly expected the MHS to simultaneously manage health care costs and provide outstanding health care to its beneficiaries. The MHS worked hard to manage its business more efficiently and effectively.

With the influx of Service members with complex war wounds to some of the Department's older hospitals and outpatient facilities – where caregivers were removed from the military treatment facilities through deployment – the MHS needed a new focus. We rewrote the MHS mission to: Sustain a medically ready military force and provide world-class health services for those injured and wounded in combat.

One thing is clear: There is a lot of coherence in how Health Affairs and the Services see the future. We are working on new performance measures to transform the MHS into a performance-based organization that creates value for its staff, customers, and stakeholders. We agree that well understood, objective measures of success and business plans that link with the strategic plan will help us respond more rapidly to

change, such as the incidence and prevalence of the wounds caused by improvised explosive devices (IEDs).

The future of the MHS also requires us to develop a program to better understand and treat a not-well-understood diagnosis – mild traumatic brain injury (TBI). We also understand that the seven-year war has put additional stress on military families. We are committed to working closely with the Under Secretary of Defense for Personnel and Readiness to reduce even further our low levels of binge drinking, smoking, accidents, illicit drug use, domestic abuse and divorce.

The MHS Strategic Plan – Keeping Warfighters Ready. For Life.

Our goal is excellence in clinical care (including prevention and protection), teaching, and research. We focus on combat care, humanitarian assistance, and disaster readiness, especially in those areas where others cannot operate. We strive to foster communication and “jointness” among our Services; key government agencies, such as the Departments of Health and Human Services (HHS), Homeland Security and State; nongovernmental organizations; and international organizations.

We are shaping our strategic plan with the recommendations contained in the 2006 Quadrennial Defense Review (QDR), Medical Readiness Review (MRR), Base Realignment and Closure Commission (BRAC) reports, the six task forces and independent review groups from whom we have heard in the last year, as well as several MHS strategic offsite meetings in 2007 and 2008.

This plan – developed in concert with the Surgeons General, the Joint Staff and our line leaders – recognizes that our stakeholders, including this congressional body representing the American people, expect the following outcomes from the resources invested in military medicine:

- A fit, healthy and protected force;
- The lowest possible deaths, injuries and diseases during military operations, superior follow-up care, and seamless transition with the Department of Veterans Affairs (VA);
- Medical advancement through education and research opportunities that only the MHS can do;
- Satisfied beneficiaries;
- Creation of healthy communities;
- Humanitarian and disaster relief at home and abroad; and
- Effective management of health care costs.

We are revamping our internal measures, so we can better determine what is working and what is not. We welcome open competition and reward cooperation. We encourage innovation from all of our personnel while maintaining a disciplined focus on our mission.

A Fit, Healthy and Protected Force & Lowest Possible Deaths, Injuries and Diseases

Our primary objective is ensuring that every Service member is medically protected and fit for duty. Together with the military commanders, we use a variety of tools to achieve this outcome.

Based on outcomes data, process measures, and independent assessments by health care organizations around the country, our military medical personnel have performed extraordinarily on the battlefield and in our military treatment facilities (MTFs) worldwide. We are proud of these accomplishments – improving virtually every major category of wartime medicine, and many areas of peacetime medicine, including:

- **Lowest Disease, Non Battle Injury (DNBI) Rate.** As a testament to training, medical readiness and preparedness, preventive medicine approach and occupational health capabilities, we are successfully addressing the single largest contributor to loss of forces – disease. The present DNBI rates for Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) are the lowest ever reported, 5% and 4% per week respectively. By comparison, the DNBI rates in Desert Shield/Desert Storm were 6.5% per week, Operation Joint Endeavor (Bosnia) were 7.1% per week, and Operation Joint Guardian (Kosovo) were 8.1% per week.
- **Lowest Death to Wounded Ratio.** Our agility in reaching wounded Service members, and capability in treating them, has altered our perspective on what constitutes timeliness in life-saving care from the “golden hour” to the “platinum fifteen minutes.” We are saving lives of wounded troops who would not have survived even 10 years ago. For example, the wounded-in-action in-theater survival rate has been 97%, compared with 75% in World War II and 81% in Vietnam.
- **Reduced time to evacuation.** We now expedite the evacuation of Service members following forward-deployed surgery to stateside definitive care. Using airborne intensive care units and the latest technology, we have moved wounded Service members from the battlefield to the highest quality of definitive care in the United States in as little as 48 hours.

Our commanders expect the MHS to ensure that Service members are physically fit and that we promote healthy behaviors. We instituted an Individual Medical Readiness (IMR) metric to assess each Service member’s preparedness for deployment. The IMR provides commanders with a picture of the medical readiness of their soldiers, sailors, airmen and marines down to the individual level. Current health assessments and

dental examinations and up-to-date medical vaccination records comprise some of the measures we use to calculate the IMR of U.S. military forces.

Global Infectious Disease. The Department has programs to protect our Service members against a variety of illnesses. We continue to view smallpox and anthrax as real threats that may be used as potential bioterrorism weapons against our soldiers, sailors, airmen and marines. To date, with vaccines we have protected almost 1.6 million Service members against anthrax spores and more than 1.1 million against the smallpox virus. These vaccination programs have an unparalleled safety record and are setting the standard for the civilian sector. Since the Food and Drug Administration (FDA) published the Final Order confirming that the anthrax vaccine adsorbed (AVA) is safe and effective for its labeled indication to protect individuals at high risk for anthrax disease, we restarted the mandatory anthrax vaccination program.

The DoD has also been a leader in planning for a possible global epidemic of avian influenza. The lessons of the 1918 pandemic, which killed more American soldiers in WWI than the enemy did, has not been lost on the military. We recognize that as a globally deployed force we are uniquely vulnerable, and also responsible for contributing to the global efforts in surveillance, education (i.e., hygiene) and rapid eradication.

Health Assessments. We are also ensuring our Service members are medically evaluated before deployments (through the Periodic Health Assessment), upon return (through the Post-Deployment Health Assessment) and then again 90–180 days after deployment (through the Post-Deployment Health Reassessment). These health assessments provide a comprehensive picture of the fitness of our forces and highlight areas where we need to intervene. For example, we have learned that Service members do not always recognize or voice health concerns at the time they return from deployment.

For the period of June 1, 2005, to January 31, 2008, 495,526 Service members have completed a post-deployment health reassessment, with 147,638 (29.8%) of these individuals receiving at least one referral for additional evaluation. By reaching out to Service members three to six months post-deployment, we have found that the most prevalent concerns are physical concerns, e.g., back or joint pain and mental health concerns. This additional evaluation gives medical staff an opportunity to provide education, reassurance, or additional clinical evaluation and treatment, as appropriate. Fortunately, as these clinical interactions occur, we have learned that only a fraction of those with concerns have diagnosed clinical conditions. These surveys have also revealed an unexpected finding: Very few of the Service members who reported concerns about alcohol were offered counseling. This is now being addressed.

Seven years ago, TBI was not part of our nation's vernacular. Today the MHS is working on a number of measures to evaluate and treat Service members affected or possibly affected by TBI. (I will discuss the new Defense Center of Excellence for TBI and psychological health under the section titled Creation of Healthy Communities, Physical Facility Issues.) We published the new assessment forms with the TBI screening questions and other improvements on September 11, 2007. Since then, the

Services have worked hard to modify their respective electronic data collection systems. They finished this work in late December. In addition, the Armed Forces Health Surveillance Center-Provisional (AFHSC-P), which is the repository for the electronic forms, has successfully tested data feeds from the Army, Air Force, and Navy systems. No problems were identified.

The Services will start using the new forms for health assessments, and dates will vary with each Service. To ensure a smooth and timely start, we issued a policy memorandum to establish a 60-day implementation phase during which AFHSC-P will accept both the old and new versions of the forms. We have encouraged the Services to start using the new versions of the forms immediately rather than waiting for the formal announcement. The Army plans to start selected pilot tests of the new forms between now and April 1, 2008. The Navy, Air Force, and Coast Guard all expect to start using the forms in March 2008.

The Department is working on a number of additional measures to evaluate and treat Service members affected or possibly affected by TBI. In August 2006, we developed a clinical practice guideline for the Services for the management of mild TBI in-theater. We sent detailed guidance to Army and Marine Corps line medical personnel in the field to advise them on ways to look for signs and to treat TBI.

The “Clinical Guidance for Mild Traumatic Brain Injury (mTBI) in Non-Deployed Medical Activities,” October 2007, included a standard Military Acute Concussion Evaluation (MACE) form for field personnel to assess and document TBI for the medical record. The tool guides the evaluator through a short series of standardized questions to obtain history, orientation (day, date, and time), immediate memory (repeat a list of words), neurological screening (altered level of consciousness, pupil asymmetry), concentration (repeat a list of numbers backwards), and delayed recall (repeat the list of words asked early in the evaluation). The evaluator calculates and documents a score, which guides the need for additional evaluation and follow-up. The MACE also may be repeated (different versions are available to preclude “learning the test”), and scores may be recorded to track changes in cognitive functioning.

U.S. Central Command (USCENTCOM) has mandated the use of clinical guidelines, which include use of the MACE screening tool, at all levels of care in theater, after a Service member has a possible TBI-inducing event. Furthermore, Landstuhl Regional Medical Center is using MACE to screen all patients evacuated from the USCENTCOM area of responsibility with polytrauma injuries for co-morbid TBI. In addition, MACE is used in MTFs throughout the MHS.

To supplement mental health screening and education resources, we added the Mental Health Self-Assessment Program (MHSAP) in 2006. This program provides military families, including National Guard and Reserve families, web-based, phone-based and in-person screening for common mental health conditions and customized referrals to appropriate local treatment resources. The program includes screening tools for parents to assess depression and risk for self-injurious behavior in their children. The MHSAP also includes a suicide-prevention program that is available in DoD schools.

Spanish versions of these screening tools are also available. This voluntary and anonymous program is designed to provide increased awareness education in the area of mental health conditions and concerns. It supplements the more formal assessment programs and extends the educational process to families. Our robust outreach program increased awareness for military and family members around the globe. More than 2,000 participants a month use the Web-based education and more than 160,000 participants each year use the in-person educational events. With this program, our goal is to reduce the stigma of suffering from mental health conditions, and to foster an environment that encourages self-referral and/or colleagues and battle buddies looking out for one another.

In 2006, we published a new DoD Deployment Health Instruction. Among its many measures to enhance force health protection is a requirement for the Services to track and record daily locations of DoD personnel as they move about in-theater and report data weekly to the Defense Manpower Data Center. We can use the data collected to study long-term health effects of deployments and mitigate those health effects in future conflicts. An example might be to determine where an outbreak of dysentery or tuberculosis began in order to identify and treat those who were exposed or to learn more about some mystery illness by studying what geographic location was visited by those who came down with it.

At the direction of Congress, we executed new health benefits which extend TRICARE coverage to members of the National Guard and Reserve. We implemented an expanded TRICARE Reserve Select (TRS) health plan for Reserve Component personnel and their families, as mandated by the NDAA for fiscal year (FY) 2007. Today, more than 61,000 reservists and their families are paying premiums to receive TRS coverage. In addition, we made permanent their early access to TRICARE upon receipt of call-up orders and their continued access to TRICARE for six months following active duty service for both individuals and their families. Our FY 2009 budget request includes \$407 million to cover the costs of this expanded benefit.

Medicine on the Global Stage. Internationally, our medical forces deploy with great speed, skill and compassion. Their accomplishments in responding to international disasters further our national security objectives; allow us to constructively engage with a number of foreign nations; and save civilian lives throughout the world. Our military-civilian teams are working well with the State Department, Centers for Disease Control and Prevention, and World Health Organization (WHO).

Operating on the global stage, our medics – from the youngest technicians to the most experienced neurosurgeons – perform in an exemplary manner in service to this country. We must make necessary changes to our policies and processes, while remaining mindful of the skills, dedication, and courage of our medical forces.

At the 2008 Military Health System Conference we held our first medical ethics panel to address the issues that military medical professionals face, such as when health policy and even the law may not be aligned with their personal values. We also traveled to Guantanamo Bay where we found excellent medical care. To be sure, we invited the American Correctional Association physicians to make their own visit, and we conferred

with the American Medical Association and Physicians for Human Rights and suggested some modifications to procedures.

We also found good medical care at Camp Cropper and applauded the new strategy of focusing on education in what Islam really stands for, which together with job training and a generally gentler approach, has reduced recidivism by 90%. We also are exploring whether the daily physical exams of new detainees from all over Iraq could provide information about the health of Iraqis that could be helpful to the Minister of Health.

We need to do more to recruit and train health personnel who want to understand how to help people help themselves, whether in the diverse nations of Africa, with varied needs, or a predominantly Arabic and Islamic country such as Iraq, with multiple passionate religious sects and decades of brutalization and corruption, but a glorious past. To this end, we organized an interagency orientation for Bruno Himmler, M.D., the new HHS Health attaché to Ambassador Crocker in Iraq, and appointed Colonel (retired) Warner Anderson, M.D., director of our new International Health directorate, where he has assembled a multi-disciplinary team. We also co-led the first national meeting of doctors in two decades in Baghdad last month, and we are doing a needs assessment based on what we learned. We already know we need to do more in training trainers in medicine and in bioengineering. Some of this has begun with our meetings there and with the start of a telehealth consultation service to connect provincial doctors with Iraqi medical school professors and U.S. experts, including Iraqi-American doctors. We are also supporting Gen. Petraeus' efforts to build primary health clinics, and we are working with him and Ambassador Crocker to be sure each Provincial Reconstruction Team has a health expert.

Medical Advancement through Education and Research Opportunities That Only the MHS Can Do

As of February 2008, a total of 1,123 Service members had suffered an amputation while serving in support of Operation Enduring Freedom or Operation Iraqi Freedom. The majority (70 to 80%) of these amputations involve the loss of an entire limb, hand or foot. Half of all the amputations resulted from IEDs. Under the leadership at Walter Reed, the Military Advanced Training Center opened in September 2007 to accelerate improvements in amputee care. Together with prosthetics research and innovations developed and tested at the Center for the Intrepid in San Antonio – a great gift from the Fisher family – nearly 15% of amputees now remain on active duty. Many others are helped by Health Affairs' Computer/Electronic Accommodations Program.

Military Medical Research. On May 25, 1961, President John F. Kennedy said in his Man on the Moon address, "I believe we possess all the resources and talents necessary. But the facts of the matter are that we have never made the national decisions or marshaled the national resources required for such leadership."

We have an opportunity to restore military medicine to the greatness of the Walter Reed era. We have an opportunity through breakthroughs in stem-cell research to be leaders in regenerative research – to heal burns, restore sight, regrow limbs, and repair brain damage.

The MHS is excited to bring these opportunities together. No one knows how fast stem-cell technology can move, but we do know that we must not let bureaucracy get in the way of improving military medical research. Nor should we find comfort in old ways. While training leaders is something we do well, we also need the services to promote those with the talent and desire to excel in medical or public health research, which requires they build a team in one location for a decade, foregoing the frequent moves that are the traditional path to promotion.

Medical Education. The MHS needs to continue to recruit people who are willing to go in harm's way. We have challenges – some from the concern over the obligations of military service; some from the internal competition from within the Services; and some from the larger demographic and cultural trends in our society that lead people down other career paths.

In the past, the Health Professions Scholarship Program – or HPSP – helped the MHS meet its recruitment and retention numbers for its medical forces. Today, however, health professions are competing against many other professional opportunities for young people – and some seem to appear more lucrative or more interesting. Young people entering the health work force want greater job flexibility, which is not a feature of life in the military. We need to acknowledge that and confront it – head on. To this end, we have made a recruiting video that we will show at schools and have supported by the new movie *Fighting For Life* about our Uniformed Services University of the Health Sciences (USUHS). Our retired leaders will be speaking at colleges and medical meetings across the country. We have also urged USUHS and the Services to use their statutory flexibility to offer a menu of programs to students who hesitate to apply when they learn of the seven-year service requirement.

The MHS will pay special attention to recruiting and educational programs, especially through USUHS, or as the MHS calls it “America’s medical school.” Over the next few years, the MHS will strive to help USUHS to be the best in the country in training for combat casualty care, infectious disease, psychological health, brain and eye injuries, regenerative medicine (stem cells), health information technology, medical ethics, TBI, health system administration, graduate nursing and global public health efforts. The MHS hopes to demonstrate that it does not just train experts and managers, it trains leaders.

We see USUHS as the premier training center, offering telehealth and distance learning for our international partners.

Particularly important in health care is that we recruit women leaders. We also need to recognize the sacrifices of the selfless leaders whom we attract. We do this now on our website.

Finally, we see USUHS as the institution that will add to the 17 Nobelists who got their start in military medicine. We see future scientists winning the prize at USUHS for work done at USUHS.

Medical Training. The MHS also supports the joint training of medics and corpsmen in the new Medical Education and Training Center at Fort Sam Houston. We are working to add to the skill sets of these heroes – 168 of whom have been lost in Iraq or Afghanistan. We are looking for new opportunities to honor their courage and selflessness.

Satisfied Beneficiaries

Here in the United States, our beneficiaries continue to give the TRICARE program high marks in satisfaction. MHS beneficiaries' overall satisfaction with medical care in the outpatient and inpatient settings compares very favorably against national civilian benchmarks. The quality of our medical care is further attested to by the fact that all DoD fixed MTFs are accredited by one of these two nationally recognized accrediting organizations (The Joint Commission and the Accreditation Association for Ambulatory Health Care).

We also fared well on the 2007 American Customer Satisfaction Index survey produced by the University of Michigan and other groups to rate satisfaction with the federal government. Those surveyed gave DoD medical centers a score of 89% satisfaction with their inpatient care – the second highest satisfaction score by federal agencies/departments surveyed in the benefits-recipients segment.

In our own surveys, overall satisfaction with the TRICARE health plan has risen consistently each year since 2001 from 44 percent to 59 percent. Given the stresses of war during this time period, this is a remarkable achievement. The annual Outpatient Satisfaction Survey of MHS beneficiaries provides feedback that permits us to benchmark the satisfaction of beneficiaries with their outpatient experience at MTFs against civilian health maintenance organizations. For the period of October 2006 through September 2007, MHS beneficiaries' overall satisfaction with medical care in the outpatient setting was 6.13 compared with the national civilian benchmark of 6.23 (on a seven-point scale where 7 is completely satisfied). For the same time period, MHS beneficiaries' overall satisfaction with outpatient clinics was 6.07 compared with the national civilian benchmark of 6.13.

The MHS also administers the TRICARE Inpatient Satisfaction Survey to assess beneficiary satisfaction with inpatient care (MTF and civilian network). We administer the survey in two formats. First, we conduct the mail survey annually and mail it to 45,000 inpatients in CONUS and OCONUS. The telephone survey is administered on a quarterly basis to 620 (per quarter) inpatients. Sixty-two percent of 620 inpatients (July-September 2007) surveyed by telephone indicated they were very satisfied with the inpatient care provided by the MHS. In addition, 11% reported dissatisfaction and 27% reported they were somewhat satisfied.

Moreover, we added financial incentives to our managed care support contracts to improve beneficiary satisfaction from our contract partners and to ensure our contractors are financially rewarded for care delivered in the private sector. Through our new MHS governance and strategic plan, we are focusing on the effectiveness and efficiencies of MTFs and adding performance-based management and patient-centered care initiatives to transform our patients' experiences.

TRICARE launched a new website in 2007 with a new approach to delivering information to its beneficiaries that is based on extensive user research and analysis. The redesigned My Benefit portal at www.tricare.mil offers comprehensive information with a more user-friendly layout and an updated look, while providing up-to-date TRICARE benefit information in seconds. The My Benefit portal's simplified navigation system makes using the site easier than ever before. A key feature of the redesign is that users now receive personalized information about their health care benefits by answering a few simple questions about their location, beneficiary status and current TRICARE plan.

Recently, my staff launched a new website, www.health.mil. Its purpose is to inspire innovation, creativity and information sharing across the MHS. Our website is transparent in that every feature includes a comment box. I invite everyone to use the website as a tool to break down barriers and share information among military medical personnel and other government agencies and organizations outside the government.

The site provides a way to create a partnership for health that brings the Service members and family, the military leader and the medical provider-planner together with the objective of patient-focused health care. Visitors to the site can post comments, take surveys, watch web cams, subscribe to podcasts, and read unfiltered opinion from MHS leaders on our blog.

Creation of Healthy Communities

We have the internal ability to expand upon two major initiatives in the coming years: 1) increasing the use of evidence-based medicine, and 2) increasing the patient-provider partnership in sustaining health.

Competent medical care is comprehensive, conscientious, compassionate, coordinated, confidential, computable, communicated clearly, controlled by consumer choices and cost effective. Getting there requires continuous commitment (and courage).

We also have a responsibility to prevent disease by educational campaigns that promote a healthy diet, exercise, vaccines, use of seatbelts, responsible consumption of alcohol, and tobacco cessation. We are actively seeking innovative ways to incentivize beneficiaries and caregivers to reach these goals.

We need to do more to enlist patients as partners in their health care. We are increasing the services available to specific populations – seeking to stem the adverse effects of alcohol abuse, tobacco usage, and obesity. The DoD has developed and implemented a series of demonstration and pilot projects to address the key health

behaviors associated with premature and preventable death identified in the 2002 Health Related Behavior Survey.

Healthy Lifestyles Initiatives. These projects address the increase in tobacco use, obesity, and alcohol misuse and abuse among beneficiaries, both active and non-active duty identified in the survey. We are primarily focusing these health promotion activities on disease prevention and the adoption of healthy behaviors, while testing the effectiveness of comprehensive benefits not currently covered by TRICARE.

The tobacco cessation and weight management demonstration projects are comprehensive behavioral interventions. The tobacco cessation demonstration provides pharmacotherapy in addition to a telephone hotline, a web-based educational tool, and personalized quit kits. Preliminary demonstration study results indicate all cessation rates have shown increases in abstinence as measured at the completion of each milestone quarterly survey. The weight management demonstration provides health/weight loss coaching, as well as telephone and web-based educational and motivational information. The study enrollment period ended March 2007. There are 1,755 beneficiaries enrolled in the randomized control trial and 716 in the participation of self-motivated programs. Final study results are projected to be completed in December 2008.

The Program for Alcohol, Training, Research and Online Learning (PATROL), a web-based alcohol abuse pilot project targeting young, active duty Service members on eight military installations started in May 2006 and ended in September 2007. One month after the pilot study rollout, participants who received one of the programs had a significant reduction in heavy and binge drinking. These results were sustained at the six month follow-up survey. The program results will be used to enhance and complement other efforts being undertaken in this important area, which will result in an improved state of military readiness.

Disease Management. The MHS has implemented a system-wide approach to disease management to improve the health status of our beneficiaries with specific chronic disease conditions through the provision of proactive, evidence-based care to patients and their families. Our disease management initiatives are patient centered; with goals of educating and empowering patients to live a healthier lifestyle, designing and implementing preventive care services, and reducing the need for costly emergency visits and inpatient stays through effective monitoring of patient conditions.

As of June 2007, the program now includes patients with diabetes, in addition to the asthma and congestive heart failure patients enrolled since September 2006. These three chronic conditions are among the diseases identified by Disease Management Association of America (DMAA) as having the greatest potential for reducing the medical expenditures and improving patient quality of life through disease management.

As mandated by the NDAA for FY 2007, a report on the design, development, and implementation of the program on disease and chronic care management, which is due to Congress this year, describes our plan to address: diabetes; cancer; heart disease; asthma; chronic obstructive pulmonary disease; and depression and anxiety disorders.

The ongoing centralized evaluations by the TRICARE Management Activity (TMA) and the Services are providing valuable information regarding the effectiveness and efficiency of our disease management program. In addition to measuring select processes (e.g., engagement rates), we will also assess clinical outcomes, utilization outcomes, humanistic outcomes, and financial outcomes consistently across the MHS. Once enough data become available, we will use a scorecard to facilitate oversight and evaluation of disease management services. Moreover, the scorecard will be instrumental in identifying best practices for use throughout the MHS.

High quality care involves the provision of safe care, which includes employing steps to minimize preventable harm to patients. We are placing emphasis on and reinforcing to the health care professionals, as well as the patients, how important it is to be informed, educated and active participants in their care. Within the MHS, we use Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS) as a mechanism to improve quality and patient safety. Developed by the Department of Defense (DoD) Patient Safety Program in collaboration with the HHS Agency for Healthcare Research and Quality (AHRQ), TeamSTEPPS provides an evidence-based teamwork system aimed at optimizing patient outcomes by improving communication and other teamwork skills among health care professionals. After 20 years of research and evidence on teams and team performance in such diverse areas as aviation, nuclear power, and other High-Reliability Organizations (HROs), we have learned that teams of individuals who communicate effectively – and back each other up – compensate for individual fallibility and dramatically reduce the consequences of inevitable human error, resulting in enhanced safety and improved performance. Communication and coordination are critical elements in any medical environment. TeamSTEPPS leads the way in improving this vital area, giving both military and civilian medicine a roadmap for a safer health care system, and a vehicle to accomplish it worldwide.

Electronic Medical Record. The future is the Personal Health Record, which will empower patients, so they may take responsibility for their care and exercise some oversight over their care. Because so many MHS patients go back and forth to caregivers in the private sector, it is good news that DoD and VA are among the leaders of the American Health Information community led by the HHS Secretary.

AHLTA – DoD’s global electronic health record and clinical data repository – significantly enhances MHS efforts to build healthy communities. AHLTA creates a life-long, computer-based patient record for each military health beneficiary, regardless of location, and provides seamless visibility of health information across our entire continuum of medical care. This gives our providers unprecedented access to critical health information whenever and wherever care is provided to our Service members and beneficiaries. In addition, AHLTA offers clinical reminders for preventive care and clinical practice guidelines for those with chronic conditions.

In November 2006, we successfully completed worldwide deployment of AHLTA Block 1 at all DoD MTFs. Our implementation support activities spanned 11 time zones and included training for 55,242 users, including 18,065 health care providers. DoD’s Clinical Data Repository is operational and contains electronic clinical records for more

than nine million beneficiaries. AHLTA use continues to grow at a significant pace. As of February 29, 2008, our providers had used AHLTA to process 71,412,847 outpatient encounters, and they currently process more than 124,000 patient visits per workday.

As we add dental capabilities to AHLTA, the number of providers using the system, and encounters documented, will increase. We expect a deployment decision for AHLTA Block 2, which includes a dental module, in this quarter. We expect it will take two years to fully deploy AHLTA Block 2.

We are working to add additional components to AHLTA. For example, we are working with the VA to implement a new inpatient capability. Its implementation will provide VA and DoD clinicians a fully integrated electronic health record for essential DoD and VA ambulatory and inpatient information. Our project team has completed a six-month assessment of DoD and VA inpatient clinical processes and is beginning an assessment of potential technical solutions to meet that goal, with recommendations due to us in the summer of 2008. A jointly agreed upon technical solution for the inpatient electronic health record module will further enhance our clinical data sharing. Our current data sharing is already decreasing redundant tests and procedures for our patients, and reducing errors that are inherent to a paper records system.

AHLTA contains the largest computable and structured medical data repository, leading the nation in standards adoption and interoperability. Before the end of this decade, we will be using AHLTA as a central research and planning tool, leveraging its computable health data to improve patient outcomes through prevention, early detection, and proper intervention. We are determined to make further improvements to make the system faster and easier, more private and secure, so that doctors, nurses, and patients all begin to use it to promote safe and cost-effective health care.

We are also using our DoD and VA information sharing experience to advance the President's health information technology goals. We are working closely in a leadership role with other federal agencies, e.g., the American Health Information Community, Health Information Technology Policy Council and Healthcare Information Technology Standards Panel (HITSP), to lead the nation toward adopting electronic health records. In particular, our DoD and VA collaboration work has helped HITSP to accelerate the establishment of national standards. We foresee significant benefits in advancing health informatics and standards through better quality and greater efficiency in health care delivery. The Certification Commission for Healthcare Information Technology (CCHIT) announced that DoD's product AHLTA Version 3.3 is pre-market, conditionally CCHIT Certified and meets CCHIT ambulatory electronic health record (EHR) criteria for 2006. Pre-market, conditionally certified EHRs are new products that are fully certified once their operational use at a physician office site has been verified.

It is important to note that the MHS is in transition from a paper medical record to an electronic medical record. The paper medical file is the National Archives and Records Administration- (NARA) recognized MHS medical record. NARA has just begun the AHLTA data inventory, which is the first step in having AHLTA recognized as an official government record. NARA certification will take approximately two years.

The MHS will not have a completely paperless medical record for many years. In the meantime, like the vast majority of organizations converting to electronic health records, we will have a hybrid system.

Identifying the Way Forward for Rehabilitative Care and Transition. Last year, the *Washington Post* addressed important issues that deserved and received our immediate and focused attention. First and foremost, we are listening. We are actively surveying (by telephone, on the web and in person) our wounded Service members and their families, and we are acting on the answers they provide. Our goal is to improve patient satisfaction, and these surveys let us know where we need to put resources to continuously improve. In addition to surveys, I encourage leadership to spend time with Service members and their families who are receiving long-term rehabilitative care. On February 14, we held our first webcast town-hall meeting on our new website www.health.mil to receive additional, anonymous feedback from the wounded, injured, ill and their families. We are taking all of this input back to DoD leadership – where we have clear leadership – as we develop and implement solutions.

The Army and the Department have taken swift action to improve existing conditions and enhance services provided at Walter Reed Army Medical Center (WRAMC). We are also identifying areas that need further study and improvement. Army leadership initiated immediate steps to control security, improve access, and complete repairs at identified facilities to provide for the health and welfare of our nation's heroes. They also held accountable the personnel responsible for the failures, as only the military will do.

Six task forces and commissions have provided recommendations to the MHS over the past year. The most challenging recommendations came out of the independent review group (IRG) commissioned by Secretary Gates on March 1, 2007. The IRG reported its final findings to the Secretary of the Army, the Secretary of the Navy, and me on April 16, 2007.

- An underlying theme in their report was the recognition of the moral obligations and the human and budgetary costs of war/national security, and that the Department, the government, and the nation must be prepared to meet those obligations.
- The 25 specific findings and over 60 recommendations provided in the IRG's final report addressed two main areas of concern: 1) continuum of care and 2) leadership, policy and oversight. Key among the findings was the cumbersome and adversarial nature of the current DoD disability evaluation system.
- Among findings and recommendations related to health care delivery, the IRG concluded that while we provide first class trauma and inpatient care to Service members at the medical centers, there is a breakdown in health services and care management during transition to outpatient status.

- The IRG also found room for improvement in comprehensive care, treatment and administrative services, with a need for a more interdisciplinary collaborative approach. The need for sufficient and properly trained case managers to help wounded Service members navigate the health system was paramount in the IRG's conclusions.
- TBI, post traumatic stress disorder, along with a shortage in mental health staff, were issues requiring particular attention.
- Specific to WRAMC, the IRG outlined a "Perfect Storm" of events impacted by BRAC, A-76, staffing and training limitations, and funding constraints.

DoD and VA are working together to address these issues through a Senior Oversight Committee (SOC), co-chaired by the Deputy Secretaries of each Department. The SOC is developing implementation plans and future funding requirements for eight "lines of action" that address such issues as the disability system, case management, data sharing between the Departments, facilities requirements, personnel and pay support, among other issues, as well as such wounded warrior health issues as TBI and psychological health. The recommendations and decisions from this group are being implemented now.

In all cases, we will regularly inform the people we serve – Service members, families, military leaders, Congress, the Secretary and the President – on our progress. We will share our progress with the public.

I am confident that each of these items is fixable with sustained leadership and oversight. The Department categorizes the problems as follows:

1. Physical Facility Issues.

MHS clinics and hospitals must be healing environments that lift the spirit by their bright colors and views of nature, and by the sight and sound of falling water. They must be quiet, clean and clean-smelling, and have features that promote independence, patient control, and welcome family participation. MHS facilities must have the latest technology, such as imaging and electronics, and the latest features that promote safety, such as HEPA-filtered air, carpeting, design that reduces the risk of falls, and informatics safeguards that reduce the risks of medical errors and breaches of privacy. We can best meet the rising expectations of our beneficiaries and the especially unique health needs of our wounded Service members through the planned consolidation of health services and facilities in the National Capital Region. The 2005 BRAC decision preserves a precious national asset, Walter Reed, by sustaining a high-quality, world-class military medical center with a robust graduate medical education program in the Nation's Capital. The plan is to open this facility by 2011.

On March 3, 2008, we awarded a \$109,025,544 (first increment) contract for the design and construction of the Walter Reed National Military Medical Center in Bethesda, Maryland. The total contract amount is not to exceed \$641,400,000 to

establish the medical center at the current Bethesda, Maryland, location of the National Naval Medical Center.

In the interim, we will not deprive the current WRAMC of resources to function as the premier medical center it is. In fact, in 2005 we funded \$10 million in capital improvements at WRAMC's Amputee Center – recognizing the immediate needs of our warrior population. The new facility opened its doors on September 12, 2007. The sight of amputees running the track or climbing the wall will never be forgotten by those who visited that day, and since.

Many of the health issues our wounded warriors face are slow to emerge and are extremely complex to fully evaluate and treat.

Our new Defense Center of Excellence for Psychological Health and Traumatic Brain Injury will integrate quality programs and advanced medical technology to give us unprecedented expertise in dealing with psychological health and TBI. In developing the national collaborative network, the Center will coordinate existing medical, academic, research, and advocacy assets within the Services, with those of the VA and HHS, other federal, state and local agencies, as well as academic institutions. The Center will lead a national collaborative network to advance and disseminate psychological health and traumatic brain injury knowledge, enhance clinical and management approaches, and facilitate other vital services to best serve the urgent and enduring needs of our wounded warriors and their families.

2. Process of Disability Determinations. We believe resources and processes need to be better aligned. Our first step in assessing processes will be to identify the desired outcome. We must redraw our processes with the outcomes we have in mind, with as much simplicity and timeliness as possible. We know that both the Service member and the Department expect:

- Full rehabilitation of the Service member to the greatest degree medically possible;
- A fair and consistent adjudication of disability; and
- A timely adjudication of disability requests – neither hurried nor slowed due to bureaucratic processes.

We currently have a pilot program in place to improve the disability process and implement one system. Our goal is to create a process that requires one exam and one rating, for use by both DoD and VA within current law. While this pilot is helpful and may yield efficiencies to benefit today's soldiers, it is clear that the Departments have some overlapping roles. In particular, the DoD and VA both do disability ratings. This process is confusing to the soldier, and unnecessarily duplicative. We believe that DoD's role should be to determine fitness to serve, and that VA should determine the % disability. This is a key recommendation of the Dole/Shalala commission. The new Disability Evaluation System pilot program, which began in late November, will provide

smoother post-separation transition for veterans and their families – including medical treatment, evaluation, and delivery of compensation, benefits and entitlements.

3. Process of Care Coordination. The quality of medical care we deliver to our Service members is exceptional. Independent review supports this assertion. Yet, we need to better attend to the process of coordinating delivery of services to members in long-term outpatient, residential rehabilitation. The Army has assessed, and our office is reviewing, the proper ratio of case managers to wounded Service members. We are also reviewing the administrative and information systems in place to properly manage workload in support of Service members and their families.

The Army's new Warrior Transition Brigade became operational at WRAMC on April 26, 2007, to assist soldiers assigned to medical holdover. As of February 4, 2008, the 35 Warrior Transition Units throughout the Army had 9,774 wounded warriors assigned to them (this number includes Active Component and Reserve Component members). Many of the Warrior Transition Unit cadre have volunteered for their assignments, and each officer or noncommissioned officer goes through an interview process before he or she is selected.

Each wounded warrior is also assigned a primary care manager, a nurse case manager and a squad leader to ensure no Soldier falls through the cracks. They even follow up with Soldiers after they return to their units or transfer to the VA. We are beginning to receive external recognition of the success of the Warrior Transition Units and we will monitor this initiative to ensure we meet and exceed future expectations of Service members and their families.

We receive beneficiary input through the Army's toll-free hotline. In addition, the MHS and the Army are conducting surveys of wounded warriors and their families, so we may assess what is going well and areas that need improvement. The bottom line – we will continue to serve our warriors and other beneficiaries until we move to the new campus at Bethesda.

Early Signposts on the Road to Recovery. Our goal is to ensure everyone who needs care has access to it, and that we have no heroes-cum-lost sheep living on the street or under bridges. Our deserving men and women need facilities that attract the best doctors, nurses, and techs and are places of choice for our beneficiaries to receive care.

There are areas in which we lead the nation, and as we focus our research efforts, we will add to the areas in which we already lead, such as influenza vaccination, pneumovax vaccination, colon cancer screening, burn survival, and inpatient and outpatient satisfaction with TRICARE. We are also monitoring patient confidence, which is improving much sooner than we expected. We are creating a dashboard to review our performance on the issues that matter to patients, and we will hold ourselves and the Services accountable to the same standards across the MHS.

Humanitarian and Disaster Relief at Home and Abroad

In the past year, we also have reexamined our mission, vision and core competencies and made important steps to prepare the MHS to better support U.S. Strategic objectives as we prepare our military forces and our military medical forces for a future in which the U.S. champions aspirations for human dignity. The MHS is a big part of the soft-power equation. Our medical forces deploy with great speed, skill, and compassion to provide humanitarian assistance and disaster relief. Surveys have shown that after we provide humanitarian assistance, public opinion toward the United States improves.

I believe our role in humanitarian assistance and disaster relief, combat casualty care, and trauma care have been greatly undervalued in the past. We are revamping our internal measures to better quantify these contributions and to determine what is working and what is not. As the world's 9-1-1 emergency service, people around the globe look to the MHS in a catastrophe, such as the tsunami in Indonesia, earthquake in Pakistan, hurricanes in the United States, and earthquake in Peru. Many military medical professionals also have participated in the humanitarian assistance missions of the Comfort and the Mercy and elsewhere. Last August, the president of Peru was surprised to see the Assistant Secretary of Defense for Health Affairs get off the plane with the Red Cross from the adjacent country of Ecuador – less than 48 hours after the earthquake.

Humanitarian assistance plays a critical role in winning hearts and minds. As Secretary Gates said in November, 2007, “We can expect that asymmetric warfare will be the mainstay...success will be less a matter of imposing one's will and more a function of shaping behavior of friends, adversaries and most importantly the people in between.” President Bush said in March 2007, “The U.S. military is a symbol of strength for this nation; they're also a symbol of the great compassion of the American people.”

A great humanitarian opportunity for the MHS is coming with the stand-up of the Africa command. AFRICOM will allow the MHS to test whether an unarmed doctor and nurse assisting people in a troubled country can do as much to protect the brigade as barbed wire, T-Walls, and MRAPs. Their efforts will say that the U.S. military cares, protects, builds, teaches, and trusts – enough to go out unarmed.

I predict the people we serve in Africa – like the Iraqis I worked with – will be deeply impressed that the MIL-CIV teams are male and female, of every complexion, of many ethnic origins and religions, all working as a team.

Effective Management of Health Care Costs

The Department is committed to protecting the health of our Service members and providing the best health care to more than nine million eligible beneficiaries. The FY 2009 Defense Health Program funding request is \$23.6 billion for Operations and Maintenance, Procurement and Research, and Development, Test and Evaluation Appropriations to finance the MHS mission. Total military health program requirements, including personnel expenses, is \$42.8 billion for FY 2009. This includes payment of \$10.4 billion to the Department of Defense Medicare Eligible Retiree Health Care Fund, and excludes projected savings of \$1.2 billion, based on recommendations provided by

the Department of Defense Task Force on the Future of Military Health Care for benefit reform found in the President's Budget.

The Task Force on the Future of Military Health Care published its final report on December 20, 2007. The Department embraces the recommendations developed by the Task Force, including using best practices and striving for greater efficiencies in the MHS, as well as adjustments to enrollment fees. In particular, the Task Force recognized the need to rebalance the share of health care costs borne between the government and the military retiree. In accordance with the Task Force's recommendation, the fee increases for FY 2009 will mirror the Task Force's ramp to the steady state fees. On average, the enrollment fee for a retiree and family (not Medicare eligible) in TRICARE Prime will increase from \$460 to \$827 per year, with the majority of families (those with retired pay of less than \$20,000) seeing a modest increase to \$728 per year, which is roughly an increase of \$22 per month. The Task Force also included in the recommendations an introduction of an enrollment fee for TRICARE Standard, as well as increases in the Prime visit co-pays, the Standard Deductible, and pharmacy co-pays. Accordingly, we revised the savings assumption to reflect Task Force recommendations implemented over a three-year phase-in period; this assumption yields \$1.2 billion in savings.

Our primary mission is sustaining a medically ready military force and providing world-class health services for those injured and wounded in combat. Military commanders, defense leaders and our elected officials rightly expect us to simultaneously manage health care costs and provide outstanding health care to our beneficiaries. We are working hard to manage all the MHS more efficiently and effectively.

We are bringing about the most comprehensive changes to our system in a generation through the BRAC. The BRAC recommendations will improve use and distribution of our facilities nationwide, and affect health care delivery and medical training across the MHS. The consolidation of medical centers in the National Capital Area and San Antonio will improve operations by reducing unnecessary infrastructure, rationalizing staff, and providing more robust platforms to support Graduate Medical Education. In some areas, we expect to significantly enhance care by providing services closer to where our beneficiaries reside, for example at Fort Belvoir, Virginia. By contrast, in smaller markets, MHS facilities will cease to provide inpatient services and instead focus on the delivery of high-quality ambulatory care. The BRAC recommendations will bring most medical enlisted training programs to Fort Sam Houston. As a result, the MHS will reduce its overall technical-training infrastructure while strengthening the consistency and quality of training across the Services.

We have important activities underway at all facilities affected by BRAC. The key to our success in BRAC is a sound planning principle that is shaping these new structures in ways that are joint, interoperable, non-redundant, and effective. In short, we will build the platforms necessary to "train as we fight."

We do have an unprecedented opportunity now to take the first steps in modernizing many of our key facilities through the BRAC program, global re-stationing,

Army Modularity, and the regular medical MILCON program. We can ensure our hospital designs promote integrity during the clinical encounter, empower our patients and families, relieve suffering, and promote long-term health and wellness. Hospitals that say “we care and are not satisfied with anything but excellence” attract patients and clinicians.

We can deliver this healing environment, and we can use evidence-based design and quantify the outcomes. For example, there is compelling evidence of the relationship between providing high-efficiency particulate air (HEPA) filtration in areas where we care for severely immunocompromised patients. If HEPA filtration exists where we treat burn patients, surgical patients, neutropenic patients, bone-marrow transplant patients, and children with acute myelogenous leukemia, we will avoid unnecessary infections. And, we will save lives. In addition, increasing natural light, reducing noise, and maximizing exposure to nature all have quantitative outcomes that can – and are – being measured.

We will also replace the aging and overcrowded facilities at the United States Army Medical Research Institute for Infectious Diseases (USAMRIID) with a cutting-edge, modern research facility that will continue to produce medical countermeasures to the world’s deadliest diseases. The new USAMRIID will serve as the cornerstone of the emerging National Biodefense Campus at Fort Detrick, Maryland, which is currently under development with the Department of Homeland Security and the National Institute of Allergy and Infectious Diseases. We are building a replacement facility to support the U.S. Army Institute of Chemical Defense (USAICD) at Aberdeen, Maryland, the nation’s premier center of excellence to identify and develop medical countermeasures for chemical warfare agents. The transformation of our physical infrastructure helps us meet the demands of the evolving war on terrorism and the potential threats we face today.

Despite efficiently managing health care costs and utilizing a variety of initiatives, we have much work to do. We continue to use a number of proven means to reduce health care costs in our system. These include:

- Obtaining significant discounts for pharmaceuticals at our MTFs and mail-order venue, making voluntary pricing agreements with pharmaceutical manufacturers to lower our costs in the TRICARE Retail Pharmacy Network, and implementing discounted federal pricing for prescription drugs dispensed through the TRICARE retail pharmacy program;
- Continuing to effectively manage the DoD Uniform Formulary. We avoided approximately \$450 million in drug costs in FY 2006, and over \$900 million in drug costs in FY 2007 due to key formulary-management changes and decisions;
- Contract strategies. We have reduced administrative costs through effective TRICARE contracting strategies, and our effort to further enhance the next generation of the TRICARE contracts is well underway;

- Further increases in VA and DoD sharing of facilities, capabilities, and joint procurements; and
- The introduction of new prime vendor agreements to lower costs of MTF medical and surgical supplies. The MHS has aggressively negotiated preferential pricing with medical supply vendors across the country, and we project cost avoidance of \$28.3 million.

We began implementation of the Prospective Payment System (PPS) in FY 2005. Its purpose is to adjust the medical budgets of the three direct care components (Army, Navy, Air Force) based on their performance, rather than previous spending levels. Up to the present, that performance has been measured in basic units of outputs. Performance, however, is not just a function of the number of activities, but also the quality of those activities in meeting the needs of the beneficiary population. We are exploring ways to modify our budgeting approach to recognize that the quality of those activities is also key.

Using our strategic planning tool – The Balanced Scorecard – we are identifying the most critical mission activities, and then applying Lean Six Sigma methodology to create a data-driven, decision-making culture for process improvement. The Service Surgeons General have aggressively incorporated this methodology into their business operations, and we are already witnessing the fruits of this commitment to building better processes. We have also hired a nationally recognized expert in Lean Six Sigma to help facilitate integration of the National Capital Area and San Antonio under our BRAC work.

In the fall 2006, we began the Innovations Investment Program, to identify the best practices in place at select MTFs or best practices utilized by private-sector health care firms and introduce them to DoD on a global scale. Our intent is to accelerate the use of best practices, using a joint-service, interdisciplinary team of experts to evaluate, validate and then implement proven approaches to better health care delivery. The evaluation phase is already underway, and we plan to begin substantive program changes in the coming year.

As the civil and military leaders of the Department have testified, we must place the health benefit program on a sound fiscal foundation or face adverse consequences. Costs have more than doubled in six years – from \$19 billion in FY 2001 to \$39 billion in FY 2007 – despite MHS management actions to make the system more efficient. Our analysts project this program will cost taxpayers at least \$64 billion by 2015. These increases are attributable to the extension of TRICARE coverage to Reservists, TRICARE for Life, TRICARE’s increasing services (which have led many to drop their employer plan), an aging population, the war, and medical inflation. .

Over the last 13 years, the TRICARE benefit was enhanced through reductions in co-pays, expansions in covered services (particularly for Medicare-eligible beneficiaries), new benefits for the Reserve Component, and other additions, but the premiums paid by beneficiaries have not changed. The benefit enhancements have come at a time when

private-sector employers are shifting substantially more costs to employees for their health care.

The twin effect of greater benefits for DoD beneficiaries with no change in premiums, coupled with reduced civilian benefits for military retirees employed in second careers in the private sector, has led to a significant increase in military retirees electing to drop their private health insurance and become entirely reliant on TRICARE for their health benefit.

Simply put, the Department and Congress must work together to allow the Department to make necessary changes to the TRICARE benefit to better manage the long-term cost structure of our program. Failure to do so will harm military health care and the overall capabilities of the DoD – outcomes we cannot afford. To this end, we must promote innovation and choice and use individual and team incentives in order to improve quality, satisfaction, and cost effectiveness.

Sharing Initiatives with VA. We have fallen short in several areas relating to those recuperating from injury and those seeking to move forward with their lives. We are committed to identifying and correcting the shortcomings that involve the joint responsibilities of DoD and VA. We have already begun working with our colleagues on corrective action.

DoD and VA are currently working on five major areas: Facilities, including housing for soldiers; case-worker and family-support personnel; improved disability determination processes; special care for TBI and the severely injured; and emphasis on care for those diagnosed with mental health conditions and post-traumatic stress disorder. Together, the DoD and our colleagues at VA will not rest until we can provide that same level of health care when the wounded come home to begin their rehabilitation and recovery.

While Service members and their families have been satisfied with health care, change is needed in the delivery of benefits. The Federal Recovery Coordination program began in November 2007 as a pilot. The role of Federal Recovery Coordinators is to be the ultimate resource to oversee the development and implementation of services across the continuum of care from recovery through rehabilitation to reintegration, in coordination with relevant governmental, private, and non-profit programs.

The 2008–2010 VA/DoD Joint Strategic Plan will improve the quality, efficiency, and effectiveness of the delivery of benefits and services to veterans, Service members, military retirees, and their families through an enhanced VA and DoD partnership. The plan incorporates the ability for a Service member to transition from one department to another and back again. The plan also has concrete performance measures and strategies that link directly to the actions of the SOC, such as joint communications, improved case management, better information sharing, and collaborative training and continuing education for health care providers.

As we continue to seek ways to improve the health care for our beneficiaries, we constantly explore new avenues of partnership with the VA. In FY07, we established 280 direct sharing agreements covering 148 unique health services with the VA. Also in FY07, 104 VA medical centers reported reimbursable earnings as TRICARE network providers. Every day we collaborate to further improve the health care system for our Service members. We have substantially increased joint procurement, and we have completed four new jointly used evidence-based clinical practice guidelines for amputation, chronic obstructive pulmonary disease, chronic kidney disease, and low back pain to improve patient outcomes.

We are committed to working with the VA on appropriate electronic health information exchanges to support veterans. The Federal Health Information Exchange (FHIE) enables the transfer of protected electronic health information from DoD to the VA at the time of a Service member's separation. We have transmitted messages to the FHIE data repository on more than 4.1 million retired or separated Service members.

Building on the success of FHIE, we also send electronic pre- and post-deployment health assessment and post-deployment health reassessment information to the VA. We began this monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository in September 2005, and the post-deployment health reassessment in December 2005. As of January 2008, VA had access to more than 2.0 million pre- and post-deployment health assessments and post-deployment health re-assessment forms on more than 838,000 separated Service members and demobilized National Guard and Reserve members who had been deployed.

The Bidirectional Health Information Exchange (BHIE) enables real-time sharing of health data for patients being treated by DoD and VA. Access to BHIE data is available through AHLTA and through VistA, the VA's electronic health record, for patients treated by both departments.

To increase the availability of clinical information on a shared patient population, VA and DoD have collaborated to further leverage the BHIE functionality to allow bidirectional access to inpatient documentation from DoD's Essentris System. In December 2007, we announced the enterprise-wide release of enhancements to the BHIE and the Clinical Data Repository/Health Data Repository (CHDR) interfaces. With these enhancements, DoD and VA are now able to view each other's clinical encounters, procedures, and problems lists on shared patients using the BHIE. This adds to the pharmacy, allergy, microbiology, chemistry/hematology data, and radiology reports we made available previously.

Additionally, DoD and VA providers may now view theater data (including inpatient data) from the Theater Medical Data Store (TMDS). And, DoD providers no longer have to log out of AHLTA and into another application to see it.

To support our most severely wounded and injured Service members transferring to VA Polytrauma Centers for care, DoD continues to send radiology images and scanned

paper medical records electronically to the VA Polytrauma Centers. WRAMC, National Naval Medical Center (NNMC) Bethesda, and Brooke Army Medical Center (BAMC) are providing radiology images electronically for patients transferring to the VA Polytrauma Centers in Tampa, Richmond, Palo Alto, and Minneapolis. Additionally, WRAMC, BAMC and NNMC scan medical records to create portable document format (PDF) documents for electronic transmission for patients transferring to the four VA Polytrauma Centers.

We have worked closely with our partners in the VA, in our shared commitment to provide our Service members a seamless transition from the MHS to the Department of Veterans Affairs. DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness," which provides guidance for collecting and transmitting critical data elements for Service members involved in a medical or physical evaluation board. DoD began electronically transmitting pertinent data to the VA in October 2005 and continues to provide monthly updates, allowing the VA to better project future workload and resource needs.

We have provided information for more than 28,000 Service members while they were still on active duty, allowing the VA to better project future workload and resource needs. When the VA receives these data directly from DoD before Service members separate, it helps to reduce potential delays in developing a benefits claim. This process ensures that the VA has all the relevant information to decide claims for benefits and services in a timely manner.

The Legacy of Military Medicine

American military medicine has led the world in epidemic surveillance, response, trauma care, disaster medicine, health information technology, fitness and prevention.

U.S. military medicine and our medical personnel are national assets, representing a readiness capability that does not exist anywhere else, and – if allowed to dwindle – could not be easily reconstituted. We must preserve these assets.

As we address the problems that lie at the intersection of personnel issues and health care delivery, it is our shared responsibility to focus on the specific problems, and not the people who have done so much to improve the health of our military Service members. We are blessed with a rich cadre of dedicated, hard-working, skilled professionals. I have complete confidence that they are rising to the occasion, learning from what went wrong, and building an even stronger, more responsive system for all.

Conclusion

Our military engagements in Iraq, Afghanistan and other locations, combined with our medical humanitarian missions and our peacetime health delivery mission have simultaneously tested the MHS. Our medics, corpsmen, nurses and surgeons operating in tents, on ships, and in planes, continue to exceed the expectations of all our stakeholders.

Yet, the critical concept that MHS leaders share is simple – we can never be satisfied with our accomplishments. The people we serve – our line commanders and civilian leadership; our Service members and military families; and the representatives of the American people in the Congress – expect us to accomplish even more, and to build upon our successes.

There is more work to do: We must invest in medical technologies to protect and defend our military community against future threats; provide wise stewardship of limited taxpayer dollars to sustain a quality health system serving more than nine million Americans; and commit to continued military and professional development of medical professionals of all types – physicians, dentists, nurses, enlisted specialists, and administrators.

Many people in many places have very high expectations for this country’s military health system. Our responsibility in the coming years is to exceed these expectations. Our obligations are to those who follow us – today’s sergeants and corporals, lieutenants and captains, and civilians now rising through the system.

With the support of the DoD leadership and of the Congress, the MHS remains committed to sustaining and passing on this legacy of achievement and stewardship for the medical leaders of the future. On behalf of the MHS, I am grateful for the resources and encouragement you provide to all who serve, and look forward to working with you this year.

- END -

STATEMENT ON
FUTURE OF THE MILITARY HEALTH SYSTEM
BY DR. GAIL R. WILENSKY
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ON THE FUTURE OF MILITARY HEALTH CARE
BEFORE THE
SUBCOMMITTEE ON MILITARY PERSONNEL
ARMED SERVICES COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES

MARCH 12, 2008

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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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STATEMENT ON
FUTURE OF THE MILITARY HEALTH SYSTEM
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BEFORE THE
SUBCOMMITTEE ON MILITARY PERSONNEL
ARMED SERVICES COMMITTEE
UNITED STATES HOUSE OF REPRESENTATIVES
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Good morning. I would like to thank the Subcommittee for inviting me to testify today on the subject of the health and financial benefits of worksite health promotion programs. My name is Ron Goetzel. I have been involved in research focused on worksite health promotion programs for the past 20 years while employed at Johnson & Johnson, Thomson Healthcare (formerly Medstat), Cornell University, and Emory University.

Over the past 20 years, my work has focused on large-scale evaluations of health promotion, disease prevention, demand and disease management programs. My evaluations have focused on large employer efforts in this area including those at Applied Materials, Boeing, Chevron, Citibank, Dow Chemical, Johnson & Johnson, IBM, Procter & Gamble, Florida Power & Light, Duke University, Sharp Health Care, Saturn Corporation, PG&E, The Associates, Novartis, Highmark, General Electric, Ford, Motorola, Delta, Lucent, International Truck and Engine, First Tennessee Bank, and Texas Instruments, to name but a few.

Defining Worksite Health Promotion

Before going any further, I'd like to define worksite health promotion programs for the subcommittee. Worksite health promotion programs are employer initiatives directed at improving the health and well-being of workers and, in some cases, their dependents. They include programs designed to avert the occurrence of disease or the progression of disease from its early unrecognized stage to one that's more severe. At their core, worksite health promotion programs support primary, secondary, and tertiary prevention efforts.

Primary prevention efforts in the workplace are directed at employed populations that are generally healthy. Examples include programs that encourage exercise and fitness, healthy eating, weight management, stress management, use of safety belts in cars, moderate alcohol consumption, and recommended adult immunizations.

Health promotion also incorporates secondary prevention directed at individuals already at high risk because of certain lifestyle practices (e.g., smoking, being sedentary, having poor nutrition, consuming excessive amounts of alcohol, and experiencing high stress) or abnormal biometric values (e.g., high blood pressure, high cholesterol, high blood glucose, overweight). Examples of secondary prevention include hypertension screenings and management programs, smoking cessation telephone quit lines, weight loss classes, and reduction or elimination of financial barriers to obtaining prescribed lipid-lowering medications.

Health promotion sometimes also includes elements of tertiary prevention, often referred to as disease management, directed at individuals with existing ailments such as asthma, diabetes, cardiovascular disease, cancers, musculoskeletal disorders, and depression, with the aim of ameliorating the disease or retarding its progression. Such programs promote better compliance with medications and adherence to evidence-based clinical practice guidelines for outpatient treatment. Because patient self-management is stressed, health-

promotion practices related to behavior change and risk reduction are often part of disease management protocols.

Establishing a Business Case for Health Promotion

The Centers for Disease Control and Prevention (CDC), in conjunction with its *Healthy People in Healthy Places* initiative, has observed that workplaces are to adults what schools are to children, because most working-age adults spend a substantial portion of their waking hours at work. The question for employers is whether well conceived worksite health promotion programs can improve employees' health, reduce their risks for disease, control unnecessary health care utilization, limit illness-related absenteeism, and decrease health-related productivity losses.

There is growing evidence that the answer is "yes." Here is the logic for increased investment in health promotion:

- 1) Many of the diseases and disorders from which people suffer are preventable.
- 2) Modifiable health risk factors are precursors to a large number of these diseases and disorders.
- 3) Many modifiable health risks are associated with increased health care costs and reduced worker productivity, within a relatively short time window.
- 4) Modifiable health risks can be improved through health promotion and disease prevention programs.
- 5) Improvements in the health risk profile of a population can lead to reductions in health care costs and absenteeism, and heightened productivity or readiness.
- 6) Well-designed and well-implemented worksite health promotion and disease prevention programs can save money, and in our research actually produce a positive return on investment (ROI).

I would now like to highlight some of the salient studies supporting these points.

Many Diseases and Disorders are Preventable, Yet Costly

A large body of medical and epidemiological evidence shows the links between common, modifiable, behavioral risk factors and chronic disease.¹ Preventable illnesses make up approximately 70 percent of the total burden of disease and their associated costs.¹ Half of all deaths in the U.S. are caused by behavioral risk factors and behavior patterns that are modifiable.^{2,3} In particular, the U.S. has been witnessing alarming increases in obesity, diabetes, and related disorders for many years.⁴ These diseases strain the

resources of the health care system, as individuals who experience them generate significantly higher health care costs.⁵

Modifiable Health Risks Increase Employer Costs

Analyses by Anderson et al.,⁶ show that ten modifiable health risk factors account for approximately 25 percent of all health care expenditures for employers. Moreover, employees with seven risk factors (tobacco use, hypertension, hypercholesterolemia, overweight/obesity, high blood glucose, high stress, and lack of physical activity) cost employers 228% more than those lacking those risk factors.⁷ Workers with these risk factors are more likely to be high-cost employees in terms of absenteeism, disability, and reduced productivity.⁸

Workplaces Offer an Ideal Setting for Health Promotion

Most people agree that the workplace presents an ideal setting for introducing and maintaining health promotion programs. The workplace contains a concentrated group of people, who share a common purpose and common culture. Communication and information exchange with workers are relatively straightforward. Individual goals and organizational goals, including those related to increasing productivity, or readiness in military parlance, are generally aligned with one another. Social support is available when behavior change efforts are attempted. Organizational norms can help guide certain behaviors and discourage others. Financial or other incentives can be introduced to encourage participation in programs. Measurement of program impact is often practical using available administrative data collection and analysis systems.

Worksite Health Promotion Can Positively Influence Employees' Health Risks

An important question to consider is whether worksite programs can change the risk profile of workers? Here again, the evidence points to a positive result. Catherine Heaney and I examined 47 peer-reviewed studies, over a 20-year period, focused on the impact of multi-component worksite health promotion programs on employee health and productivity outcomes.⁹ We concluded that there was "indicative to acceptable" evidence supporting the effectiveness of multi-component worksite health promotion programs in achieving long-term behavior change and risk reduction among workers. The most effective programs offered individualized risk-reduction counseling, coaching and self-management training to the highest risk employees within the context of a healthy company culture and supportive work environment.⁹

More recently, the CDC Community Guide Task Force released the findings of a comprehensive and systematic literature review focused on the health and economic impacts of worksite health promotion.^{10,11}

Health and productivity outcomes from worksite interventions were reported from 50 studies. The outcomes included a range of health behaviors, physiologic measurements, and productivity indicators linked to changes in health status. Although many of the changes in these outcomes were small when measured at an individual level, such changes at the population level were considered substantial.

Specifically, the Task Force found strong evidence of worksite health promotion program effectiveness in reducing tobacco use among participants, dietary fat consumption, high blood pressure, total serum cholesterol levels, the number of days absent from work because of illness or disability, and improvements in other general measures of worker productivity. Insufficient evidence of effectiveness was found for some desired program outcomes, such as increasing dietary intake of fruits and vegetables, reducing overweight and obesity, and improving physical fitness. But overall, the review of literature came up with very positive findings related to health and economic outcomes.

Worksite Health Promotion Can Achieve a Positive Return on Investment

There is now a growing body of evidence suggesting that worksite programs can also save money and even pay for themselves. Several literature reviews that weigh the results from experimental and quasi-experimental research studies suggest that programs grounded in behavior change theory and that utilize tailored communications and individualized counseling for high-risk individuals achieve cost savings and produce a positive return on investment.^{12,13,14} The ROI research is grounded in evaluations of employer-sponsored health promotion programs. Studies often cited with the strongest research designs and large numbers of subjects included those performed at Johnson and Johnson,^{15,16} Citibank,¹⁷ Dupont,¹⁸ the Bank of America,^{19,20} Tenneco,²¹ Duke University,²² the California Public Retirees System,²³ Procter and Gamble,²⁴ and Chevron Corporation.²⁵ In a widely cited example of a rigorous ROI analysis, Citibank reported a savings of \$8.9 million in medical expenditures from its health promotion program as compared to a \$1.9 million investment, thus achieving an ROI of \$4.56 to \$1.00.¹⁷ A recent contribution to the ROI literature can be found in a study published in the February 2008 issue of the *Journal of Occupational and Environmental Medicine* which found a \$1.65 to \$1.00 ROI for a worksite program put in place at Highmark, a health plan in Pennsylvania.²⁶ Even accounting for certain inconsistencies in design and results, most of these worksite programs produced positive cost outcomes.

Conclusion

In summary, I have put forth some of the main arguments in favor of increased investment in health promotion programs for the military. I believe that these programs will not only improve the health and readiness of our soldiers but also save money in the long run.

Thank you again for your time and attention and I welcome your questions and comments.

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Information From:

Ron Z. Goetzel, Ph.D., Research Professor and Director Institute for Health and Productivity Studies Emory University, Rollins School of Public Health. Vice President, Consulting and Applied Research Thomson Healthcare 4301 Connecticut Ave., NW -- Suite 330 Washington, DC 20008

Federal Contract Information: If you or the entity you represent before the Committee on Armed Services has contracts (including subcontracts) with the federal government, please provide the following information:

Number of contracts (including subcontracts) with the federal government:

Current fiscal year (2008): 74 _____;
 Fiscal year 2007: 60 _____;
 Fiscal year 2006: 52 _____.

Federal agencies with which federal contracts are held:

Current fiscal year (2008): DHHS Agencies (CMS, AHRQ, CDC, SAMHSA, PSC), U.S. Dept of Veterans Affairs, Natl Bureau of Economic Research, Institute for Defense Analysis;
 Fiscal year 2007: DHHS Agencies (CMS, AHRQ, CDC, SAMHSA, PSC), U.S. Dept of Veterans Affairs, Natl Bureau of Economic Research;
 Fiscal year 2006: DHHS Agencies (CMS, AHRQ, CDC, SAMHSA, PSC), U.S. Dept of Veterans Affairs, Natl Bureau of Economic Research, Congressional Research Service.

List of subjects of federal contract(s) (for example, ship construction, aircraft parts manufacturing, software design, force structure consultant, architecture & engineering services, etc.):

Current fiscal year (2008): Healthcare research & consulting services and licensed data;
 Fiscal year 2007: Healthcare research & consulting services and licensed data;
 Fiscal year 2006: Healthcare research & consulting services and licensed data.

Aggregate dollar value of federal contracts held:

Current fiscal year (2008): \$52,000,000 _____;
 Fiscal year 2007: \$87,500,000 _____;
 Fiscal year 2006: \$33,500,000 _____.

Federal Grant Information: If you or the entity you represent before the Committee on Armed Services has grants (including subgrants) with the federal government, please provide the following information:

Number of grants (including subgrants) with the federal government:

Current fiscal year (2008): 2 _____;
 Fiscal year 2007: 4 _____;
 Fiscal year 2006: 4 _____.

Federal agencies with which federal grants are held:

Current fiscal year (2008): DHHS (CDC and NIH) _____;
 Fiscal year 2007: DHHS (CDC and NIH), U.S. Dept of Education (TIRR/TLRU);
 Fiscal year 2006: DHHS (CDC and NIH), U.S. Dept of Education (TIRR/TLRU).

List of subjects of federal grants(s) (for example, materials research, sociological study, software design, etc.):

Current fiscal year (2008): Healthcare research & consulting services and licensed data;
 Fiscal year 2007: Healthcare research & consulting services and licensed data;
 Fiscal year 2006: Healthcare research & consulting services and licensed data.

Aggregate dollar value of federal grants held:

Current fiscal year (2008): \$1,300,000 _____;
 Fiscal year 2007: \$1,600,000 _____;
 Fiscal year 2006: \$1,000,000 _____.

DOCUMENTS SUBMITTED FOR THE RECORD

MARCH 12, 2008

Memo

To: Lorraine Lewis
From: Joan Veal
David Richards
Re: Outline of Mail Order savings and Explanatory Notes
CC: Bill Chisholm
Joel Kavet
Date: 03/18/2008

In response to your request for information about the Funds' prescription mail service savings, please forward the following to Trustee Wilensky. Also, let her know that we can supply more detailed or additional information if desired.

Information about Mail Savings Calculations:

In general, higher savings at mail service occur due to a) significantly higher discounts off the AWP price than the Funds receives at retail pharmacies, b) elimination of all dispensing fees at mail service and c) higher rebates for mail service prescriptions.

Specifically (2007 data):

- (1) Drug cost: the average cost per days' supply was slightly lower at mail service (\$1.96 versus \$2.01); with just under 17 million days of medication supply dispensed at mail service, this translates to about \$850,000 in savings¹. However, the mail prescription mix of drugs was significantly different than at retail pharmacies and cannot be used alone as a comparative.
- (2) Rebates: for 2007, the rebate level for mail service was 3.3 times higher than for retail services, although the days' supply was only 2.5 times higher. The 2007 savings related to mail order prescription rebates was greater than \$5.00 per prescription.

¹ Based on amount actually paid, which includes co-payments and differentials; mail order has lower costs despite lower co-payments.

(3) Dispensing fee: dispensing fees are eliminated at mail service; the 2007 related savings was greater than \$5.00 per prescription.

(4) For the Funds, each 2% increase in mail service saves us over \$1.0 million per year.

Methodology for calculating mail service savings: Savings are compiled by tabulating the cost of each individual mail order prescription, versus receiving the same days' supply of the same drug at a retail pharmacy. These individual prescription differences in cost are then tabulated together to accrue the total savings.² Individual prescription discounts vary, and, within the total mix of drugs dispensed to the Funds there will occasionally be prescriptions that are actually less expensive at retail establishments. Within the top 50 drugs for 2007 however, all but one drug were less expensive at mail service than through the retail network. Some examples, adjusted to the average 34 day supply obtained at retail pharmacies:

Brand Drug A #4 (Average 2007 AWP= \$163.78)

(1) Average gross cost ³ , 34 days retail:	\$31.98
(2) Average gross cost, 34 days mail :	<u>28.40</u>
Difference:	\$ 3.58 (11.2%)

Generic Drug B # 10 (Average 2007 AWP= \$ 32.48)

(1) Average gross cost, 34 days retail:	\$13.91
(2) Average gross cost, 34 days mail:	<u>8.61</u>
Difference:	\$ 5.30 (38%)

There is no doubt that PBMs make a profit on their mail order business. In particular, mail order generics are most profitable for PBMs. PBMs assure that their contracting terms do result in an overall savings for use of their service versus retail services. They want to drive business to their mail service.

² Higher discounts for most prescriptions result in a higher aggregate total savings. However, discounts may vary by generic manufacturer; for some individual prescriptions the charge may be higher at mail service.

³ Gross cost includes dispensing fee, minus related rebate amounts.

REVIEW OF TASK FORCE REPORT
RELATIVE TO PHARMACY MAIL ORDER

PURPOSE: The purpose of this review is to elaborate on the Task Force's recommendations designed to increase the use of mail order for medications under the TRICARE program. It is intended to respond to the request by Congresswoman Boyda for more information on cost comparisons between retail pharmacy and mail order. This request was made during Dr. Wilensky's appearance on behalf of the DoD Task Force on the Future of Military Health Care before the Personnel Subcommittee of the House Armed Services Committee at a hearing on March 12, 2008.

SUMMARY OF TASK FORCE RECOMMENDATIONS RELATING TO MAIL ORDER:

For tier 1 drugs (which would be "preferred" drugs, not simply "generic" drugs per proposed formulary changes), the co-payment for mail-order (i.e., the TRICARE Mail Order Program, hereinafter "TMOP") a 90-day prescription would be reduced from \$3 to \$0. Co-payments in the TRICARE retail network (a 30-day prescription) would be increased from \$3 to \$15.

For tier 2 drugs (which would be called "other" instead of "brand name"), the TMOP co-payment would be increased from \$9 to \$15, and that for retail (again, 30- vs. 90- days) from \$9 to \$25.

For tier 3 drugs (non-formulary), both the TMOP and retail co-payments would be increased from \$22 to \$45 (still a 30- vs. 90- price advantage for selecting mail order).

[In cases under the TRICARE programs in which percentages (for co-payment or co-insurance) apply rather than fixed dollar amounts, no changes to the relative percentages were recommended.]

In addition to the above financial incentives, in its interim report (May, 2007), the Task Force recommended that DoD engage in an outreach program to publicize the value of using TMOP. Since then, TMA has developed a new outreach program. In its final report (hereinafter, the "Report"), the Task Force said that this recently fielded educational initiative must be fully implemented and monitored for effectiveness, and revised as necessary.

SUMMARY OF ANALYSIS

Before adopting the above recommendations, and as part of its analysis and deliberations, the Task Force considered but rejected a mandatory mail-order program.

The Task Force recognizes the value of access to the local pharmacy for beneficiaries. Indeed, for certain drugs and for certain beneficiaries, there is no practicable alternative.

However, when there are options, financial incentives should help increase mail-order usage.

The \$0 co-payment was carefully considered before its acceptance by the Task Force. The Task Force viewed the overall projected cost-savings from increased use of mail-order justified a zero amount. The principle of increasing the cost-differential between points of service was viewed as more important than the actual co-payment numbers selected. However, the actual numbers selected did take into account how the TRICARE co-payment structure compares to other drug plans (the plan should be more generous and should consider price points that affect patient behavior in selecting the point of service).

The analysis also factored in another important concern: beneficiaries in the TRICARE program can use the outpatient pharmacy of the Military Treatment Facilities (MTF) without cost to the beneficiary. Of course, time and distance may eliminate or reduce this option for many beneficiaries.

Underlying all of the analysis of the pharmacy benefit and its associated costs is that medication is part of medical treatment, and must be connected to overall medical treatment—overall clinical effectiveness and overall medical spending. For example, the changes to the pharmacy cost-sharing structure should not adversely affect medical care by creating or increasing financial burdens that undermine appropriate use medication (e.g., lower usage could be offset by higher hospitalizations). Changes must not adversely affect beneficiaries' health.

The Task Force recognizes the value of the retail pharmacy and face-to-face interaction with the pharmacist the importance of such access to TRICARE beneficiaries.

The Task Force also heard evidence on federal pricing at the retail point of service but declined to make any recommendation on that matter.

The Task Force also heard evidence of how pharmaceutical costs are greatly affected by prescription practices, but did not make any recommendations in this area as well.

The Task Force considered other existing models with the Military Health System (MHS) for pharmacy delivery, to include the Department of Veterans Affairs Consolidated Mail Outpatient Pharmacy, the use of DoD refill centers, and the use of a centralized high-dollar pharmacy. The Task Force did not find that they had been adequately evaluated in terms of goals, costs, savings, or requirements, and thus chose not to make recommendations concerning their continuation, expansion, or cessation.

COST AND COST-RELATED INFORMATION ON MAIL ORDER AND RETAIL PHARMACY

The MHS average cost for a retail prescription for 30-day equivalents (as of March 2007) is \$70. For TMOP, it was \$34. For the MTF, it was \$19. This data was presented by

DoD [see page 76 of Report]. The Report notes that it is not clear whether these data reflect the actual costs of dispensing. It states: “To truly understand the differences in costs, DoD would have to ensure that the total costs of dispensing—not just drug costs—are included in cost comparisons.” [page 76 of Report] Furthermore, “cost comparisons must be made using specific medications.” [page 76 of Report] Elsewhere in the Report [mostly in chapter 5 at pages 31 to 35], the Task Force cites deficiencies in MHS accounting systems and reporting. It notes the need for significant improvement.

The Task Force examined previous reports and studies in reaching its recommendations. In 2005, DoD asked RAND to assess factors contributing to rising costs of prescription medications for military retirees and their families. That study, through an examination of claims data, noted the significant increase in pharmacy costs after Congress expanded the pharmacy benefit for Medicare-eligible beneficiaries (the TRICARE Senior Pharmacy Program). Coincident with this change, there was a significant shift in pharmacy activity from MTFs to the retail channel for delivery. In part, because of higher prices to DoD from the use of retail pharmacies, they became the largest component of DoD’s pharmaceutical costs. [page 80 of Report] As noted above, apart from price differences, the increased cost of retail is due to lack of access to MTFs or unavailability of certain drugs at the MTF.

In encouraging greater use of TMOP, the Task Force considered that TMOP incentives would help offset the costs resulting from increased use of retail pharmacies. This view is consistent with trends and cost-containment strategies in the private sector. “Mail order pharmacy is the fastest growing segment of the retail pharmacy marketplace.” [page 80 of Report]

The Task Force received testimony from those associated with DoD programs and from those representing private industry relevant to its recommendations in this area, salient parts of which are summarized below.

At the February 6, 2007, Task Force meeting, Rear Admiral Thomas J. McGinnis, Chief of the Pharmaceutical Operations Directorate of the TRICARE Management Activity, provided an overview of the DoD Pharmacy Program. He testified that the mail order network was underutilized and stated that DoD paid about 40 percent less for the same product in mail order of what is paid in the retail network. [Transcript at page 70]. It is not entirely clear to what extent this difference reflects the impact of voluntary price agreements to obtain utilization rebates from manufacturers for drugs dispensed in the retail network. There was testimony that those agreements were not used until DoD “lost” a federal lawsuit in late 2006 that precluded DoD’s use of mandatory rebates. The speaker stated that discounts were “very limited” at that time. [Transcript, pages 70-71]. A statement that retail pharmacy represents 50 percent of the workload but constitutes 63 percent of the spending corroborates the assessment of a higher price in the retail segment. Admiral McGinnis specifically stated that for the top 50 drugs available across all points of service, it is 50 percent more for those same products in the retail channel. [Transcript at page 72] This level of granularity is not contained in the Report itself. The Task Force also received evidence that for private insurance companies, for example,

mail order usage typically represents 20 to 25 percent of prescriptions filled versus 7 percent in DoD plan. [page 82 of the Transcript]

The Honorable David M. Walker, Comptroller General of the United States, briefed the Task Force on April 18, 2007, encouraging it to recommend that DoD bring its co-payment structure for prescription medications into parity with those of other public and private payers to increase use of the less expensive mail order option over the use of more expensive retail pharmacies. [Report at page 84]

At the same meeting, MEDCO and Express Scripts, major pharmacy benefit managers, explained how highly automated, high-volume mail order dispensing can move prescriptions from the retail channel to lower cost mail service for maintenance drugs.

TriWest, one of the managed care support contractors stated that "DoD could and should modify pharmacy co-payments to promote home delivery of prescriptions in lieu of in-store purchases." [Report at page 84]

On March 7, 2007, Ms. Deirdre Parke Hollomon of the Retired Enlisted Association testified to the Task Force specifically on the present functioning of the DoD pharmacy program:

The least expensive method of dispensing drugs for the Department of Defense seems clearly to be through the MTFs, although it is difficult to calculate the exact costs of an MTF's pharmacy operation. However, with a series of closings and downsizings as MTF clinics as mentioned before there are fewer and fewer beneficiaries who are able to use MTFs. Next in cost, thanks to the federal pricing and the TMOP contract, is a mail order program home delivery program. It saves DoD a great deal of money compared to dispensing drugs to the retail pharmacy network when the program is used for appropriate drugs. We are told that approximately 40 percent of the drugs presently ordered through the various TRICARE pharmacy sites would be appropriate for this program... It is calculated that DoD saves \$175 a prescription for the average of the most expensive drugs if filled through TMOP rather than from a pharmacy network [March 7 Transcript at pages 40-42]

Also on that date, the National Association for Chain Drug Stores as well as an official from Walgreen Company testified. Among other things, they described how retail operations work, and the difference in pricing power for brand name drugs and generics. For brand name drugs, they have much less pricing power than they do with generic drugs because of the greater competition for market share in generic drugs. [Transcript at page 145] For brand names, because retail does not control the formulary, the discounts flow from the manufacturers to the health plans or pharmacy benefit managers. Other parts of their testimony explained generally how retail pharmacies are reimbursed—for the product and for the dispensing service. [Transcript at 145-149]

The witnesses acknowledged that the Veterans Healthcare Act of 1992 provided DoD with the authority to negotiate for pricing discounts with drug manufacturers that results in substantial savings, and that currently those discounts are only provided for prescription drugs that are dispensed by military treatment facilities and through TMOP. So that differential is why the prices for retail prescriptions are "artificially high" in comparison. [p.149-150] They said that Congress should clarify that the Department had the authority to negotiate for prices for retail prescriptions" Other programs, virtually every other program receives some type of discount, rebate, or price concession from manufacturer with the exception of the TRICARE retail network. In Medicare Part D prescription drug benefit rebates are provided to both the retail and mail programs, and there is a statutory requirement that those rebates and price concessions must be obtained and must be passed through. [Transcript at pages 149-152]

In summary, there was substantial evidence of a considerably higher price incurred by DoD for prescriptions filled through the retail channel. Without more exactitude in the price difference, the Task Force was convinced that greater use of mail order would be beneficial to the Government and beneficiaries.



Proposed Fee Changes based on Task Force on the Future of Military Health Care Recommendations

- Individual cost shares for TRICARE (annual fees and deductibles) have remained the same since 1995. As a result, the Department pays a continually increasing percentage of its beneficiaries' health costs. In 1995, beneficiaries paid approximately 27 percent of their healthcare costs. Today they pay only 12 percent.
- Even with adjustments, the TRICARE benefit will remain a comprehensive health plan with smaller cost shares than those for the Federal Employees Health Benefit Program and nearly all other health benefit plans in the U.S.

Proposed Changes in TRICARE Cost Share for Retirees and Family

Fiscal Year	Prime ("HMO")		Extra ("PRO") and Standard ("Fee-for-Service)		Pharmacy Co-Payment	
	Enrollment Fee	Enrollment Fee	Standard	Deductible	Retail	Mail Order
					30 Day Supply	90 Day Supply
			Retired Pay \$0 to \$19,999			
<i>FY 07 - Current</i>						
<i>Out-of-Pocket Expenses</i>	\$230 Individual/ \$460 Family			\$150 Individual/ \$300 Family	\$3 General/ \$9 Brand/ \$22 Non-Formulary	\$3 General/ \$9 Brand/ \$22 Non-Formulary
<i>Proposed Rates for FY 09¹</i>	\$364/\$728			\$209/\$417	\$158.25/\$315	\$158.25/\$315
			Retired Pay \$20,000 to \$39,000			
<i>FY 07 - Current</i>						
<i>Out-of-Pocket Expenses</i>	\$230 Individual/ \$460 Family			\$150 Individual/ \$300 Family	\$3 General/ \$9 Brand/ \$22 Non-Formulary	\$3 General/ \$9 Brand/ \$22 Non-Formulary
<i>Proposed Rates for FY 09¹</i>	\$444/\$888			\$32/\$64	\$158.25/\$315	\$158.25/\$315
			Retired Pay \$40,000 and above			
<i>FY 07 - Current</i>						
<i>Out-of-Pocket Expenses</i>	\$230 Individual/ \$460 Family			\$150 Individual/ \$300 Family	\$3 General/ \$9 Brand/ \$22 Non-Formulary	\$3 General/ \$9 Brand/ \$22 Non-Formulary
<i>Proposed Rates for FY 09¹</i>	\$594/\$1,188			\$37/\$75	\$158.25/\$315	\$158.25/\$315

¹Original Task Force Recommendation are in state FY 2008 dollars. Numbers above reflect a 7% index for FY09.

Prime Visit Copays	Outpatient Visits non-Mental Health	ER Visits	Mental Health Visits
Current thru FY 2009 ²	\$12	\$30	\$25 private/\$17 group

²Task Force recommended delay for 2 years then cumulative updates after 5 years with no annual indexing

**WITNESS RESPONSES TO QUESTIONS ASKED DURING
THE HEARING**

MARCH 12, 2008

RESPONSE TO QUESTION SUBMITTED BY MR. MCHUGH

Dr. CASSELLS. Thank you for your follow-up question regarding Veteran Service Organization (VSO) support of TRICARE fee increases. You asked for VSO support in writing. Below, I have provided citations from the VSO websites in which they concede that TRICARE fee increases may be necessary but should not exceed increases in military compensation or should be tied to true healthcare costs. As for my personal conversations with members of the Coalition and Alliance and other VSOs, we do not record minutes for these meetings, as we feel it would discourage the free exchange of ideas that make our interactions so valuable. Thank you for your follow-up question. The Military Health System does understand that knowing the tolerances of fee increases is an important part of the discussion.

“Percent Fee Increase in Any Year Shouldn’t Exceed % Increase in Military Compensation.”

MOAA fee-increase briefing, “Health Care Cost-Shifting to Military Beneficiaries,” MOAA, accessed August 15, 2008. http://www.moaa.org/lac/lac_resources/siteobjects/published/B40B0C69836F0E9D9744C384897CE90C/41BB16DC1E9E71D48DE23BE6A8B7E2EC/file/TRICAREFeeBrief.pdf

“While understanding fee increases may be necessary in the future, NMFA believes all decisions regarding fee increases should be put on hold until the Congressionally-mandated study is completed to determine what efficiencies DOD can implement.”

Joyce Wessel Raezer, Kathy Moakler, “NDAA Conference Committee Debates Many Provisions,” NMFA, accessed August 15, 2008, http://www.nmfa.org/site/PageServer?pagename=ndaa_conference_provisions

“Adjustments to the enrollment fee are acceptable if tied to true healthcare cost.”

CAPT Michael P. Smith, “Statement by CAPT Michael P. Smith, USNR (Ret) National President, Reserve Officers Association of the United States Before the Task Force on the Future of Military Health Care March 7, 2007,” ROA, accessed August 15, 2008, <https://secure2.convio.net/roa/site/SPageServer?pagename=TaskForceHealthCareTestimony&JServSessionsIdr011=cj0uzoxbq1.app5a>

“Prevent DOD plans to significantly increase annual TRICARE Prime enrollment fees for military retirees.”

2007-2008 AFSA Legislative Platform, AFSA, accessed August 15, 2008, https://www.hqafsa.org/AM/Template.cfm?Section=Top_Issues&Template=/CM/HTMLDisplay.cfm&ContentID=2610 [See page 13.]

RESPONSES TO QUESTIONS SUBMITTED BY MRS. BOYDA

Dr. GOETZEL. TRICARE uses several metrics to determine beneficiary satisfaction with the services we provide to eligible beneficiaries. Our primary method of gathering information is through telephone and mail surveys. The information presented to you today represents results from three core surveys that depict beneficiary satisfaction with medical services from the TRICARE network of civilian providers.

The Health Care Survey of DOD Beneficiaries (HCSDB) measures the healthcare experiences of eligible Military Healthcare System (MHS) beneficiaries around the world during the previous 12 months. For comparison, 61 percent of civilian health plan users rated their health plan eight or higher (on scale of 0–10 (0=worst, 10=best)). Among MHS beneficiaries, 60 percent of those enrolled to a civilian primary care manager (PCM) in the North Region rated their health plan eight or higher. Sixty-five percent of those enrolled to a civilian PCM in the South Region rated their health plan eight or higher and 66 percent enrolled in the West Region rated their health plan eight or higher.

The TRICARE Outpatient Satisfaction Survey provides a monthly assessment of beneficiary satisfaction with ambulatory care. For comparison, 72 percent of civilian health plan users rated their healthcare eight or higher (on scale of 0–10 (0=worst,

10=best)). Sixty-four percent of MHS beneficiaries enrolled to a civilian PCM in the North Region rated their healthcare eight or higher. Sixty-six percent of those enrolled in the South Region rated their healthcare eight or higher and 65 percent of West Region enrollees rated their healthcare eight or higher.

The TRICARE Inpatient Satisfaction Survey provides an annual assessment of beneficiary satisfaction with their inpatient experience. For comparison, 60 percent of civilian health plan users rated their inpatient care nine or higher (on scale of 0–10 (0=worst, 10=best)). Among MHS beneficiaries, 59 percent of those enrolled to a civilian PCM in the North Region rated their inpatient care nine or higher. Sixty percent of enrollees in the South Region rated their inpatient care nine or higher, and 60 percent of West Region enrollees rated their satisfaction with a score of nine or higher. [See page 99.]

Dr. WILENSKY. Independent Government Estimate of TRICARE Retail Pharmacy (TRRx) Costs to the Government versus TRICARE Mail Order Pharmacy (TMOP) Costs to the Government

Prior to implementation of the National Defense Authorization Act for Fiscal Year 2008 (FY 2008 NDAA) granting DOD authority to access Federal Pricing discounts in TRRx		
	TRRx (Retail)	TMOP (Mail)
Average cost to the Government for a 90 day supply of brand-name prescription*	\$476.86	\$232.47
After implementation of FY 2008 NDAA Government cost estimates		
Average cost to the Government for a 90 day supply of brand-name prescription*	\$304.55	\$232.47

*Includes overhead, dispensing fees, administrative fees, mailing (in TMOP), and co-pays

DISCUSSION: Based on this analysis, it is estimated that passage of the FY 2008 NDAA will reduce Government retail prescription costs significantly. This analysis also estimates that after initial implementation of FY 2008 NDAA, retail prescription Government costs will remain approximately 24% higher when compared to TMOP.

The prices the Department of Defense (DOD) pays in TMOP are based on Federal Ceiling Price (FCP), which is the maximum price that manufacturers can charge the Big Four (DOD, VA, Public Health, and Coast Guard) for brand-name drugs. The non-federal average manufacturer price (non-FAMP) is the average price paid to the manufacturer by the wholesaler for drugs distributed to non-federal purchasers (such as retail pharmacies). FCP equals 76% of the previous fiscal year's non-FAMP. In retail, after implementation of the FY 2008 NDAA, the refund due to the Government from pharmaceutical manufacturers will be based on the difference between the non-FAMP and the FCP subtracted from the actual retail price paid by the Government. The retail price, before the FY 2008 NDAA mandated refund is applied, reflects the additional costs associated with the retail distribution model. In addition, the DOD Pharmacy and Therapeutics process has obtained prices lower than FCP for some drugs dispensed via mail, which accounts for a portion of the price differential between the retail and mail points of service. [See page 22, and supporting documentation on page 89.]

RESPONSE TO QUESTION SUBMITTED BY MS. SHEA-PORTER

Dr. CASCCELLS. We are not aware of shifting any costs to other taxpayers for providing healthcare to military veterans and their families. By law, title 42 United States Code (U.S.C.), section 1395cc(a)(1)(J), acute care hospitals accepting Medicare beneficiaries must also accept TRICARE beneficiaries, and we pay for care covered by the TRICARE benefit, which covers all medically necessary treatments for injuries or illnesses (title 10, U.S.C., section 1079(a)(13)). TRICARE is the primary payer for care provided by the States through their Medicaid programs.

While we cannot positively rule out the possibility that one or more States have other taxpayer-funded programs that would pay for the healthcare for patients with a federal health benefit, we are not aware of such programs. [See page 25.]

QUESTIONS SUBMITTED BY MEMBERS POST HEARING

MARCH 12, 2008

QUESTIONS SUBMITTED BY MR. MCHUGH

Mr. MCHUGH. Assistant Secretary Casscells, your testimony tells us that because of the influx of troops with complex war wounds, deteriorating medical facilities and deployed care givers, you rewrote the MHS mission because the MHS needed a new focus. The new mission is to “sustain a medically ready military force and provide world-class health services for those injured and wounded in combat.” That coupled with your stated focus of the MHS on combat care, humanitarian assistance and disaster readiness makes me wonder about your commitment to your title 10 responsibilities to provide healthcare to all 9.2 million beneficiaries. Where do retirees fit in your new mission and focus particularly in light of your plan to raise TRICARE fees for this group?

Dr. CASSCELLS. Retirees are a key element to the MHS mission. They are so for two reasons. First, in delivering care to retirees and their families, military providers develop and maintain the skills necessary to provide those world-class health services to the injured and wounded in combat. Second, they have earned a benefit. After serving a career in the military, the nation owes these warriors a first-class health benefit. It is incumbent for the MHS to see that they get that benefit. Our need to raise TRICARE fees, based on the recommendations of the Task Force on the Future of Military Health Care, restores to some extent the cost-sharing relationship between the Government and the retirees that existed when TRICARE began in 1995. Those benefits will still be significantly more generous than the vast majority of employer-sponsored health plans and we are committed to ensuring that the care delivered continues to be first-rate.

Mr. MCHUGH. Assistant Secretary Casscells, the President’s budget reflects an estimated \$1.2 billion cost savings generated by these behavior changes in the beneficiary behavior. How much of the estimated savings is based on the beneficiaries opting out of TRICARE or using healthcare less?

Dr. CASSCELLS. Of the \$1.2 billion estimated cost savings (if the fee changes that the task force proposed are adopted), \$398 million was based on the beneficiaries’ behavioral response in choosing what health insurance to use. We estimate that, instead of the number of retirees who use TRICARE increasing from 2.36 million to 2.41 million with the current enrollment fees and deductibles, the new enrollment fees and deductibles will result in only 2.32 million retirees using TRICARE. In addition, we estimate a savings of \$42 million based on lower utilization in response to the higher deductibles.

Mr. MCHUGH. DOD’s proposals to increase TRICARE fees were based in part on the principle that beneficiaries would opt out of TRICARE and decrease the amount of healthcare they use as a result of having to pay more. The estimated \$1.2 billion cost savings reflected in the present budget includes savings generated by these behavior changes. The task force report does not specifically mention either change in beneficiary behavior and you have testified that you do not agree with this strategy. With that, do you agree that DOD can save \$1.2 billion in the fiscal year 2009 by implementing the task force recommendations? How much do you think they can save?

Dr. CASSCELLS. We did not make an estimate of how much TRICARE would save based on the task force recommendations. Our objective was to reverse the trend of the increasingly small share of the cost borne by the beneficiary of the Military Health System (MHS).

I do not accept the Department’s estimates of the number of beneficiaries who would drop TRICARE because of the fee increases. As long as TRICARE is substantially more generous than other health insurance in terms of benefits and cost sharing, retirees will continue to rely on TRICARE.

Better coordination of benefits among retirees who are eligible for private health insurance as well as TRICARE may help slow the growth of DOD medical costs while providing better care coordination for retirees. The task force recommended a study, and then possibly a pilot program, aimed at better coordinating insurance practices among those retirees who are eligible for private health insurance as well as TRICARE. This study and pilot program could reveal a harder number for projections.

