UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 27 2008

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr. Chairman:

I am pleased to submit to you the (enclosed) report from the Department of Defense Task Force on the Future of Military Health Care.

The Congress asked the Task Force to assess and recommend changes that would help sustain the military health care services being provided to members of the Armed Forces, retirees, and their families Consistent with that mission stated in the John Warner National Defense Authorization Act for Fiscal Year 2007 (Section 711 of Public Law 109-364), the Task Force submitted its report to me on December 20, 2007

The report contains 12 recommendations and additional action items designed to maintain and improve the Military Health System for the long term I believe that the Task Force has provided good advice, and I appreciate its contributions. Overall, its assessments and recommendations are evidence-based and well-reasoned. A detailed evaluation of the report is underway. A senior oversight committee, composed largely of leaders in the Military Health System, has been established to evaluate all the recommendations and actions with the objective of developing a timely and feasible implementation plan The plan is due by the end of this year, and I look forward to sharing it with you.

Thank you for your support of the Military Health System

Sincerely,

David S C Chu

Enclosure
As stated

cc
The Honorable John McCain
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR - 27 - 2008

The Honorable Ben Nelson
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510-6050

Dear Mr Chairman

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The Honorable Lindsey O. Graham
Ranking Member

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WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 27 2008

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U S. House of Representatives
Washington, DC 20515-6035

Dear Mr Chairman

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Enclosure
As stated

cc
The Honorable Duncan Hunter
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 27 2008

The Honorable Susan Davis
Chairwoman, Subcommittee on Military Personnel
Committee on Armed Services
U S House of Representatives
Washington, DC 20515-6035

Dear Madam Chairwoman

I am pleased to submit to you the (enclosed) report from the Department of Defense Task Force on the Future of Military Health Care

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As stated

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The Honorable John M McHugh
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 27 2008

The Honorable Robert C Byrd
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510-6025

Dear Mr. Chairman·

I am pleased to submit to you the (enclosed) report from the Department of Defense Task Force on the Future of Military Health Care

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Enclosure
As stated

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The Honorable Thad Cochran
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 27 2008

The Honorable Daniel K Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510-6028

Dear Mr Chairman.

I am pleased to submit to you the (enclosed) report from the Department of Defense Task Force on the Future of Military Health Care

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Enclosure
As stated

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The Honorable Ted Stevens
Ranking Member

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

MAR 27 2008

The Honorable David R Obey
Chairman, Committee on Appropriations
U.S House of Representatives
Washington, DC 20515-6015

Dear Mr. Chairman

I am pleased to submit to you the (enclosed) report from the Department of Defense Task Force on the Future of Military Health Care

The Congress asked the Task Force to assess and recommend changes that would help sustain the military health care services being provided to members of the Armed Forces, retirees, and their families Consistent with that mission stated in the John Warner National Defense Authorization Act for Fiscal Year 2007 (Section 711 of Public Law 109-364), the Task Force submitted its report to me on December 20, 2007

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Sincerely,

David S. C Chu

Enclosure
As stated

cc
The Honorable Jerry Lewis
Ranking Member

DEPARTMENT OF DEFENSE

Task Force on the

Future of Military Health Care

FINAL REPORT

A SUBCOMMITTEE OF THE
DEFENSE HEALTH BOARD

DEPARTMENT OF DEFENSE

Task Force on the

Future of Military Health Care

FINAL REPORT

A SUBCOMMITTEE OF THE
DEFENSE HEALTH BOARD

December 2007

Department of Defense
Task Force on the Future of Military Health Care

December 20, 2007

The Honorable Robert M. Gates
Secretary of Defense
The Pentagon
Washington, D.C. 20301

Dear Mr. Secretary,

The Task Force on the Future of Military Health Care is pleased to submit to you the following report summarizing our work.

The Task Force was created to assess and recommend changes that would help sustain the military health care services being provided to members of the Armed Forces, retirees, and their families. With the mission specified in the John Warner National Defense Authorization Act for Fiscal Year 2007 (Section 711 of P.L. 109–364) as a constant guide, the Task Force presents this report of its findings.

The Task Force held public hearings, reviewed studies and research regarding program and organizational improvements to the military health care system, and visited military health care sites. As part of the public hearings, the Task Force also has heard extensive testimony related to improving business and management practices and realigning fee structures, which is a major focus of our findings and recommendations. The Task Force has laid a solid framework to sustain and improve the future of military health care.

In preparing the report, we were motivated by a belief that the members of our Armed Forces, their families, and military retirees, who have made and who continue to make enormous personal sacrifices in defending America, deserve a health care system that is flexible, effective, and cost-efficient. In summary, the system should provide much needed health care while considering fairness to the American taxpayer. We are confident that the general findings in this report represent a strong start toward achieving our goal.

Sincerely,

Gail R. Wilensky, Ph.D.
Co-Chair

John D.W. Corley, General, USAF
Co-Chair

Department of Defense
Task Force on the Future of Military Health Care

General John D W Corley
USAF Co-Chairman

Dr Gail R Wilensky
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Nancy Adams
Major General USAF Retired

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Rear Admiral John Mateczun
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General USAF Retired

Dr Robert Galvin

Lieutenant General James Roudebush
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The Honorable Robert Hale

Rear Admiral David J Smith

The Honorable Robert J Henke

Robert W Smith III
Major General USAF Retired

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Preface

The members of the Task Force wish to express their deep gratitude to the men and women of the Armed Forces of this Nation We recognize that those who serve and those who have served have made many sacrifices that most citizens have not been asked to make Many service members have been placed in harm s way to protect this Nation and its essential values and interests These men and women have responded to frequent and extended deployments to dangerous and remote places Their families have shared a heavy burden as well

The Task Force by the nature of its responsibilities and duties was required to examine an array of topics outlined in its congressional charter It considered military health care within the larger context of U S health care It reviewed considerable data in the civilian sector and compared military health care benefits to those provided by many U S employers and also compared the costs Health care costs are rising rapidly for the entire Nation, accounting for an ever larger share of gross domestic product and stressing many measures of affordability such as income and wages Nonetheless, the Task Force in its deliberations was mindful of the unique role in society of military service and the military health care system and of the fact that at least some of its value and capability is not subject to the kind of cost benefit or efficiency measures and analysis that might be applied to the private health care system

The Military Health System, like most employer sponsored health care plans, purchases health care, but, unlike most employer-sponsored plans, it also provides direct care to its members and other eligible beneficiaries In addition, while the Active Duty force has been downsized since the end of the Cold War and many Military Treatment Facilities have closed, the size of the nonactive population of eligible beneficiaries has grown and purchased health care has become a larger part of the defense health care budget Yet as the Task Force recognized, at all times the Military Health System must be appropriately sized and resourced to assure that the military can perform the full range of missions directed by national leadership This includes ensuring that service members are fit to deploy for arduous duty, often to dangerous places, where they can become casualties of war They must have and they deserve, high-quality health care

In its deliberations, the Task Force also recognized that military retirement is not like most civilian retirement systems To encourage military members to choose the military as a career the retirement system provides for no vesting until actual retirement which typically consists of at least 20 years of service (or the equivalent using a point system for members of the Reserve Component) Members are subject to recall after retirement if their service is needed in time of national crisis In addition, members often are required to retire earlier than civilians, sometimes upon a fixed number of years of service Moreover, the entire military compensation system differs from the typical civilian salary system because much of the compensation is 'in-kind or deferred' Thus, changes in the health care benefit must be examined in the context of this unique system and its compensation laws, policies, and programs

In this report, the Task Force endeavored to find the right balance between ensuring a cost-effective, efficient and high-quality health care system for military beneficiaries and managing a system with spiraling costs that, if unchecked, will continue to create an increasing burden on the American taxpayer. Clearly, health care for service members is paramount, and the Military Health System can make many adjustments to streamline its operations and achieve heightened effectiveness while continuing to provide high-quality care. At the same time, the system cannot be sustained at the current level without some degree of accountability and contribution from military retirees. Americans everywhere are paying high costs for health care. While military retirees deserve a more generous benefit because of their sacrifices and years of service, relatively modest increases in out-of-pocket costs will not only help stabilize the system and make it more accountable, but will also be looked upon as being appropriate by the American taxpayer. In addition, this modest contribution will help sustain the military health care system for the future, when today's Warfighters will rely on it in their retirement. The Task Force recognizes that its proposals, if accepted, will not be able to resolve the future budgetary problems that the Department of Defense will face as a result of rapid, future increasing costs of the Military Health System. These are issues that will need to be addressed by the Department of Defense and Congress in the years to come.

Executive Summary

The provision of health services and health benefits is an established and significant mission of each service branch of the U S military The extent and volume of health care services provided through military programs have grown dramatically since World War II resulting in the world's largest military health care system This system serves several distinct categories of beneficiaries including Active Duty military personnel, families of Active Duty personnel, reservists, and military retirees and their dependents Unlike civilian health care systems the Military Health System must give priority to military readiness the Nation s engagement in a long war on terror the support of a conventional war if necessary the provision of humanitarian relief and response to natural disasters, and the achievement of other missions required by national command authorities

Given the current and likely future commitments of the military, it is urgent that several persistent and new challenges facing today's current Military Health System be addressed These include a complex health care environment that demands increased emphasis on best practices, the need for efficient and effective procurement and contract management rising costs the expansion of benefits, the increased use of benefits by military retirees and the Reserve military components, continued health care inflation, and TRICARE premiums and cost-sharing provisions that have been level for nearly a decade

These challenges must be considered in the contexts of the current and ongoing needs of Active Duty military personnel and their families, the critical need for medical readiness of Active Duty military personnel the aging of the military retiree population and the broader backdrop of the U S health care economy, in which the military health care system operates To sustain and improve military health care benefits for the long run actions must be taken now to adjust the system in the most cost-effective ways The Military Health System must be appropriately sized resourced, and stabilized to ensure force readiness and the provision of the highest quality most cost-effective health care to beneficiaries

Congressional concerns about the rising costs of the military health mission were reflected in Section 711 of the National Defense Authorization Act for Fiscal Year 2007, which established the Task Force on the Future of Military Health Care to make recommendations to Congress on a broad range of military health care issues Rising health care costs result from a multitude of factors that are affecting not only the Department of Defense (DoD) but also health care in general these factors include greater use of services increasingly expensive technology and pharmaceuticals, growing numbers of users, and the aging of the retiree population

This is the Task Force s final report to Congress the interim report was delivered in May 2007 Since its first meeting on December 21, 2006 the Task Force convened 13 public meetings in Washington D C and meetings in San Antonio Texas, and Norfolk Virginia, to gather information pertinent to the topics listed in its charge It received informational briefings and written statements and held discussions with stakeholders of the Military Health System and other experts in health care

management and financing. In August 2007, four members of the Task Force travelled to Qatar, Iraq, and Germany to meet with leadership at Military Treatment Facilities at operating bases to discuss issues of concern relating to health care delivery, health care operations, medical personnel morale, and organizational structure.

The Task Force also reviewed reports, studies, and reviews produced by the Government Accountability Office, the Assistant Secretary of Defense (Health Affairs), and others, as specifically directed in its charge. In developing its recommendations, the Task Force sought strategies that are based on the best information available, with rationales that can be clearly articulated. In addition, as recommendations were developed, their impact on beneficiaries, especially any financial impact, was explicitly addressed.

In responding to one element of its charge, the Task Force declined to make recommendations at this time. Given the services' differing views and the uncertain state of legislative developments regarding further military to civilian conversions, the Task Force does not take any position on this matter. Final legislative direction and its effect on the services' ability to meet mission requirements, and the demands of peacetime health care, should be considered before further action is recommended.

Finally, although not tasked to review issues pertaining to the recruitment and retention of medical personnel needed for force readiness and a comprehensive health care system, the Task Force notes the critical need for focused study and action in this area.

The Task Force is an independent entity. Thus, based on the authorizing language creating it and its charge, its members have operated on the premise that deliberations would proceed with no preconceived outcomes or recommendations. Its starting points were established guidance in law, regulation, and policy. These guideposts framed discussions and served as departure points in the consideration of any potential changes to existing policy. The Task Force conducted its deliberations in an open and transparent process, remaining accessible and responsive to all concerned constituencies.

Findings and Recommendations

The Task Force concludes that, first and foremost, DoD must maintain a health care system that meets the military's readiness needs. DoD should make changes in its business and health care practices aimed at improving the effectiveness of the military health care system. The Task Force also believes that those treated by this system—military members and retirees, as well as their dependents—deserve a generous health care benefit in recognition of their important service to the Nation. However, to be fair to the American taxpayers, the military health care benefit must be reasonably consistent with broad trends in the U.S. health care system.

To implement these overarching conclusions, the Task Force makes several broad recommendations. Many of these recommendations, if implemented, would affect the entire Military Health System. Other recommendations are focused on the health benefits for military retirees. Importantly, the Task Force recommends no changes in the minimal costs now paid by Active Duty military personnel or their family members for health care.

Integration of Direct and Contracted Care

Findings

The Military Health System does not function as a fully integrated health care system but is divided into a direct care system which is itself composed of separate service systems, and a system of contracted services (e g , managed care support contracts and pharmacy) DoD needs a strategy for health care delivery that integrates the direct care system and the contracts supporting DoD health care delivery (i e , purchased care) Lack of integration diffuses accountability for fiscal management, results in misalignment of incentives and limits the potential for continuous improvement in the quality of care delivered to beneficiaries

In major markets within the Military Health System such as the National Capital Region or San Antonio there is insufficient planning and accountability at the local level to ensure integrated provision of services There is no single point of accountability for costs within a particular market, for services provided to the beneficiary population, or for health care outcomes

There are several factors contributing to the lack of an integrated strategy DoD procedures do not provide for an integrated approach to accountability and financial empowerment for managing overall population health care This is coupled with fiscal constraints that separate the funding of the direct care and purchased care systems thereby limiting the flexibility needed at the local level to make the most cost-effective and beneficial health care delivery decisions for beneficiaries

Recommendation 1 Develop a Strategy for Integrating Direct and Purchased Care

DoD should develop a planning and management strategy that integrates the direct health care system with the purchased care system and promotes such integration at the level where care is provided This strategy will permit the maintenance and enhancement of the direct care system's support of the military mission while allowing for the optimization of the delivery of health care to all DoD beneficiaries

Action Items

- The Office of the Secretary of Defense, the Joint Staff, and the military departments should develop a strategy for health care delivery that integrates the direct and the purchased care systems
- DoD should
  - provide incentives that optimize the best practices of direct care and private sector care
  - fiscally empower the individuals managing the provision of integrated health care and hold the same individuals appropriately accountable,
  - draft legislative language to create a fiscal policy that facilitates an integrated approach to military health care, and
  - develop metrics to measure whether the planning and management strategy produces the desired outcomes

Implement Best Practices

Findings

The Task Force inquiry into best practices was organized into three areas of focus 1) program evaluation, 2) financial controls, including overall controllership, eligibility and enrollment, and TRICARE as a second payer, and 3) prevention and disease management

Selected aspects of TRICARE contractors' performance and beneficiaries experience of care have been assessed, but this information is not accessible to beneficiaries In addition, alignment with public and private sector quality assessment and transparency initiatives is variable DoD has a substantial opportunity to join with other major purchasers to be an important part of the solution Current practices in the Military Health System are overly focused on controlling unit prices rather than on clinical and fiscal outcomes The Military Health System could be well served by its collaboration with the private sector and other federal agencies and should continue to improve it

Recommendation 2 Collaborate with Other Payers on Best Practices

DoD should charter an advisory group to enhance Military Health System collaboration with the private sector and other federal agencies in order to share adopt, and promote best practices

Action Items

- DoD should
  - align with the Departments of Health and Humans Services and Veterans Affairs the Office of Personnel Management, and private sector organizations to make health care quality and costs more transparent and easily accessible by all beneficiaries
  - use performance based clinical reporting by managed care support contractors and the direct care system
  - strengthen incentives to providers and health insurers to achieve high-quality and high-value performance, and
  - implement a systematic strategy of pilot and demonstration projects to evaluate changes in Military Health System practices and identify successful practices for more widespread implementation

Findings

The DoD policies, practices, and procedures for the oversight of enrollment and eligibility data appeared to be of fairly high quality, however, as is true in the private sector s oversight of health plan financial controls and coordination of benefits, weaknesses in the system can arise Several factors continue to create an especially challenging environment for eligibility determinations and tracking These include the pace of activity, the numbers of beneficiaries coming into or going out of the system the heavy reliance on Reserve Components the use of TRICARE as a second payer for some beneficiaries and the frequent changes in family structure of beneficiaries These changes have a significant impact on a system that relies largely on the self-reporting of events that trigger eligibility or ineligibility for benefits These trends justify an external audit in the area of financial controls

Recommendation 3 Conduct an Audit of Financial Controls

DoD should request an external audit to determine the adequacy of the 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

Action Items

- DoD should
  - charge the auditor with assessing the most efficacious and cost-effective approach, for example fraud identification and prevention and system changes to the Defense Management Data Center and/or Defense Enrollment Eligibility Reporting System,
  - ensure that audit recommendations are implemented and include follow-up and
  - establish a common cost accounting system that provides true and accurate accounting for management and supports compliance with law that TRICARE be a second payer when there is other health insurance

Findings

The services are conducting wellness and prevention programs generally consistent with recommendations of the National Commission on Prevention Priorities. In addition they have prioritized suicide prevention and stress management, however, overcoming stigma in seeking early low-level stress counseling remains an important problem. Although DoD prevention efforts are extensive, they appear to be of limited effectiveness in the areas of weight management and smoking cessation and they lack transparency and DoD-wide coordination

DoD has several initiatives in place to improve its disease management programs and is currently awaiting findings and recommendations from an external study of their effectiveness. However, case management in the Military Health System is not standardized across the system, which does not optimize the opportunity for better health care coordination

Recommendation 4 Implement Wellness and Prevention Guidelines

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 to ensure military readiness and optimal beneficiary health

Action Items

- To promote accountability and transparency in fiscal management and quality of services, DoD should
  - continue to prioritize prevention programs in accordance with the National Commission on Prevention Priorities,
  - implement and resource standardized case management and care coordination that extends beyond the Wounded Warrior to other beneficiary groups across the spectrum of care
  - ensure timely performance feedback to clinical providers managers and the chain of command through a timely and easily accessible reporting system such as a provider score card and
  - maintain high level visibility of business and clinical performance for the entire enterprise via the Tri Service Business Planning Process and the Military Health System Balanced Score Card Metric Panel

Improve Efficiencies and Cost Effectiveness of the Military Health Care Procurement System

Findings

In 1996, the DoD obligation for medical service contracts was $1 6 billion By 2005 this obligation had increased to $8 billion—a 412 percent increase This growth in service acquisition spending has resulted in part from recent trends and changes, including military and civilian workforce downsizing, outsourcing initiatives, the expansion of the TRICARE benefit and the need to meet new requirements and demands To reduce growth in the cost of medical service contracts, DoD has initiated some activities to streamline acquisition management and performance based service contracts, however, more can be done to contain costs

The Task Force found several systemic obstacles to the use of more efficient and cost-effective contracting strategies for health care support and staffing services many of which are being addressed through current initiatives, such as using strategic sourcing, standardizing the acquisition processes, establishing multiple award task orders and implementing other strategies for streamlining the process

Recommendation 5: Prioritize Acquisition in the TRICARE Management Activity

DoD should restructure the TRICARE Management Activity to place greater emphasis on its acquisition role.

Action Items

- DoD should:
  - elevate the level of the Head of Contracting Activity;
  - ensure acquisition personnel are certified according to the Defense Acquisition Workforce Improvement Act[1] and have strong competencies in health care procurement;
  - ensure that the management of acquisition programs is consistent with the Defense Acquisition System process;
  - create a system of checks and balances by separating the acquisition functions from the requirements/operations and the budget/finance functions and placing them under a Chief Acquisition Officer-equivalent who operates independently and is on same level in the organization as the Chief of Health Plan Operations and Chief Financial Officer; and
  - implement a study to determine if it is in the best interests of the government to colocate the TRICARE Deputy Chief, TRICARE Acquisitions organization and its acquisition counterparts.

Recommendation 6: Implement Best Practices in Procurement

DoD should aggressively look for and incorporate best practices from the public and private sectors with respect to health care purchasing.

Action Item

- DoD should examine and implement strategies to ensure compliance with the principles of value-driven health care consistent with Executive Order 13410, "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs."

1 The Defense Acquisition Workforce Improvement Act was signed into law in November 1990 and requires the Secretary of Defense to establish education and training standards, requirements, and courses for the civilian and military acquisition workforce. The requirements are based on the complexities of the job and are listed in DoD 5000.52-M, "Career Development Program for Acquisition Personnel." Civilian positions and military billets in the acquisition system have acquisition duties that fall into 14 career fields path. The Act has been amended a few times since its enactment with extensive changes in 2003. See http://library.dau.mil/DAWIA_LT_FO_09092007_FINAL.pdf.

Recommendation 7: Examine Requirements in Existing Contracts

DoD should reassess requirements for purchased care contracts to determine whether more effective strategies can be implemented to obtain those services and capabilities.

Action Items

- DoD should
  - examine whether the benefits from waiving cost accounting standards outweigh the risks associated with the waiver;
  - examine the 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;
  - test and evaluate through pilot or demonstration projects the effectiveness of carved out chronic disease management programs; and
  - examine the overarching contracting strategy for purchased care to consider whether certain functions should be
    - added to managed care support contracts (e.g., marketing/education and TRICARE for Life claim processing), and/or
    - carved out from managed care support contracts (e.g., specialized contracts to enhance disease management or other innovative pilot programs).

Improve Medical Readiness of the Reserve Component

Findings

The transition of the Guard and the Reserve from a strategic reserve to an operational force has placed additional demands on the Military Health System from the readiness and health benefit perspectives. With the October 1, 2007, changes to the TRICARE Reserve Select benefit comes the increased need for education to inform the eligible population about these changes and the total benefit. In addition, Task Force discussions with members of the Reserve Component revealed several key areas of concern:

- the need for a Total Force solution set that addresses both readiness and health care as a benefit;
- the need for a seamless health benefit to promote medical readiness and family stability, which enhances deployability; and
- the need for improved education and information dissemination to reservists about their health care benefit options and how to use the military health care system.

As the Task Force reviewed the issues related to medical readiness and the Reserve Component, it discovered that many of these same issues also apply to subsets of the Active Component. Strategies implemented to enhance readiness and improve the benefit for the Reserve Component would ultimately improve conditions for the Total Force.

Recommendation 8 Improve Medical Readiness of the Reserve Component

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

Action Items

- DoD should
  - after three to five years, assess the impact of recent changes in TRICARE Reserve Select eligibility on readiness issues. This assessment should include examining the adequacy of the provider network to absorb the additional workload and to provide sufficient geographic coverage for the dispersed beneficiary population,
  - improve information dissemination about the health benefit program to both the service member and his/her family members, particularly at times not associated with mobilization/demobilization
  - harmonize and leverage the work of other review groups to streamline processes to promote better "hand offs" from the DoD to the Veterans Affairs health system, and reduce administrative "seams" in the Military Health System to ensure beneficiaries receive adequate service, and
  - expand efforts to promote provider participation in the network in nonprime service areas to improve access

Modify the Pharmacy Benefit to Encourage More Cost Effective Use

Findings

The Task Force heard convincing arguments that private sector plans have been able to reduce the growth in pharmacy costs while retaining clinical effectiveness by providing beneficiaries with greater incentives to utilize preferred drugs and fill maintenance prescriptions using mail order services. Generic drugs have the lowest copayment, followed by formulary drugs and nonformulary drugs. However, current DoD pharmacy copayment policies do not provide adequate incentives for patients to use the most cost-effective alternatives, such as the mail order pharmacy or a Military Treatment Facility. Employing financial incentives to encourage the use of the mail order pharmacy across all beneficiary groups should decrease retail pharmacy costs while preserving access to the local pharmacy. The current DoD formulary tier structure and copayment policies do not create effective incentives to stimulate compliance with clinical best practices or to use the most cost-effective point of service for medications

Recommendation 9 Change Incentives in the Pharmacy Benefit

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

Action Items

- The tier structure should be as follows
  - Tier 1 Preferred—preferred medications to include selected over-the-counter drugs, cost-effective brand products, generics
  - Tier 2 Other formulary medications
  - Tier 3 Nonformulary medications
  - Tier 4 Special Category Medications—very expensive, specialty, and/or biotechnology drugs with a mandated point of service. The DoD Pharmacoeconomic Center would specify the tier for establishing copayments and points of service for the most cost-effective delivery for the special medication

- Congress should
  - grant authority to DoD to selectively include over-the-counter medications in the formulary based on clinical effectiveness and cost-effectiveness as evaluated and recommended by the Pharmacoeconomic Center and
  - grant authority to DoD to mandate the point of service for certain carefully selected medications (Special Category Medications) based on prior established criteria that take into consideration high clinical risk, short supply, or extreme cost, as recommended by the Pharmacoeconomic Center
- 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. This pilot should test and evaluate alternative approaches successfully implemented in the private sector that would seek to reduce the total health care spend, increase mail order use, better integrate pharmacy programs and clinical care, and maintain or improve beneficiary satisfaction. The goal of such a pilot program would be to achieve better total financial and health outcomes in the Military Health System as a result of an integrated pharmacy service. The overall results in total costs and health outcomes in this one region should eventually be compared with those in the other regions to determine the best approach for the Military Health System in terms of total spend and outcomes.

Update and Revise Retiree Cost Sharing

Findings

TRICARE's cost sharing provisions—that is, the portion of costs borne by retiree beneficiaries and the government—are not always conducive to the provision of the best health care for military retirees and are rapidly becoming an anachronism. Because costs borne by retirees under age 65 have been fixed in dollar terms since 1996, when TRICARE was being established, the portion of medical care costs assumed by these military retirees has declined by a factor of two to three, and, unless action is taken, that portion will continue to fall. This decline in the share of costs paid by the under-65 retiree has resulted in higher costs for DoD, but the Task Force believes that cost pressures should not be the only reason for change. Rather, the Task Force believes that cost-sharing provisions for retirees should be altered because, in some cases, the changes may help improve retiree health care, rationalize the use of care resources, and improve accountability. Also, the current cost-sharing provisions run so counter to broad trends in U.S. health care that they produce an increasing burden in terms of costs to U.S. taxpayers. Finally, the Task Force found that current TRICARE plans for retirees do not provide sufficient choices among TRICARE options.

Recommendation 10: Revise Enrollment Fees and Deductibles for Retirees

a. DoD should propose and Congress should accept phased-in changes in enrollment fees and deductibles for retirees under 65 that restore cost-sharing relationships put in place when TRICARE was created.

Most fees and deductibles should be tiered, so that they are higher for those receiving higher retired pay. The Task Force also recommends changes in other features such as copayments and the catastrophic cap. Most of these changes should be phased in over four years.

b DoD should propose and Congress should accept a modest enrollment fee for TRICARE for Life beneficiaries

The fee is not proposed in order to reduce DoD costs Rather, a modest fee will foster personal accountability and is consistent with the Task Force philosophy that military retiree health care should be very generous but not free This change should be phased in over four years

c The Task Force strongly recommends that DoD should propose and Congress should accept automatic, annual indexing of enrollment fees that maintain the cost-sharing relationship put in place when TRICARE was created to account for future increases in per capita military medical costs

Unless automatic indexing is put in place the cost shares restored by the one time change in retiree cost sharing will not be maintained Other elements of cost sharing such as deductibles and copayments, should not be indexed annually but should be reassessed at least every five years

Action Items

- DoD should implement, and Congress should accept, all the cost sharing recommendations listed above
- Congress would need to make specific changes in the law as follows
  - modify existing law to change the enrollment fee with tiering based on retiree pay for Prime Family and Prime Single
  - establish a fee for TRICARE Standard with tiered deductibles for Family and Single, and
  - adjust the catastrophic cap
- In addition Congress would have to authorize the Secretary of Defense or his designee, to make changes to the enrollment fees and tiered salary ranges initially based on the newly developed DoD index and make changes to copayments, deductibles and the catastrophic cap as necessary at least every five years making certain to stay within the DoD approved index
- DoD should examine the feasibility of establishing other TRICARE options so that all retirees can be assured of having comparable choices among TRICARE options such as Prime and Standard

Findings

There are coordination issues for the group of military retirees under age 65 who have access to TRICARE and are also employed and who have access to their employers health insurance plan One-fourth of retirees do not have access to private employer insurance For these individuals, TRICARE is clearly their main and only health coverage, and there are no issues of coordination However, estimates from a 2006 survey of military retirees suggest that even though 65 percent of retirees under the age of 65 and 58 percent of their dependents are eligible for insurance from the retirees employer, only 40 percent elect private coverage for themselves while 29 percent elect dependent coverage This suggests that the majority (60 percent) of retirees who are eligible for private insurance through their employer are instead using TRICARE as a primary payer For these individuals DoD pays all medical costs even though they are employed and have access to employer health benefits

Congress designed TRICARE to be a second payer, and most retirees use it this way. However, TRICARE cannot act as a second payer if it is not aware of the retirees' employer insurance, and retirees may choose to use whichever coverage is most advantageous for a particular episode of medical care, which could result in less-than-optimal health care. Still other retirees are eligible for medical insurance through a private employer, but voluntarily choose to drop that coverage or not access it when available and use TRICARE. The number of retirees in this group is substantial.

The Task Force believes that steps should be taken to better coordinate health insurance for those under-65 retirees with both TRICARE and private employer insurance. For these individuals, the goal is to ensure that the retiree relies on only one insurance plan, and hence one set of providers, with TRICARE acting as no more than a second payer. Better coordination could help hold down the growth in DoD medical costs while also improving health care.

Recommendation 11: Study and Pilot Test Programs Aimed at Coordinating TRICARE and Private Insurance Coverage

DoD should commission a study, and then possibly a pilot program, aimed at better coordinating insurance practices among those retirees who are eligible for private health care insurance as well as TRICARE.

Command and Control Structure to Manage the Military Health System

Findings

There has been considerable debate by other DoD groups about the costs and benefits of a unified or more integrated command and control structure for the Military Health System, culminating with the most recent recommendation for a Defense Health Agency. A Government Accountability Office 2007 review of the studies undertaken by DoD determined that DoD "did not perform a comprehensive cost-benefit analysis of all potential options." Among other things, GAO recommended that "DOD develop performance measures to monitor the progress of its chosen plan toward achieving the goals of the transformation." Given the relatively short period that has passed since the Government Accountability Office made this recommendation, the Task Force believes it is premature to make additional recommendations. However, the Task Force believes it is appropriate that DoD and Health Affairs monitor and assess the effects of any proposed changes. Furthermore, consistent with the October 2007 report from the Government Accountability Office, DoD should evaluate any additional options for change in terms of the costs and benefits to be derived from each option under consideration.

Recommendation 12: Develop Metrics by Which to Assess the Success of Military Health System Transformation

DoD should develop metrics by which to measure the success of any planned transformation of the command and control structure of the Military Health System, taking into consideration its costs and benefits.

In sum, what is needed is a focus on strategic integration and preserving the best aspects of the current system, while improving and enhancing the delivery of accessible, quality health care over the long term. The system must be as effective and efficient as possible, while being affordable to the government and to beneficiaries, and it should borrow best practices from the public and private sectors. Changes to the system should not diminish the trust of beneficiaries or lower the current high quality of health care services that are provided to Active Duty and Reserve military personnel and their family members and to retirees and their family members.

Introduction

The history of military health care dates back more than two centuries, when Congress enacted legislation requiring care for the "regimental sick" as well as care for the "relief of sick and disabled seamen." Subsequent legislation allowed for the care of military dependents, and later legislative language created provisions for the care of military retirees and their dependents.

The provision of health services and health benefits is an established and significant mission of each service branch. In fact, the extent and volume of health care services provided through military programs have grown dramatically since World War II, resulting in the world's largest military health care system. This system serves several distinct classes of beneficiaries, including Active Duty military personnel, families of Active Duty personnel, reservists, and military retirees and their dependents. At the same time, unlike civilian health care systems, the Military Health System (MHS) must give priority to military readiness, the Nation's engagement in a long war on terror, the support of a conventional war if necessary, the provision of humanitarian relief and response to natural disasters, and the achievement of other missions required by national command authorities. The military health care system, which has evolved in various ways since its creation, was modified substantially in Fiscal Year 1994 when the Department of Defense (DoD) initiated the TRICARE program. TRICARE was intended to better control the escalating costs of medical care, provide quality care for a downsized military, and for an ever-increasing number of retired military beneficiaries, and realign the system to the closure of many military medical facilities.

TRICARE provides medical care to eligible beneficiaries through a combination of direct care in military clinics and hospitals and civilian-purchased care. Medical services provided at Military Treatment Facilities (MTFs) include outpatient and inpatient care for medical and surgical conditions, pharmacy services, physical examinations, dental care, and diagnostic, laboratory, and radiological tests and services.

The roles and contributions of the Reserve Component have changed since the end of the Cold War. From 1945 to 1989, reservists were called to active duty as part of a mobilization by the federal government only four times, an average of less than once per decade.[1] Since 1990, reservists have been mobilized by the federal government six times, an average of nearly once every three years.[2] Additionally, since September 11, 2001, the Reserve Component has been used extensively to support the Global War on Terrorism (GWOT). In fact, about 500,000 reservists have been mobilized, primarily for contingency operations in Afghanistan and Iraq. As a result, Reserve units are becoming more integrated into military operations, calling for a new relational model between the Active Duty and Reserve Components, and increasing the demands on the MHS with subsequent increases in health care expenditures.

1 GAO, Military Personnel: DoD Needs to Establish a Strategy and Improve Transparency over Reserve and National Guard Compensation to Manage Significant Growth in Cost, GAO-07-828, Washington, D.C., 2007, p. 11. Note: The General Accounting Office changed its name to the Government Accountability Office on July 7, 2004. GAO is used throughout this document to refer to either entity.
2 Ibid.

Impetus for This Report

Congressional concerns about the rising costs of the military health mission were reflected in Section 711 of the National Defense Authorization Act for Fiscal Year 2007, which established the Task Force on the Future of Military Health Care to make recommendations to Congress on a broad range of military health care issues (See Appendix B for the complete charge to the Task Force.) This is the Task Force's final report to Congress, the interim report was delivered in May 2007 (See Appendix C for Preliminary Findings and Recommendations.) In announcing the creation of the Task Force, Deputy Defense Secretary Gordon England noted that "the military health program has many important challenges, the most critical being the rapidly growing costs of health benefit coverage and the need to make adjustments so this great program can continue far into the future."

Although the commitment to military health and readiness cannot waiver, current financial trends will pose significant challenges. Rising health care costs result from a multitude of factors that are affecting not only DoD but also health care in general; these factors include greater use of services, increasingly expensive technology and pharmaceuticals, and growing numbers of users.

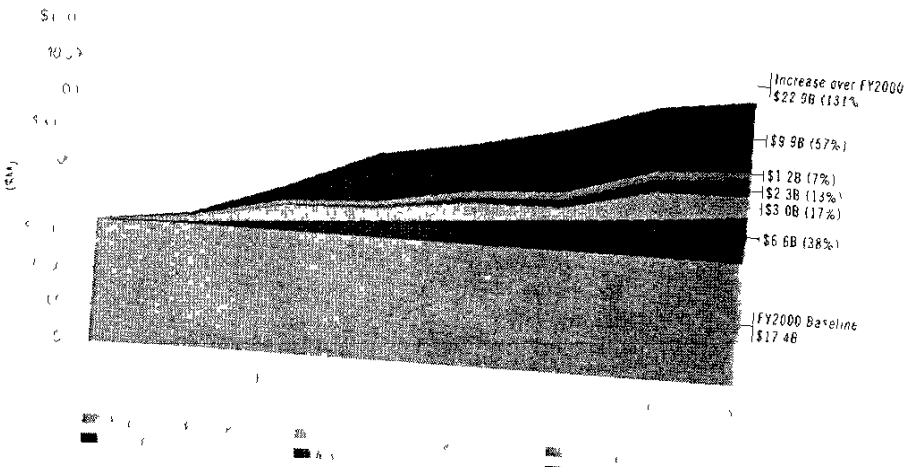
Costs of the military medical mission have doubled in the past six years, from $19 billion in Fiscal Year 2001 to $39.4 billion in Fiscal Year 2007.[3] The fastest rate of growth in DoD health care spending was in pharmacy services. Between Fiscal Years 2000 and 2007, TRICARE spending on prescription drugs more than quadrupled, from $1.6 billion in 2000 to $6.5 billion in 2007.

At these rates of growth, analysts project costs of the MHS to reach $64 billion in Fiscal Year 2015, with an expansion of the DoD military health budget from 8 to 12 percent of the entire DoD budget by Fiscal Year 2015, up from 4.5 percent in 1990 (see Figure 1). In addition, beneficiaries are paying exactly the same amount in terms of fees and copayments as they did 10 years ago. As a result, the portion of costs borne by beneficiaries has fallen from 27 percent of total costs in Fiscal Year 1995 to 12 percent today.[5] Benefits also are expanding. Although private sector organizations increasingly are scaling back on coverage and passing more costs to employees, Congress has expanded benefits and eliminated most cost-shares for Active Duty personnel and their dependents and also has added a TRICARE for Life (TFL) benefit and the TRICARE Reserve Select Program.

Although improvements in internal efficiency will be critical to containing costs, and the rebalancing of government and beneficiary cost-shares is being explored, such measures will be insufficient to stem the tide of rising health care costs, although they may help to slow their rate of growth.

3 The interim report is available at www.dodtutorchedthrare.net/images/103-06-1/Home/Task_Force_Interim_Report_053107.pdf
4 Mark Yow, Program Budget and Execution Division, TMA Office of Chief Financial Officer, Response to Task Force RFI, November 20, 2007. Note: The Fiscal Year 2007 figure includes the DoD Medicare Eligible Retiree Health Care Fund normal cost contribution, but excludes the two-year traumatic brain injury post-traumatic stress disorder supplemental.
5 Patricia Hobbs, TMA Office of Chief Pharmaceutical Operations, Response to Task Force RFI, November 15, 2007.
6 Ibid.

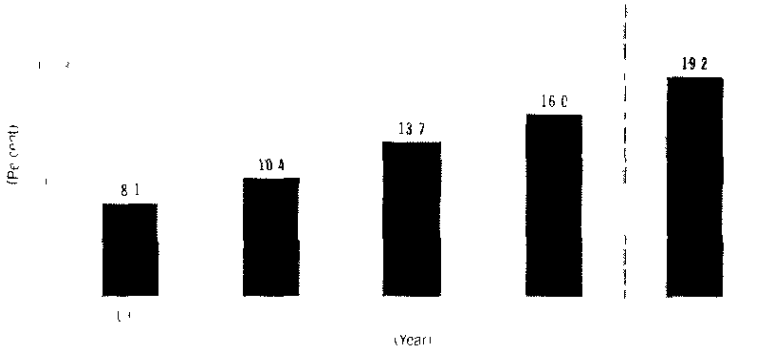
GROWTH IN THE UNIFIED MEDICAL BUDGET



The DoD health care budget must be viewed within the context of the overall growth in health care spending in the United States and any recommendations for change will be influenced by trends in the overall national health care economy. Health care expenditures in the United States represent a greater percentage of gross domestic product (GDP) than they do in any other country. At $2.2 trillion or 16.5 percent of GDP, the 2006 U.S. National Health Expenditures dwarf expenditures in other major sectors of the economy. According to GAO, nationwide health care spending as a percentage of GDP totaled 16 percent in 2005, compared to 8.1 percent in 1975 and is projected to grow to 19.2 percent in 2015 (see Figure 2).[8] Health care spending continues to increase at a rate greater than the rate of growth in the overall economy. Since 1970, health care spending has grown at an average annual rate of 9.9 percent, or about 2.5 percentage points faster than GDP.[9] Drivers of health care spending in general include population growth and aging, increases in health insurance coverage, medical inflation, and increased utilization of services, both in terms of volume and intensity.

7 Blue Cross Blue Shield 2007 Medical Cost Reference Guide, at www.bcbs.com/betterknowledge/mcrg/2007-medical-cost-reference-guide_2.pdf, p. 6.
8 David M. Walker, Comptroller General of the United States, DoD's 21st Century Health Care Spending Challenges, Brief to the Task Force, April 18, 2007.
9 Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, at www.cms.hhs.gov/NationalHealthExpendData/, see Historical NHE summary including share of GDP, CY 1960-2005, file nhegdp05.zip.

GROWTH IN HEALTH CARE SPENDING HEALTH CARE SPENDING AS A PERCENTAGE OF GDP



Activities of the Task Force

The Task Force held its first meeting (administrative only) on December 21, 2006. During this meeting the group was oriented to its task and received background materials relating to its charge. Task Force members appointed by the Secretary of Defense from outside of DoD elected a co-chair as directed by statute (the department co-chair was appointed by the Secretary of Defense). The members agreed to operate in a plenary fashion until the Task Force substantially completed and submitted its interim report. It then established subcommittees to study the broader range of issues addressed in this final report.

The first public meeting of the Task Force was held on January 16, 2007. The Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs provided information on the MHS, and key staff members of that office provided a detailed overview of the Defense Health Program, with an emphasis on budgetary and financial matters and the administration's 2006 proposed legislation relating to these matters.

The Task Force convened 13 public meetings in Washington, D.C., 1 in San Antonio, Texas, and 1 in Norfolk, Virginia, to gather information pertinent to the topics listed in its charge. It received informational briefings and written statements and held discussions with stakeholders of the MHS and other experts in health care management and financing. (See Appendix D for meeting dates, locations, speakers, and participating organizations.)

The Task Force also reviewed reports, studies, and reviews produced by GAO, the Assistant Secretary of Defense for Health Affairs, and others, to include—as specifically directed by Section 711(c)(2)—the findings and recommendations of the Healthcare for Military Retirees Task Group of the Defense Business Board. (See Appendix E.)

Several Task Force members made an informational visit to the United Mine Workers of America Health and Retirement Funds program to learn more about its health plan operations, in large part because of its highly regarded outreach program and pharmacy benefits management program. The Task Force also toured military medical facilities in San Antonio—the U.S. Army Institute of Surgical Research Burn Center at Fort Sam Houston and the Brooke Army Medical Center's Center for the Intrepid, a state-of-the-art rehabilitation facility. At these sites, the Task Force members received briefings related to regional care, hosted a town meeting, and held five panel hearings and discussions with groups consisting of spouses, retirees, members of the Guard and Reserve Components, enlisted members, and officers.

In August 2007, four members of the Task Force travelled to Qatar, Iraq, and Germany to meet with leadership at MTFs at operating bases and headquarters to discuss issues of concern relating to health care delivery, health care operations, and organizational structure. The Task Force members received mission briefings on specific activities relating to the transport of patients and delivery of health care within the Central Command area of responsibility.

In September 2007, the Task Force members traveled to Virginia Beach, Virginia to solicit views regarding quality, access, cost, and commentary on its interim report through panel hearings consisting of Guard and Reserve members, spouses, under age 65 retirees, and network providers for TRICARE members. In four separate subcommittee meetings, Task Force members solicited additional views on the military health care system from 23 military medical personnel. These service members included enlisted personnel and officers from all branches of the military who had recent deployment experience in Southwest Asia. Additionally, the Task Force hosted a Town Hall meeting, examining key issues relating to the future of military health care within the direct and purchased care systems.

At the public meetings held between February and October 2007, the Task Force was briefed on the following issues:

- DoD representatives presented information on the pharmacy benefits program and TRICARE Managed Care Operations, including the specifics of cost-sharing between the government and beneficiaries;
- the Surgeons General of the Army and Navy, the Deputy Surgeon General of the Air Force, and the Joint Staff Surgeon spoke about direct care programs and deployed medicine;
- industry experts on the management and operation of health care programs and services (UnitedHealthcare Group) gave presentations on the role of retail pharmacies in DoD's pharmacy program;
- representatives of beneficiary advocacy organizations provided their perspectives on the state of military health care, military pharmacy programs, past legislation and legislative proposals, and cost-sharing;
- contractors responsible for TRICARE managed care support discussed operational issues;
- commercial interests that have not bid on TRICARE contracts presented issues that have discouraged their involvement in military health care;
- representatives of private health plans described their programs in wellness, disease prevention, and disease and case management;
- DoD representatives from the services described wellness, disease prevention, and disease and case management efforts planned or under way;
- DoD representatives described current and planned acquisition management and procurement initiatives.

- DoD leadership responsible for medical education and training and for recruiting and retaining health care personnel described activities at the regional and national levels, including reorganizations following Base Realignment and Closure activities
- representatives of DoD described military/civilian conversion issues, and
- senior officials of TMA discussed TFL and Medicare alignment and coordination

The April 2007 San Antonio visit was a source of additional information on retail pharmacy and mail order programs and perspectives from industry experts on pharmacy issues

About This Report

This Task Force was charged with a slate of objectives that included assessment across the full range of military health operations and the development of recommendations on wellness initiatives, education programs, accurate cost accounting, universal enrollment, system command and control, the procurement process, military and civilian personnel mix, dual-eligible Medicare-eligible beneficiary needs, efficient and cost-effective contracts, and the beneficiary-government cost sharing structure to sustain military health benefits over the long term. This cost-sharing structure was of significant importance, because the Task Force was required to report on this element in its interim as well as in this final report

The authorizing language that established the Task Force stipulated that it submit an interim report on its activities to the Secretary of Defense and the Committees on Armed Services of the Senate and the House of Representatives. Specifically, the charge required that the Task Force provide in the interim report its findings and recommendations regarding

> (H) The beneficiary and Government cost-sharing structure required to sustain military health benefits over the long term, particularly with regard to cost sharing under the pharmacy benefits program. (See Appendix B for the complete charge.)

Thus, the interim report focused primarily on presenting preliminary findings and recommendations related to providing a pharmacy benefit that is cost-effective and that promotes accountability by all parties, including beneficiaries. In addition, it addressed other cost-sharing approaches and efficiencies with regard to the entire MHS

In this final report, the Task Force reports on its continued consideration of issues related to the topics raised in the interim report and provides more specific guidance. It also provides its findings and recommendations related to the rest of its charge

Guiding Principles

Given the current and likely future commitments of the military, it is critical to address several persistent and new challenges facing today's current Military Health System These include rising costs, the expansion of benefits, the increased use of benefits by military retirees and the Reserve military components continued health care inflation, and TRICARE premiums that have been level for nearly a decade These challenges must be considered in the contexts of the current and ongoing needs of Active Duty military personnel and their families, the critical need for medical readiness of Active Duty military personnel the aging of the military retiree population, and the broader backdrop of the U S health care economy, in which the military health care system operates To sustain and improve military health care benefits for the long run actions must be taken now to adjust the system in the most cost-effective ways

The Task Force is an independent entity Thus, based on the authorizing language creating it and its charge, its members have operated on the premise that deliberations would proceed with no preconceived outcomes or recommendations Its starting points were established guidance in law, regulation, and policy These guideposts framed discussions and served as departure points in the consideration of any potential changes to existing policy The Task Force conducted its deliberations in an open and transparent process, remaining accessible and responsive to all concerned constituencies

In developing its recommendations, the Task Force sought strategies that are based on the best possible information available, with rationales that can be clearly articulated In addition, as recommendations were developed, their impact on beneficiaries, especially any financial impact was explicitly addressed

As its beginning step, the Task Force debated and adopted a set of guiding principles to use in assessing the desirability of recommended changes The Task Force first adopted an overarching principle

> **All recommended changes must focus on the health and well-being of beneficiaries and be cost-effective, taking into account both short-term and long-term budgetary costs as well as the effects on the specific guiding principles noted below**

The Task Force then adopted six specific guiding principles These principles require that the changes recommended by the Task Force, when taken as a whole, must

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 by, among other approaches, reflecting best health care practices in the private sector and internationally

4) avoid any significant adverse effects on the ability of the military compensation system including health benefits, to attract and retain the personnel needed to carry out the military mission effectively,

5) balance the need to maintain generous health care benefits in recognition of the demanding service rendered by military personnel to their country with the need to set and maintain a fair and reasonable cost-sharing arrangement between beneficiaries and DoD, and

6) align beneficiary cost sharing measures to address fairness to taxpayers by promoting measures that enhance accountability and the judicious use of resources

In sum, what is needed is a focus on preserving the best aspects of the current system while improving and enhancing the delivery of accessible, quality health care over the long term The system must be as effective and efficient as possible, while being affordable to the government and to beneficiaries borrowing from best practices in the public and private sectors Changes to the system should not diminish the trust of beneficiaries nor lower the current high quality of health care services that are provided to Active Duty and Reserve military personnel, their dependents, and retirees

This final report presents findings and recommendations that the Task Force believes are consistent with these guiding principles

Overview of the Military Health System

The mission of the Military Health System (MHS) is to provide health support for the full range of military operations and sustain the health of all who are entrusted to MHS care

This health support includes

- providing patient care
- sustaining the skills and training of medical personnel for peacetime and wartime
- managing beneficiary care
- promoting and protecting the health of the forces, and
- continuing to manage the benefits

In Fiscal Year 2007 the MHS had total budget authority of $39.4 billion and served approximately 9.1 million beneficiaries including Active Duty personnel and their families and retirees and their families (see Table 1)[1]

Table 1 DoD TRICARE Eligible Beneficiary Population

POPULATION	FY 2007
Active Duty	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	[illegible]
Subtotal TRICARE Non Active Duty Under 65 Eligible	[illegible]
Medicare Eligible (65 and older)	[illegible]
Total	[illegible]

Source: Allen Middleton, Acting Deputy Assistant Secretary of Defense for Health Affairs and Acting Chief Financial Officer, TRICARE Management Activity, The Military Health System and the Defense Health Program: An Overview for the Task Force on the Future of Military Health Care, Brief to the Task Force, January 16, 2007

The MHS includes 133,000 personnel—86,000 military and 47,000 civilian—working at more than 1,000 locations worldwide, including 70 inpatient facilities and 1,085 medical, dental, and veterinary clinics[2]

1 Mark Yates, Program Budget and Execution Division, TMA Office of Chief Financial Officer, Response to Task Force RFI November 20, 2007. Note: The Fiscal Year 2007 figure includes the DoD Medicare Eligible Retiree Health Care Fund normal cost contribution, but excludes the two-year traumatic brain injury/post traumatic stress disorder supplemental.
2 Allen Middleton, Acting Deputy Assistant Secretary of Defense for Health Affairs and Acting Chief Financial Officer, TRICARE Management Activity (TMA), The Military Health System and the Defense Health Program: An Overview for the Task Force on the Future of Military Health Care, Brief to the Task Force, January 16, 2007.

Sources of MHS Funding

The MHS relies on a complicated appropriations process with several fluctuating components that make tracking over time complex. The MHS receives its funding from numerous appropriations sources with different timeframes and restrictions. The most significant source is the Defense Health Program (DHP) Operations and Maintenance (O&M) appropriation, which must be obligated in one fiscal year, but 2 percent of the total can be carried over to the next fiscal year.

The DHP O&M appropriation funds day-to-day operations across a wide variety of medical, dental, and veterinary services. This appropriation also funds readiness that is not already funded by the service line appropriations, including those related to education and training, occupational health and industrial health care, and facilities and information technology. Other appropriations within the DHP include the following: Research, Development, Test, and Evaluation, which is a two-year appropriation, and Other Procurement, which is a three-year appropriation. The DHP O&M appropriation does not compensate military personnel working at Military Treatment Facilities (MTFs). The Military Personnel appropriation is outside the DHP, but it covers compensation of all military personnel. The Military Construction appropriation is another appropriation that supports the MHS but is also outside the DHP.

The TRICARE Program

TRICARE replaced the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in 1994, becoming a triple-option rather than a dual-option system. TRICARE uses the health care resources of the Army, Navy and Air Force and supplements these services with networks of civilian health care providers. The first TRICARE Region began operations in March 1995. By June 1998, implementation of the regionally managed health care program was complete for Active Duty, activated Guard and Reserves, and retired members of the Uniformed Services, their families, and survivors.

Military dependents and retirees must choose among three TRICARE options:

- TRICARE Prime, a voluntary health maintenance organization-type option, in which MTFs are the principal source of health care;
- TRICARE Extra, a preferred provider option; or
- TRICARE Standard, a fee-for-service option (the original CHAMPUS program).

Guard and Reserve service members on active duty are automatically enrolled in TRICARE Prime. In October 2004, the Transition Assistance Management Program was implemented to provide TRICARE for 180 days following active duty. In April 2005, the TRICARE Reserve Select Program was launched to provide a premium-based TRICARE Health Plan offered for purchase to Reserve Component members who qualify (see discussion in Chapter 7). In 2006, TRICARE benefits were extended to dependents whose sponsor died on active duty.

Tables 2 and 3 compare fees and cost sharing for the eligible populations.

Table 2 TRICARE Fees—Eligible Active Duty, Guard, and Reserve Family Members

	TRICARE PRIME	TRICARE EXTRA	TRICARE STANDARD
Annual Deductible	[illegible]	[illegible]	[illegible]
Annual Enrollment Fee	[illegible]	[illegible]	[illegible]
Civilian Outpatient Visit	[illegible]	[illegible]	[illegible]
Civilian Inpatient Admission	[illegible]	[illegible]	[illegible]
Civilian Inpatient Behavioral Health	[illegible]	[illegible]	[illegible]
Civilian Inpatient Skilled Nursing Facility Care	[illegible]	[illegible]	[illegible]
	[illegible]		

Table 3 TRICARE Fees—Retirees (Under 65), Their Family Members and Others

	TRICARE PRIME	TRICARE EXTRA	TRICARE STANDARD
Annual Deductible	[illegible]	[illegible]	[illegible]
Annual Enrollment Fee	[illegible]	[illegible]	[illegible]
Civilian Outpatient Visit	[illegible]	[illegible]	[illegible]
Civilian Inpatient Admission	[illegible]	[illegible]	[illegible]
Civilian Inpatient Skilled Nursing Facility Care	[illegible]	[illegible]	[illegible]
Civilian Inpatient Behavioral Health	[illegible]	[illegible]	[illegible]

TRICARE for Life

Effective October 2001 TRICARE for Life (TFL) began providing lifelong comprehensive health care benefits to Medicare eligible beneficiaries age 65 and older or disabled. As of the end of Fiscal Year 2007 there are 936,000 military retirees, 580,000 military spouses, and 422,000 survivor spouses who are Medicare-eligible.[3] TFL is available for all dual TRICARE-Medicare eligible Uniformed Services retirees, including:

- retired members of the Reserve Component who are in receipt of retired pay
- Medicare-eligible family members
- Medicare eligible widows/widowers,
- certain former spouses, and
- beneficiaries under age 65 who are also entitled to Medicare Part A because of a disability or end-stage renal disease

Dependent parents and parents-in-law are eligible for the TRICARE Senior Pharmacy (TSRx) Program on a space-available basis at an MTF. In order to be eligible for TSRx benefits outside the MTF, they must be entitled to Medicare Part A, and if age 65 on or after April 1, 2001 they must be enrolled in Medicare Part B. Additionally, they are eligible for TRICARE Plus, and the US Family Health Plan.

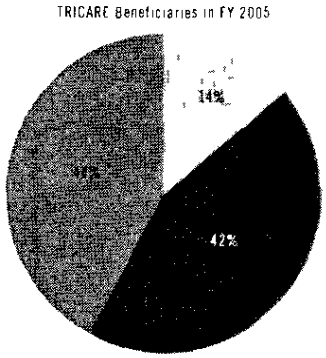
Currently, there are no enrollment fees for TFL, however, beneficiaries are required to purchase Medicare Part B. For services payable by both Medicare and TFL, Medicare pays first, any other health insurance pays second, and the remaining beneficiary liability may be paid by TFL. If services are rendered by a civilian provider, the provider first files claims with Medicare. Medicare pays its portion and then forwards the claim to TFL for processing. Then, TFL sends its payment for the remaining beneficiary liability directly to the provider.

Nearly two million beneficiaries are over the age of 65 and otherwise eligible for Medicare, according to an April 2006 report of the Defense Advisory Committee on Military Compensation. The report cites Congressional Budget Office estimates that project that by 2013 the TFL benefit will increase DoD health care costs by 44 percent.[4]

3 Figures from DFTRS and Retired Pay file from DoD Office of the Actuary as of Fiscal Year 2007
4 The Military Compensation System: Completing the Transition to an All Volunteer Force—Report of the Defense Advisory Committee on Military Compensation, April 2006

Figure 1 depicts the status of TRICARE beneficiaries in Fiscal Year 2005. A majority of beneficiaries are not Active Duty personnel: 44 percent are retirees and dependents (generally under age 65), and 14 percent are TFL retirees and dependents (generally age 65 and older).

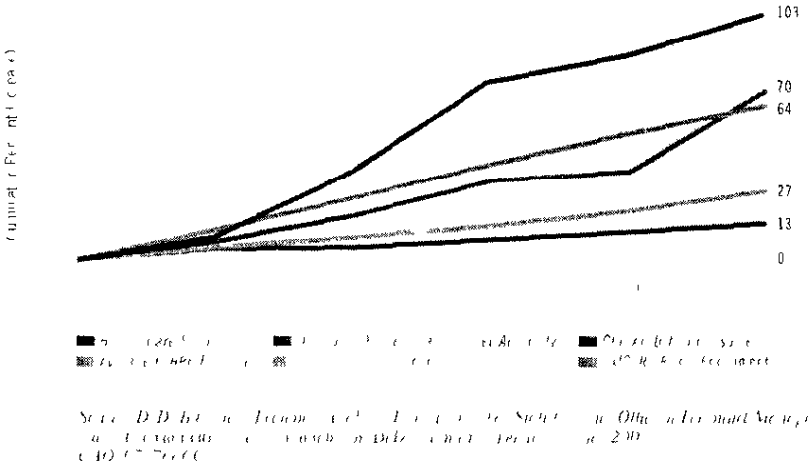
MAJORITY OF TRICARE BENEFICIARIES ARE NOT ACTIVE DUTY PERSONNEL



Comparison of Growth of DoD Health Care Spending with Other Indicators

As of 2005, DoD health care spending had increased by more than 100 percent since 2000, while the cumulative increase in the DoD total discretionary budget authority grew 70 percent (see Figure 2) over this period. During the same five-year period, the average Federal Employees Health Benefits Program (FEHBP) premium (available to federal civilian employees) grew 64 percent, while the TRICARE Prime Enrollment Fee remained unchanged (see Figure 2).

COMPARISON OF GROWTH IN DoD HEALTH CARE SPENDING, TRICARE ENROLLMENT FEES, OTHER INSURANCE PREMIUMS, AND ECONOMIC INDICATORS

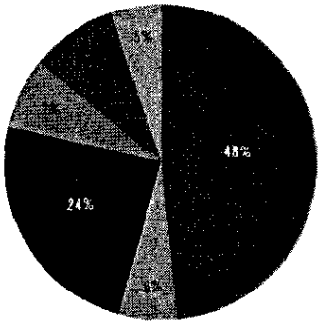


The fastest rate of growth in DoD health care spending was in pharmacy, which nearly quadrupled between 2000 and 2007, from $1.6 billion to $6.5 billion, for approximately 16 percent of the Unified Medical Budget.[6]

Figure 3 depicts estimates of factors contributing to increases in DoD's health care spending, of which nearly half can be attributed to the TFL benefit.

5 NetCharts NDX Data, 4 RX 30 Day Adjusted Prescriptions, April 24, 2007. See https://exportal.army.mil
6 The Fiscal Year 2006 Unified Medical Budget was $38 billion according to John Kokulis, Special Assistant to the Assistant Secretary of Defense for Health Affairs (HA) and Former Deputy Assistant Secretary of Defense (HA), Office of the Secretary of Defense, Sustaining the Military Health Benefit, Brief to the Task Force, January 16, 2007.
7 NetCharts NDX Data, 4 RX 30 Day Adjusted Prescriptions, April 24, 2007. See https://exportal.army.mil

DoD ESTIMATES OF FACTORS CONTRIBUTING TO INCREASES IN DoD'S HEALTH CARE SPENDING, FY2000–FY2005

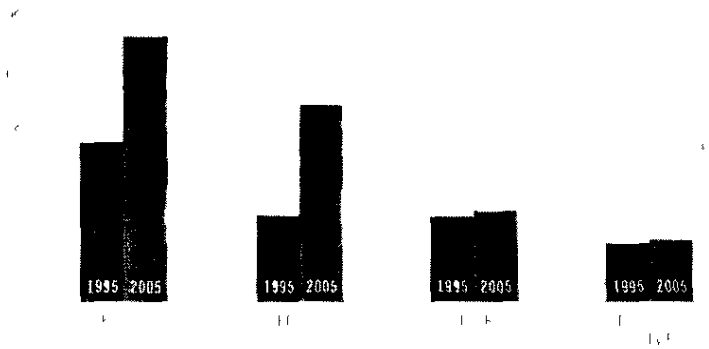


Over the last decade, the government's share of TRICARE's financing has grown, while beneficiaries' costs have remained unchanged or have been lowered, due to the following

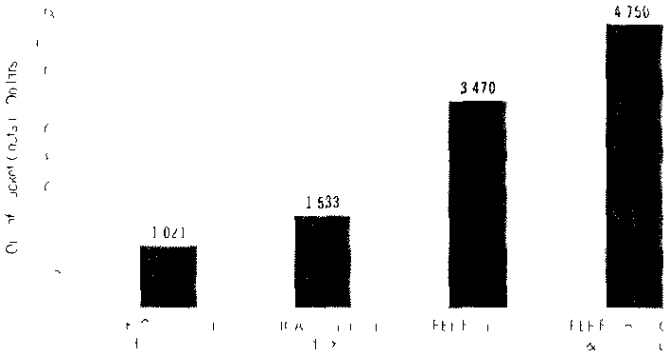
- no enrollment fee for TRICARE Standard and Extra and no increase in the enrollment fee for TRICARE Prime since 1996,
- the lowering of the catastrophic capitation for under-65 retirees and dependents in 2001 (from $7,500 to $3,000)
- no increase in TRICARE deductibles since 1996
- the elimination of TRICARE Prime copayments for dependents of Active Duty service members
- congressional expansion of benefits four times since 2001 and
- the declining out-of-pocket share for TRICARE costs that has resulted from medical inflation (DoD reports that under-65 retirees and dependents paid 11.6 percent of their health care costs in Fiscal Year 2006,[8] down from 27 percent in Fiscal Year 1996[9]) (see Figures 4 and 5)

8 Bob Opsut, OASD(HA)/HB&TP, Response to Task Force RFI, November 2[illegible], 2007
9 David M. Walker, Comptroller General of the United States, DoD's 21st Century Health Care Spending Challenge, Brief to the Task Force, April 18, 2007

TRICARE COST SHARES HAVE REMAINED FLAT



COMPARISON OF AVERAGE OUT OF POCKET COSTS–INCLUDING PREMIUMS COPAYMENTS COINSURANCE AND DEDUCTIBLES–FOR A FAMILY OF THREE IN VARIOUS HEALTH PLANS 2005



It is worth noting that there also are health plan differences between TRICARE and other federal and private sector plans.[10] For example, TRICARE counts a beneficiary's enrollment fee toward the catastrophic cap on the beneficiary's out-of-pocket costs, while other public and private payers usually exclude a beneficiary's premium from counting toward the cap.

10 Ibid.

TRICARE copayment requirements for prescription drugs are not structured to encourage the use of the less expensive mail order option over the use of the more expensive retail pharmacies. Best practice suggests the general rule of thumb is that mail is twice retail with commercial economics (this assumes a 30-day fill for retail and a 90-day fill for mail).[11] The average Express Scripts plan has a $10 copayment for retail generic prescription drugs and $20 for mail order generic prescription drugs.[12] In Fiscal Year 2004, TRICARE beneficiaries obtained more than twice as many prescriptions from retail pharmacies as from mail order pharmacies. Other payers use stronger financial incentives to steer patients toward the least costly option.

Access to Care

Along with cost and quality, access to health care is seen as one of the three pillars that underlie health care policy.[13] Access to care is essential to the quality of health care outcomes. Patients who can promptly schedule appointments with their respective health care providers will have higher satisfaction, will likely return to work sooner, and may well have better medical outcomes.[14] Access is generally defined as a measure of a patient's ability to seek and receive care with a provider of choice, at a time of the patient's choosing, regardless of the reason for the visit.[15] Counting the third next available appointment is the health care industry's standard measure of access to care and indicates how long a patient waits to be seen.[16]

Access is also an important attribute for the MHS and its beneficiaries. In fact, the MHS has a statutory obligation to its TRICARE Prime beneficiaries to meet certain access standards. For example, the wait time for an appointment for a well patient visit or a specialty care referral cannot exceed four weeks, for a routine visit the wait time for an appointment cannot exceed one week, and for an urgent care visit, the wait time for an appointment cannot generally exceed 24 hours.[17]

The MHS puts a premium on access by constantly measuring appointments made against the departmental appointment type access standards.[18] For example, in September 2007, beneficiaries across the MHS were able to receive an acute appointment within the standard 92 percent of the time, a routine appointment within the standard 84 percent of the time, a specialty referral within the standard 93 percent of the time, and a wellness appointment within the standard 97 percent of the time.[19] These figures also can be accessed and parsed by individual services, MTFs, and clinics. MHS leaders are constantly apprised of these figures to ensure that they meet access commitments to their enrolled beneficiaries.

In its annual report to Congress, the MHS reported the use of broader metrics that tracked various aspects of beneficiary access against civilian benchmarks.[20] In contrast to the departmental appointment type access standards, these MHS measures generally lagged behind civilian benchmarks for access. For example, the MHS measured trends in satisfaction regarding the ability of all beneficiary categories (Active Duty, Active Duty family members, and retirees and their family members) to obtain care from military and civilian sources of care. Retired beneficiaries and their family members continued to report higher levels of satisfaction with their ability to obtain care than did Active Duty personnel or their family members.

11 Nancy Calbreath, Steven B. Miller, Express Scripts, Brief to the Task Force, April 18, 2007.
12 Ibid.
13 Roles of State Legislatures and State Governments in Determining Health Policy, Presentation by Dr. John T. McDonough, Executive Director, Health Care for All, See: www.ncsl.org/programs/health/statepolicy/mcdonough.ppt#257,3 The Three Pillars of Health Policy.
14 Access: Time to Third Next Available Appointment, Wisconsin Collaborative for Healthcare Quality, Inc., See: www.qualitymeasures.ahrq.gov/summary/summary.aspx?doc_id=10913&q=access+AND+time+AND+third.
15 Ibid.
16 Ibid.
17 32 C.F.R. §199.17(p)(5)(ii) (2005).
18 See http://mytricare.tricare.osd.mil/AccessToCare/TOC/AtC.htm.
19 File name: AccessToCareSummary_MHS.xls, extracted from Atc monthly reports Sept 07.zip, November 8, 2007 from the TRICARE Operations Center website at http://mytricare.tricare.osd.mil/ArchivedReports/ATC/ATC.htm.
20 Evaluation of the TRICARE Program: FY 2007 Report to Congress, Report submitted by the Health Program Analysis and Evaluation Directorate, TRICARE Management Activity, Office of the Assistant Secretary of Defense (HA), February 7, 2007.

However, all three categories lag behind their civilian counterparts in reporting access to care when needed.[21]

The MHS also measured trends in obtaining access to a personal or specialty provider, a major determinant of an individual's satisfaction with a health plan.[22] MHS users reported a declining rate of satisfaction between Fiscal Years 2004 and 2006 in accessing a personal physician, but a stable rate of satisfaction in obtaining referral care to a specialist. Still, the MHS lags behind the civilian benchmarks in these categories as well.[23]

Since TRICARE began in 1995, nonenrolled TRICARE beneficiaries in some locations have complained about difficulties accessing non-network civilian providers who will accept them as patients. In addition, these beneficiaries have cited concerns that the MHS has focused more attention on TRICARE Prime beneficiaries, which allows the MHS to manage beneficiaries' care, and has given less attention to the options available for nonenrolled TRICARE beneficiaries.[24] In response to these concerns, the National Defense Authorization Act of 2004 directed DoD to monitor nonenrolled TRICARE beneficiaries' access to care through a survey of civilian providers.[25] In addition, the same legislation required DoD to designate a senior official to take actions to ensure access to care for nonenrolled TRICARE beneficiaries.[26]

GAO reported that the TRICARE Management Activity (TMA) and its managed care support contractors used various methods to evaluate access to care, and the resulting measures indicated that nonenrolled TRICARE beneficiaries' access to care is generally sufficient and that access problems appear to be minimal.[27] Despite this finding, TMA, managed care support contractors, and beneficiary and provider representatives cited various factors as impediments to network and non-network civilian providers' acceptance of nonenrolled TRICARE beneficiaries and different ways to address them.[28] These impediments include concerns that are specific to the TRICARE program, such as reimbursement rates and administrative issues, as well as issues that are not specific to TRICARE, such as providers not having sufficient capacity in their practices for additional patients and provider shortages in geographically remote areas. TMA and the managed care support contractors have specific ways to respond to impediments related to TRICARE reimbursement rates and administrative issues, while the other issues are more difficult to address.[29]

During the Task Force off-site visits, enrolled and nonenrolled beneficiaries voiced concerns regarding access to health care. A beneficiary from San Antonio noted that it was difficult to obtain a primary care appointment from a local MTF.[30] In addition, it was also very difficult to get an appointment with the primary care provider assigned to the beneficiary.[31] This view was echoed by another beneficiary in relation to another local MTF.[32] The most common reason cited regarding these difficulties was the increasing effect of military deployments on the lack of availability of medical providers to see patients assigned to an MTF.[33] A beneficiary from Virginia Beach, Virginia, noted that because so many MTFs have been closed as a result of Base Realignment and Closure directives, beneficiaries face diminished opportunities to avail themselves of care within a particular MTF.[34]

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21 Ibid., p. 35.
22 Ibid., p. 36.
23 Ibid.
24 GAO, Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option, GAO-07-048, Washington, D.C., December 2006, p. 2-3.
25 See National Defense Authorization Act of 2004, §723 (P.L. 108-136), (117 Stat. 1392, 1532-34) (2003).
26 Ibid.
27 GAO, Defense Health Care: Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE's Managed Care Option, GAO-07-048, Washington, D.C., December 2006, p. 4.
28 Ibid., p. 5.
29 Ibid.
30 Testimony of Tanya Strow to the Task Force, Official Transcript of the Task Force on the Future of Military Health Care, Town Hall Meeting, San Antonio, Texas, April 9, 2007, p. 12-13.
31 Ibid.
32 Ibid., p. 13-14.
33 Ibid., p. 13.
34 Testimony of Paul Hamicker to the Task Force, Official Transcript of the Task Force on the Future of Military Health Care, Town Hall Meeting, Virginia Beach, Virginia, September 29, 2007, p. 24.

Direct and Purchased Care in the Military Health System

Shaping the future requires planning and strategic planning is particularly important for the future of military health care because of the resource-constrained environment and the rapidly increasing cost of health care which is driven by many factors beyond the control of DoD and its components The same level of planning that occurs when military forces are deployed—with a focus on optimizing the performance of the mission, including the integration of units, regardless of the military service that provides them—also needs to occur within the Military Health System (MHS) It is particularly critical at the intersection between the direct care and purchased care systems as well as at the intersection of the different military services, where more focus is needed on both strategic planning and integration

The unique requirements of Military Treatment Facilities (MTFs) make strategic planning and integration more complex for example, training, readying Warfighters for deployment treating the wounded building force confidence, and providing care for all categories of beneficiaries in the most cost-effective and cost-efficient manner Ultimately the appropriate balance among these competing demands will need to be reflected in an MTF s ability to shift resources appropriately in its local market while concomitantly measuring its performance and success in the MHS

Various strategies can be undertaken to better integrate services across the direct care and purchased care systems Because integration occurs more effectively at some sites, it is important to institutionalize processes that will facilitate this outcome elsewhere This will require greater flexibility and alignment at all levels to provide appropriate incentives for decisionmaking based on rationale, cost effectiveness, and benefit, rather than on simple budget allocations

As discussed in greater detail in Chapter 6 65 percent of beneficiary care is provided through a network of contracted private sector providers[1] Based on outpatient and inpatient workload, and MHS funding, substantially more health care delivery is being provided in the private sector by TRICARE network providers than is being provided through direct care in the MHS (see Box, below) In 1996, the DoD obligation for medical service contracts was $1 6 billion and by 2005 this obligation had increased to $8 billion—a 412 percent increase This growth in purchased care spending has resulted, in part from recent trends and changes, including military and civilian workforce downsizing, outsourcing initiatives the expansion of the TRICARE benefit, and the need to meet new requirements and demands Given this reality it is imperative that the MHS properly plan and integrate and prudently manage its use of direct versus purchased health care services

1 Michael Donnelly Military Health System Governance Initiative Status Update for the DoD Task Force on the Future of Military Health Care September 5 2007 Slide 7
2 GAO 07 20 Defense Acquisitions Tailored Approach Needed to Improve Service Acquisition Outcomes November 2006 p 5

Direct and Purchased Care in the MHS

In house or Direct Care [illegible]

- [illegible]
- [illegible]
  - [illegible]
  - [illegible]
  - [illegible]

Private Sector or Purchased Care [illegible]

- [illegible]
- [illegible]
  - [illegible]
  - [illegible]
  - [illegible]
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  - [illegible]
  - [illegible]
  - [illegible]

[illegible]

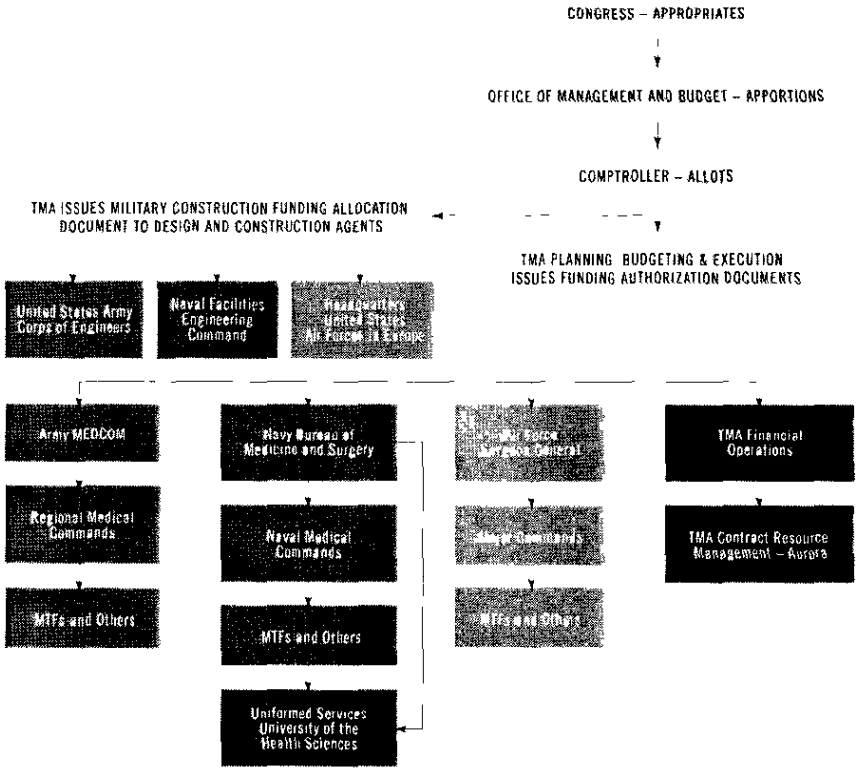
To increase the efficiency and effectiveness of the MHS, more attention needs to be given to strategic planning, but this cannot wait until the final resolution of issues involving department structure and organization (see Chapter 12). DoD must act now to establish the best architecture possible for strategic planning in order to better align direct and purchased care. GAO has noted that DoD has made progress in transforming business operations, but continues to lack a comprehensive, enterprise approach to its overall business transformation effort.

To date, DoD has not developed a plan that covers all key business decisions and that contains results-oriented goals, measures, and expectations and links organizational unit, and individual performance goals with overall investment plans.[4] As discussed elsewhere in this report, MHS financial accounting and reporting and cost accounting systems need significant improvement, or even a complete overhaul (see Chapter 5). The absence of a common accounting system across the MHS is an example of deficient integrative focus, which impedes decisionmaking regarding the best allocation and use of health care resources.

As another example, the current DoD organizational structure exacerbates the fragmentation of the health care system and its resources (see Figure 1). There are four hierarchies—the Office of the Secretary of Defense and three military services, each with its own medical organizations—as well as the Assistant Secretary of Defense, who also serves as the Director of the TRICARE Management Activity (TMA) (which has responsibility for the TRICARE contracts). This structure causes health care resources to flow through different branches of the system, resulting in a cumbersome, disintegrated system certain to have an adverse effect at the operational level. The deleterious effects of such fragmentation could be ameliorated or mitigated through improved integration.

[3] *Highlights of GAO-07-229T, testimony to the Subcommittee on Readiness and Management Support, Committee on Armed Services, U.S. Senate: Defense Business Transformation: A Comprehensive Plan, Integrated Efforts, and Sustained Leadership Are Needed to Assure Success*, November 16, 2006.
[4] *Ibid.*

DEFENSE HEALTH PROGRAM FUNDS FLOW



Figure

The fragmentation of funds begins with Congress and its restrictions on budget flexibility. House and Senate conferees have expressed concern about the transfer of funds from direct care to pay for purchased care. "To limit such transfers and continue oversight within the Defense Health Program operation and maintenance account, the conferees agree to include bill language which limits the funds available for Private Sector Care under the TRICARE program subject to prior approval reprogramming procedures." In addition, the conferees designated funding for the direct care system as a "special interest item," stating "Any transfer of funds from the Direct (or In-house) Care budget activity into the Private Sector Care budget activity or any other budget activity will require the Department of Defense to follow prior approval reprogramming procedures."

5 H.R. Rep. No. 110-434, at 355

In a statement before the Committee on Armed Services, Subcommittee on Personnel, the Under Secretary of Defense for Personnel and Readiness and the Assistant Secretary of Defense for Health Affairs stated that DoD needs flexibility to move funds between direct care and purchased care.[6] Such flexibility is precluded by restrictions imposed by Congress. They urged Congress to authorize the MHS to manage its funds "as an integrated system" which will allow funds to flow on a timely basis to where care is delivered.

In addition, flexibility in the use of funding would set MTF budgets based on workload outputs such as hospital admissions, prescriptions filled, and clinic visits, rather than historical resource levels. And MTFs "would manage their Force Health Protection and healthcare delivery missions as a comprehensive whole using a single set of performance measures."[8] Incentives and financial rewards could be provided for efficient management.

In addressing strategic planning, the Task Force recognizes that DoD has a strategic plan for the MHS based on "three pillars: 1) providing a medically ready and protected force and medical protection for communities, 2) creating a deployable medical capability that can go anywhere, anytime with flexibility, and 3) managing and delivering a superb health benefit."[9] The Task Force also recognizes that planning is ongoing and better business processes are evolving; however, greater emphasis needs to be placed on addressing the problems of integration at the "market," or MTF level, between direct care and purchased care, and among the service components.

These are not new concerns. The Military Health System Executive Review chartered a Local Authorities Working Group to examine ways to empower MTFs to improve operational efficiency and effectiveness while ensuring force health protection and quality beneficiary care.[10] That group reported that there is a "compelling need" for changing the way that MTFs operate, and that "needed changes can be best achieved by adopting performance-based management principles that give the MTFs additional flexibility to allocate and manage resources."[11] It also called for the realignment of department and individual service processes to provide clear direction and performance objectives, accurate measurement of performance and costs, and the appropriate incentives, development, and training for success in a performance-based management environment.[12] Conversion to more performance-based management will provide challenges unique to the MHS, for example, determining how the system will account for the value and cost of the highest priority mission—military readiness.

The Local Authorities Working Group acknowledged that there is an ongoing DoD business planning process, starting with the MHS strategic plan and supported at three levels: MTFs, Multi-Service Markets (MSMs), and regions. Also, DoD has made substantial changes to the management and oversight of TRICARE's purchased and direct care systems through the joint development of a governance plan. This plan established a new regional governance structure, including the creation of TRICARE Regional Offices (TROs) to manage each of the three TRICARE regions (see Chapter 6 for further discussion). The TROs integrate single MTF and MSM business plans with the TRO non-MTF business plan and develop regional business plans for health care delivery.

6 *The Military Health System: Overview: Statement by the Honorable David S. C. Chu, Under Secretary of Defense for Personnel and Readiness, and the Honorable William Winkenwerder, Jr., Assistant Secretary of Defense for Health Affairs, before the Committee on Armed Services, Subcommittee on Personnel, United States Senate, April 4, 2006, p. 4.*
7 *Ibid.*
8 *Ibid.*
9 *Military Health System Strategic Plan: Anytime, Anywhere: Keeping Warfighters Ready, For Life. Available at http://www.ha.osd.mil/strat_plan.*
10 *Military Health System Executive Review: Local Authorities Working Group Final Report, January 2005, p. iii.*
11 *Ibid., p. i.*
12 *Ibid.*

The Working Group observed a number of shortcomings in the maturing business planning process, such as an absence of attention to unique force health protection requirements, and 'weak authority' of the senior market managers. It further noted the complexity in the chain of responsibility for the health care mission involving TMA and its TROs and the services, causing each MTF to have two or three entities providing oversight of its planning and performance processes.[13]

Based on these observations, as well as testimony presented to the Task Force, a review of other reports and studies, and the extensive experience of some of the members of the Task Force at different levels of leadership and management in the MHS, the Task Force concludes that the MHS needs to focus attention on integrating its many components at the operational level. Developing a strategy for implementation is critical and is likely to not only produce efficiencies and cost effective programs, but also improve the management of beneficiary health care, making it more integrated and continuous across providers.

Findings and Recommendations

The MHS does not function as a fully integrated health care system but is divided into a direct care system, which is itself composed of separate service systems, and a system of contracted services (e.g., managed care support contracts and pharmacy). DoD needs a strategy for health care delivery that integrates the direct care system and the contracts supporting DoD health care delivery. Lack of integration diffuses accountability for fiscal management, results in misalignment of incentives, and limits the potential for continuous improvement in the quality of care delivered to beneficiaries.

In major markets within the MHS, such as the National Capital Region or San Antonio, there is insufficient planning and accountability at the local level to ensure integrated provision of services. There is no single point of accountability for costs within a particular market for services provided to the beneficiary population or for health care outcomes.

There are several factors contributing to the lack of an integrated strategy. DoD procedures do not provide for an integrated approach to accountability and financial empowerment for managing overall population health care. This is coupled with fiscal constraints that separate the funding of the direct care and purchased care systems, thereby limiting the flexibility needed at the local level to make the most cost-effective and beneficial health care delivery decisions for beneficiaries.

Recommendation 1

DoD should develop a planning and management strategy that integrates the direct health care system with the purchased care system and promotes such integration at the level where care is provided. This strategy will permit the maintenance and enhancement of the direct care system's support of the military mission while allowing for the optimization of the delivery of health care to all DoD beneficiaries.

13 Ibid., p. 39.

Action Items

- The Office of the Secretary of Defense, the Joint Staff, and the military departments should develop a strategy for health care delivery that integrates the direct and the purchased care systems
- DoD should
  - provide incentives that optimize the best practices of direct care and private sector care,
  - fiscally empower the individuals managing the provision of integrated health care and hold the same individuals appropriately accountable,
  - draft legislative language to create a fiscal policy that facilitates an integrated approach to military health care, and
  - develop metrics to measure whether the planning and management strategy produces the desired outcomes

Business and Health Care Best Practices

One of the Task Force's guiding principles is that any changes that are recommended, when taken as a whole, must result in improvements in the efficiency and clinical effectiveness of military health care by, among other approaches, reflecting best health care practices that are followed in the private sector and internationally.

In its interim report, the Task Force made recommendations about business best practices, in particular, internal controls, and called for independent audits of TRICARE and the Defense Enrollment Eligibility Reporting System (DEERS), as well an audit to determine the level of compliance with law and policy regarding TRICARE as second payer.

The Task Force also was charged to address:

> "The ability to account for the true and accurate cost of health care in the military health system."

Additionally, in the course of its deliberations, the Task Force responded to two elements of its charge relevant to health care best practices, specifically to address:

> Wellness initiatives and disease management programs of the Department of Defense, including health risk tracking, and the use of rewards for wellness;
>
> Education programs focused on prevention awareness and patient-initiated health care.

In furthering its consideration of best practices in business and health care, which included practices regarding financial controls and accounting, the Task Force reviewed various previous reports, including the report of the Healthcare for Military Retirees Task Group of the Defense Business Board, which was identified specifically in the statutory charter for this Task Force[1] and that included numerous recommendations regarding best practices. Although the Task Group reviewed a broad range of studies and reports containing many recommendations that were presented as best practices, this Task Force determined that in its approach, it would limit its recommendations to those viewed as the most strongly supported by evidence. The Task Force inquiry into best practices was organized into three areas of focus:

1) program evaluation,
2) financial controls, including overall controllership, DEERS eligibility and enrollment, and TRICARE as a second payer (where there is other health insurance), and
3) prevention and disease management.

[1] *National Defense Authorization Act for Fiscal Year 2007, P.L. 109-364, § 711(c)(2), 120 Stat. 2085, 2286 (2006) stated: (2) UTILIZATION OF OTHER EFFORTS.—In preparing the report, the task force shall take into consideration the findings and recommendations included in the Healthcare for Military Retirees Task Group of the Defense Business Board, previous Government Accountability Office reports, studies and reports by the Assistant Secretary of Defense for Health Affairs, and any other studies or research conducted by organizations regarding program and organizational improvements to the military health care system.*

Cross-Cutting Theme

A cross-cutting finding of the Task Force is that DoD has not looked sufficiently outside of its own systems to study and potentially adopt best practices in the health care field. Although the Military Health System (MHS) 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 in access, measurement, clinical quality, and overall satisfaction, are areas of significant focus and impressive innovation over the past decade. MHS leadership should be more actively engaged in broad-based discussions in these areas, attending and contributing to national conferences, and for a DoD should improve in this area in a meaningful and sustaining way. A potential solution is detailed in the initial recommendation that follows.

Program Evaluation

Executive Order 13410 established what is called the "Four Cornerstones of Value Driven Health Care," which helps to direct the provision of high-quality and efficient health care in health care programs that are administered or sponsored by the federal government. The order addresses the need for health information technology standards, quality standards, price standards, and incentives. Guidance dictates that "agencies develop quality measurements in collaboration with similar initiatives in the private and non-Federal public sectors."[2]

DoD outlines components of Executive Order 13410 for MHS beneficiaries and states that "the Department of Defense offers complete information for health care decision making through the health care transparency initiative."[3] The information provided focuses on:

- Pricing—TRICARE allowable charges for frequently used procedures and services
- Quality—The sharing of information about quality of services provided by doctors, hospitals, and other health care providers through www.qualitycheck.org
- Information Technology—The use of health information technology systems to facilitate the rapid exchange of health information – the Armed Forces Health Longitudinal Technology Application (AHLTA) and the Pharmacy Data Transaction Service (PDTS)
- High Quality and Efficiency—Developing and identifying approaches that facilitate high-quality and efficient care, to include health plan options and special programs

Selected aspects of TRICARE contractors' performance and beneficiaries' experience of care have been assessed, but this information is not accessible to beneficiaries. In addition, alignment with public and private sector quality assessment and transparency initiatives is variable. There is a growing sense of urgency regarding return on investment in health care, and this has motivated public and private sector purchasers to demand more accountability and transparency from providers. Transparency in quality reporting is frequently an initial step prior to implementation of incentive programs that reward high-quality, high-value care delivery. Because 24 percent of the increase in military health care expenditures from 2000 through 2005 is attributable to general medical inflation,[4] DoD has a substantial opportunity to join with other major purchasers and be an important part of the solution. Yet, current practices in TRICARE are far from aggressive or innovative compared with those of the Centers for Medicare & Medicaid Services (CMS), the Leapfrog Group, and other

2 Executive Order, Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs, 71 Fed. Reg. 51,089 (August 28, 2006).
3 TRICARE Management Activity, TRICARE Health Care Transparency Initiative, November 7, 2007. See www.tricare.mil/transparency.
4 David M. Walker, Comptroller General of the United States, DoD's 21st Century Health Care Spending Challenges: Brief to the Task Force, April 18, 2007.

major purchasers DoD has been working to establish relationships and collaborations with major purchasers including CMS The President's Executive Order provides a roadmap for aligning closely with the Department of Health and Human Services (HHS), the Department of Veterans Affairs (VA) and the Office of Personnel Management (OPM) for public reporting on quality and cost and for establishing incentive programs Incentives for high-quality, high-value care delivery will require incentives for beneficiaries and providers The MHS could be well served by its collaboration with the private sector and other federal agencies and should continue to improve it

Recommendation 2

DoD should charter an advisory group to enhance MHS collaboration with the private sector and other federal agencies in order to share adopt, and promote best practices

Action Items

- DoD should
  - align with HHS VA, OPM and private sector organizations to make health care quality and costs more transparent and easily accessible by all beneficiaries
  - use performance based clinical reporting by managed care support contractors and the direct care system
  - strengthen incentives to providers and health insurers to achieve high-quality and high-value performance, and
  - implement a systematic strategy of pilot and demonstration projects to evaluate changes in MHS practices and identify successful practices for more widespread implementation

Financial Controls

Internal Control Issues

Controllership presents unique challenges within the overall rubric of the military health care system's financial sustainability Controllership has been defined as a commitment to compliance, effectiveness and integrity that spells out how each is to be achieved [5] Federal management is responsible for establishing and maintaining internal controls to achieve the objectives of effective and efficient operations, reliable financial reporting, and compliance with applicable laws and regulations [6] On December 21 2004, the Office of Management and Budget (OMB), pursuant to its authority under the Federal Managers' Financial Integrity Act of 1982 [7] issued revisions to OMB Circular A-123 Management's Responsibility for Internal Control [8] OMB Circular A-123 provides guidance to federal managers on improving the accountability and effectiveness of federal programs and operations by establishing assessing, correcting, and reporting on internal control [9] DoD's Managers' Internal Control Program was established to review, assess, and report on the effectiveness of internal controls within DoD [10] Part of the program's intent is to identify and promptly correct ineffective internal controls and establish more effective internal controls when warranted [11]

5 Robert A Parker The Company He Keeps Controller Magazine March 1998 p 19 See www.businessfinancemag.com magazine/archives/article.html?articleID=4322
6 OMB Director's Letter to Heads of Executive Departments and Establishments dated December 21 2004 para 1 See www.whitehouse.gov/omb/circulars/a123/a123_rev.pdf
7 31 U S C §3512 (2004)
8 OMB Controller's Memorandum to Chief Financial Officers Chief Operations Officer Chief Information Officers and Program Managers dated December 21 2004 See www.whitehouse.gov/omb/circulars/a123/a123_rev.pdf
9 Ibid
10 DoD Instruction 5010.40 §4 Managers Internal Control (MIC) Program Procedures January 4 2006
11 Ibid

Eligibility Determinations

DoD is responsible for the distribution of authorized medical and dental benefits and entitlements as prescribed in Chapter 55 of Title 10 of the U.S. Code.[12] DEERS is the designated automated information system designed to provide timely and accurate information on those eligible for medical and dental benefits and entitlements and to prevent and detect fraud and abuse in the distribution of these benefits and entitlements.[13] It is the definitive data source to identify and verify affiliation with DoD.[14] DEERS serves as the centralized personnel data repository that supports and maintains this policy in a uniform fashion.[15] DEERS is updated by batch transactions from the Uniformed Services automated personnel, finance, medical, and mobilization management systems, VA, and CMS.[16] DEERS also is accessed and updated by online DEERS client applications.[17] Registration in DEERS is required for TRICARE eligibility.[18]

The services use a two-step process to determine eligibility to receive medical or dental care.[19] Before routine care, ancillary care, or administrative services are provided, designated Military Treatment Facility (MTF) personnel confirm the identity of patients, including those in uniform, by ensuring that they show valid identification. They also check the patient's status within DEERS to verify entitlement.[20] If the beneficiary's eligibility cannot be verified, a locally developed form is filled out and the patient is counseled that he or she must return with verification of eligibility within 30 days or he or she will be billed for care rendered.[21]

Experience in the private sector, however, has demonstrated that the primary source of errors in eligibility determinations is data entry. This mainly occurs when there is a lag time between a change in eligibility and its registration. Examples include termination of service, the aging out of a dependent, or a change in coverage due to divorce.

Best Practices

In assessing the overall issue of financial controllership, the Task Force reviewed a sampling of reports, especially audits, independent reports (including those of GAO), reports of the DoD Program Integrity Office within the TRICARE Management Activity (TMA), and Inspector General (IG) reports (DoD and the military departments). The Task Force also interviewed senior management officials from TRICARE and the Defense Management Data Center (DMDC), which is responsible to the Under Secretary of Defense for Personnel and Readiness (P&R) and which has responsibility for DEERS. Outside experts in the private sector such as Hewitt Associates and RAND were consulted as well.

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12 DoD Instruction 1341.2 §4, Defense Enrollment Eligibility Reporting System (DEERS) Procedures, March 9, 1999.
13 Ibid.
14 TRICARE Systems Manual 7950.1-M §2.1, DEERS (Change 43, May 7, 2007, to the August 1, 2002, edition).
15 DoD Instruction 1341.2 §4, Defense Enrollment Eligibility Reporting System (DEERS) Procedures, March 19, 1999.
16 Ibid.
17 Ibid.
18 DEERS Information Home on the TRICARE website at www.tricare.mil/deers/default.cfm.
19 AR 40-210 §5-1, Patient Administration Functions: Establishing Eligibility for Care, March 22, 2006.
20 Ibid., at §3-1-2-1.
21 Ibid., at §3-1-2-4.

DEERS

The policies, practices, and procedures for the oversight of enrollment and eligibility data appeared to be of fairly high quality; however, as is true in the private sector regarding the oversight of health plan financial controls and coordination of benefits, weaknesses in the system can arise. In this case weaknesses were apparent between the personnel offices of the Uniformed Services and DMDC, whose DEERS database is relied upon for verifying eligibility in different settings, such as when a person seeks access to an MTF or other health care provider in the private care segment of TRICARE. DEERS generally requires substantiating documentation (e.g., marriage certificates, birth certificates) to determine eligibility that goes beyond what usually is required in the private sector and has automated systems to detect claims for which TRICARE should not be a payer at all or for which TRICARE should be a secondary payer (DMDC maintains data on other health insurance and dual eligibility for Medicare).

According to DMDC/DEERS officials, the latest comprehensive audit was conducted in 2001,[22] which resulted in a recommendation to the Under Secretary of Defense (P&R) to develop and implement a comprehensive data quality assurance program to verify the completeness, existence, and accuracy of both the new and existing data residing in the DEERS database. DMDC informed the Task Force that the findings were disputed, and that the accuracy and reliability of data were much higher than indicated. DMDC said its level of identity verification, verification of source documents, and validation of family relationships is "much more stringent than in the commercial healthcare arena." It performs matches with Social Security data and other agencies, periodically audits identification card facilities, has markedly improved quality assurance programs, and has improved the interface with personnel systems of the services.[23]

However, even with the significant improvements that have been made in the system over the past several years, several factors continue to create an especially challenging environment for eligibility determinations and tracking. These include the pace of activity, the numbers of beneficiaries coming into or going out of the system, the heavy reliance on Reserve Components, and the frequent changes in family situations of beneficiaries. These changes have a significant impact on a system that relies largely on the self-reporting of events that trigger eligibility or ineligibility for benefits. These trends justify an external audit in the area of financial controls.

A review of other reports with related recommendations showed that often it is difficult to track the implementation of recommendations regarding the need for audits and investigative reports, at least in part because there does not appear to be a centralized, proactive locus of accountability driving financial controllership across the MHS. Also lacking are significant efforts to conduct outreach to private sector purchasers and plan sponsors of health benefit plans. Industry best practices include ensuring centralized accountability that crosses "silos," or the organizational entities, conducting continual outreach to determine best practices, and promoting enhanced reliability in personnel offices through greater automation and self-service. These practices, when combined with the integration of business rules, result in data that are more accurate and reliable for use in the coordination of health care benefits.

22 DoD Inspector General Audit Report, "Beneficiary Data Supporting the DoD Military Retirement Health Benefits Liability Estimate," D-2001-154, July 5, 2001. Note: The objective of the audit was to assess the reliability and completeness of the demographic data used to calculate the DoD military retirement health benefits liability. The Inspector General found that DEERS data provided to the actuary were reliable only 85 percent of the time—15 percent of the 8.4 million beneficiaries included in the extract were ineligible, unable to be verified, or had incorrect critical data in the DEERS record.
23 DMDC Response to the Task Force on the Future of Military Health Care Interim Report, October 10, 2007.

TRICARE as Second Payer

To the degree that TRICARE is to be a second payer (see Chapter 10), Congress has authorized the military services to bill insurance companies under the Third Party Collection Program to help pay the rising cost of providing health care to a growing number of eligible beneficiaries.[24] DoD promulgated an instruction detailing the specifics of the Third Party Collection Program.[25]

Furthermore, Congress has expressly stated that when a person is covered by both TRICARE and a third party payer (insurance, medical service, or a health plan by contract or agreement), and both TRICARE and the third-party payer cover the same benefit, then the government cannot pay for the benefit with a limited exception.[26]

The guidance provides uniform policies and procedures but it does not provide a common means of accomplishing the billing. Of the three services, the Air Force is the only one that recently converted to a two contractor national third-party collection program. Positive efforts have been noticed, as the Air Force now collects a larger portion than the other two services.[27] It may be time for the services to unify and maximize its efforts to collect from third parties, perhaps by using contractors.

When compared to the overall DoD health care budget, the Third Party Collection Program recovers a small a fraction of a percent back to the MTFs. And it is important to note that Congress did not intend to decrement the Defense Health Program budget with an expected program for third-party collection; such a program was to create an incentive to collect these funds, which were not programmed into the MTF budget.

However, in 2004, GAO posited its viewpoint after conducting an MTF third-party collection audit by stating: "Our point, taking a broader view, is that every dollar recovered from third-party insurers is one more dollar for the Congress to consider in funding the government's operations."[28] A more recent recommendation from the 2007 DoD IG and Army Audit Agency stated, "We recommend that the Surgeons General of the Army, Navy and Air Force inform the commanders of military treatment facilities that collections from insurance providers are credited to appropriations of the MTF and do not result in reduced budgets." The GAO and IG positions cannot be reconciled. After more than 10 years of the Third Party Collection Program, MTF commanders would know whether their budgets were decremented by their service and would not need to be reminded by the DoD IG.

With regard to dispensing pharmaceuticals, MTFs provide maintenance drugs in 90 day supply increments, but most Pharmacy Benefits Managers or civilian fiscal intermediaries who process the Third Party Collection Program claims of multiple civilian insurers provide payment for only a 30-day supply, leaving 60 days uncollected. MTF personnel are unaware of and Pharmacy Benefits Managers are not adhering to federal law, which allows the MTF to collect for all 90-day supplied pharmaceuticals.[29] This area, if audited, may reveal the magnitude of the apparent noncompliance with the law and the value of implementing cost-saving and enhanced enforcement mechanisms such as penalties to insurers for noncompliance or additional education and training for MTF personnel.

24 10 U.S.C. §1095(g) (2001)
25 DoD 6010.15-M, Military Treatment Facility Uniform Business Office Manual, Chapter 4, November 9, 2006
26 10 U.S.C. §1079(j)(1) (2005)
27 Quarterly Third Party Collection Report from MTFs, Uniform Business Office to TRICARE Management Activity, October 2007
28 GAO, Military Treatment Facilities: Improvements Needed to Increase DoD Third Party Collections, GAO-04-322R, Washington D.C., February 20, 2004, p. 12
29 32 C.F.R. §220.3(b)(3) (2007)

Recommendation 3

DoD should request an external audit to determine the adequacy of the 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

Action Items

- DoD should
  - charge the auditor with assessing the most efficacious and cost-effective approach, for example fraud identification and prevention and system changes to the DMDC and/or DEERS
  - ensure that audit recommendations are implemented and include follow-up and
  - establish a common cost accounting system that provides true and accurate accounting for management and supports compliance with law that TRICARE be a second payer when there is other health insurance (See also discussion below)

Financial Reporting in the MHS

The MHS comprises three internal stand-alone auditable financial statements for 1) the Services Medical Activity (SMA) 2) TMA and 3) the Medicare-Eligible Retiree Health Care Fund (MERHCF)

The financial statement information for the medical departments of the Army Air Force, and Navy are rolled up to TMA and are consolidated under one set of stand alone auditable financial statements under SMA These statements currently are not auditable because of financial and information systems problems, as well as inadequate business processes and internal controls The MHS plans to have these statements ready for audit and an unqualified opinion by Fiscal Year 2015 [30]

The financial statement information for 1) private sector care, 2) TRICARE operations (headquarter costs) and 3) the Uniformed Services University of the Health Sciences are consolidated under one set of stand-alone consolidated financial statements under TMA Like the SMA statements, these statements currently are not auditable because of financial and information systems problems, as well as inadequate business processes and internal controls The MHS plans to have these statements ready for audit and an unqualified opinion by Fiscal Year 2010 [31]

MERHCF's financial statements differ from those of SMA and TMA because they are ready for audit as a stand alone reporting entity The MERHCF financial statements were audited in Fiscal Year 2006 and received a qualified audit opinion In Fiscal Year 2005, independent auditors found that workload, medical coding and data information systems, cost accounting systems and financial data flows from one system to the next were unreliable [32]

In Fiscal Year 2006, these same deficiencies continued [33] These material weaknesses prevented the fund from receiving an unqualified opinion on its financial statements DoD is anticipating that these material weaknesses will reappear in the Fiscal Year 2007 auditors opinion of MERHCF The MHS plans to have these financial statements ready for an unqualified opinion by Fiscal Year 2009

30 *Defense Financial Improvement and Readiness Plan September 2006 p 39*
31 *Ibid*
32 *Independent Auditors Report on the MERHCF Fund from Deloitte and Touche LLP (CPA Firm) October 31 2005 to the Inspector General of the Department of Defense*
33 *Defense Financial Improvement and Readiness Plan September 2006 p 45 46*

The most significant challenge to the MHS continues to be the existence of financial, cost accounting, and information systems that do not interface well with one another, and the inability of such systems to comply with Generally Accepted Accounting Principles (GAAP) and other standards

MERHCF is currently limited to Medicare eligible retirees over age 65 The Defense Advisory Committee on Military Compensation and the Medicare Eligible Retiree Health Care Board of Actuaries both promoted the adoption of pre-Medicare-eligible retirees into the fund [34] [35] If adopted, moving the pre-Medicare eligible retirees into MERHCF would be consistent with GAAP

DoD's Performance and Accountability Report

An independent auditor's report of Fiscal Year 2006 DoD financial statements conducted through the IG's Defense Financial Auditing Service also cited standing material weaknesses and a lack of internal controls as the cause for the disclaimer of opinion [36] These control deficiencies are so significant that they can cause material misstatements (gross understatement or overstatement) in the financial statements and internal controls are lacking or are so weak that tests of internal controls are not feasible

Before an audit can be conducted on an organization's financial statements, it must provide a statement of assurance on its internal controls over financial reporting For Fiscal Year 2006, DoD provided a qualified statement of assurance for its internal controls over financial reporting However the IG's Defense Financial Auditing Service disagreed with DoD's qualified statement of assurance on internal controls over financial reporting

Internal Controls Financial Management Feeder Systems, and Reporting

The Sarbanes-Oxley Act of 2002 (PL 107-204) served as the motivating force for the federal government to re-evaluate its policies on internal controls and resulted in the issuance of OMB Circular A-123 Appendix A Internal Controls over Financial Reporting [37] This appendix specifically requires government agencies to document the process and methodology for applying the standards for assessing internal controls over financial reporting DoD has plans to implement the necessary processes and financial internal controls to improve financial reporting and continue to move toward auditable financial statements

Most DoD accounting systems were designed to record and track costs on a budgetary basis and were not designed to collect and record financial transactions on an accrual basis in accordance with GAAP In addition many of the DoD feeder systems that interface and automatically record accounting transactions into the official accounting systems were designed for logistics or other purposes and not necessarily for financial purposes or for compliance with the Federal Financial Management Improvement Act of 1996 (FFMIA) Until all DoD financial and other information systems are aligned and updated to record and report financial information in accordance with GAAP, DoD financial information will continue to be difficult to validate DoD Financial Improvement and Audit Readiness (FIAR) plans are to move the department toward auditable financial statements

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34 *The Military Compensation System Completing the Transition to an All Volunteer Force Report of the Defense Advisory Committee on Military Compensation April 2006 p 84*
35 *Report to the President and Congress on the Department of Defense Medicare Eligible Retiree Health Care Fund Department of Defense Medicare Eligible Retiree Health Care Board of Actuaries January 25 2006 p 14*
36 *Inspector General Defense Financial Auditing Service Independent Auditor's Report on the Fiscal Year 2006 Department of Defense Agency Wide Financial Statement D 2007 020*
37 *OMB Circular A 123 Management's Responsibility for Internal Control Appendix A Internal Control over Financial Reporting p 20*

DoD acknowledges that it is unable to fully implement all elements of GAAP and OMB Circular A-136 because of limitations in its financial management processes and systems and nonfinancial systems and processes that feed into the financial statements [38] In an August 2007 report GAO noted continued progress in two key areas 1) agency-required mediation plans, and 2) OMB efforts to address system implementation problems [39] However, it also mentioned that "agencies continued to struggle to modernize financial management systems," [40] and specifically singled out DoD by stating that "this problem is particularly severe at the Department of Defense" [41]

Internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial statements Internal controls over financial reporting should assure the safeguarding of assets the accurate and timely recording of transactions, and compliance with applicable laws and regulations The Fiscal Year 2006 DoD Report on Internal Controls and Compliance with Laws and Regulations states, "DoD financial management and feeder systems were not designed to adequately support various material amounts on the financial state ments These systemic deficiencies in financial management and feeder systems, and inadequate DoD business processes result in the inability to collect and report financial performance information that is accurate reliable, and timely" [42] If DoD does not have the accounting and information systems, business processes, and internal controls over financial reporting to attest to the reliability of its financial statements then DoD financial statements cannot be audited

Cost Accounting in the MHS

The effectiveness of the MHS cost accounting system also needs to be evaluated The Medical Expense and Performance Reporting System (MEPRS) is the cost accounting system that has been used by MHS for many years to calculate unit costs MEPRS is complex, with heavy reliance on multiple systems that feed and interface with each other and that are prone to user errors even at the lowest level, where labor cost allocation depends on individual input In addition, reported workload and coding effectiveness often are unreliable These are significant problems in the MHS cost accounting system that affect the correct calculation of unit costs

DoD's cost system problems are persistent and longstanding In a May 1999 GAO report to Congress on the Medicare Subvention Demonstration, GAO identified major concerns with MEPRS to include inconsistent data collection and reporting service differences in how depreciation is recorded, and the completeness of the accounting for all relevant expenses [43] In Fiscal Year 2005, independent auditors identified as unreliable workload/medical coding data/information, cost accounting systems and financial data flows from one system to the next [44] In March 2007 the IG of the United States issued a report on financial data processed by MEPRS, stating that a number of serious weaknesses were found [45]

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38 DoD Performance and Accountability Report FY 2006 p 10
39 Financial Management Long standing Financial Systems Weaknesse Present a Formidable Challenge Highlight GAO 07 911 August 2007
40 Ibid
41 Ibid p 4
42 DoD Performance and Accountability Report FY 2006 p 78
43 Medicare Subvention Demonstration DoD Data Limitation Require Adjustment and Raise Broader Concerns GAO/HEHS 99 39 May 1999 p 7 17
44 Independent Auditors Report on the MERHCF Fund from Deloitte and Touche LLP (CPA Firm) October 31 2005 to the Inspector General of the Department of Defense
45 Department of Defense Inspector General Financial Data Processed by the Medical Expense and Performance Reporting System D2007 073 March 21 2007 Executive Summary

The Assistant Secretary of Defense for Health Affairs did not concur with the IG report and stated that it misrepresented the purpose of MEPRS. He also did not concur that Health Affairs had a material weakness. He stated that the system provides detailed uniform performance indicators, common expense classification by work center/cost center, uniform reporting of personnel utilization data by work center, and a standardized labor cost assignment methodology. He stated that MEPRS was not designed to support financial accounting, financial reporting, or patient-level accounting.[16]

Improving DoD Pharmacy Cost Management

In its 2006 FIAR Plan, DoD pointed out that the PDTS system provides a good example of a modern cost accounting and health system designed to collect information about patient-level pharmacy use and costs.

MERHCF is relying on PDTS to collect accurate financial and cost accounting information at the patient level to one day achieve an unqualified opinion in its financial statements. DoD and the Enterprise Transition Plan (ETP) must successfully identify, implement, and integrate systems such as PDTS that meet the needs of patients and improve outcomes, while providing necessary and reliable cost accounting data that will meet financial reporting requirements of the MERHCF financial statements. However, integrating systems such as PDTS with current systems may be a formidable and expensive challenge.

Findings

MHS financial accounting and reporting and cost accounting systems are in need of significant improvement or even a complete overhaul. At the core of DoD's accounting problems are its deficiencies in financial reporting systems, cost accounting systems, and other administrative and program management systems that prevent the accurate reporting of financial and cost accounting information in the MHS. It is difficult to use financial statement and MEPRS cost accounting information to make decisions or comparisons with private sector data. This is due to outdated systems and inappropriate allocation of overhead, depreciation, labor, and other unit cost expenses, which make them inaccurate. Many of these financial management and feeder systems were initially designed for budgetary purposes and not necessarily for preparing financial statements in accordance with GAAP. Until DoD and the MHS correct the overall systems architecture problems and align these systems to support financial reporting and cost accounting across the agency, DoD cannot provide financial statements that are reliable or that account with a high level of confidence the true and accurate cost of health care in the MHS. In addition, lack of adequate business processes and effective financial internal controls continue to hinder DoD's ability to report financial and performance information that is accurate, reliable, and timely.[17]

MEPRS problems are persistent and longstanding and the reliability of the information it provides has always been questioned. MEPRS suffers from significant inherent problems that range from multiple unreliable systems that do not properly interface to ineffective internal controls, to lack of user knowledge and education. MEPRS problems appear to be systemic and need to be evaluated to include an assessment of the feasibility of significant change, overhaul, or replacement.

16 Department of Defense Inspector General, Financial Data Processed by the Medical Expense and Performance Reporting System, D2007-075, March 21, 2007, Management Comments and Audit Response.
17 DoD Performance and Accountability Report FY 2006, Report on Internal Control and Compliance with Laws and Regulations.

The Task Force agrees with the Assistant Secretary of Defense for Health Affairs that MEPRS was not designed for accrual accounting and GAAP compliance and that those objectives must be met through the financial accounting systems. Since it is now necessary for many government agencies to achieve GAAP compliance, this presents a major challenge for the government and specifically for DoD. These financial accounting challenges are being addressed through the FIAR plan and the ETP. However, MEPRS data continue to be unreliable and cannot provide patient-level data.

Common Accounting System

Because the Task Force also was asked to assess the "ability to account for the true and accurate cost of health care in the military health system,"[18] the Task Force would like to highlight issues involving the cost accounting system, including the need for a common cost accounting system across the MHS as a best practice. The current system, in use since 1986, is highly inaccurate and inadequate for various reasons. It does not measure the value of true outputs (health or readiness capabilities), does not capture all DoD health care costs, and is inconsistent in how labor costs are allocated (e.g., relies on self-reporting and on policies and practices that are not uniform across the services). This makes it difficult to compare direct care with private care and care provided among the services.

As noted above, the Task Force recommends that DoD establish a common cost accounting system that provides true and accurate accounting for management and supports compliance with law that TRICARE be a second payer when there is other health insurance.

Wellness Initiatives, Disease Management, Prevention Awareness, and Patient Initiated Care

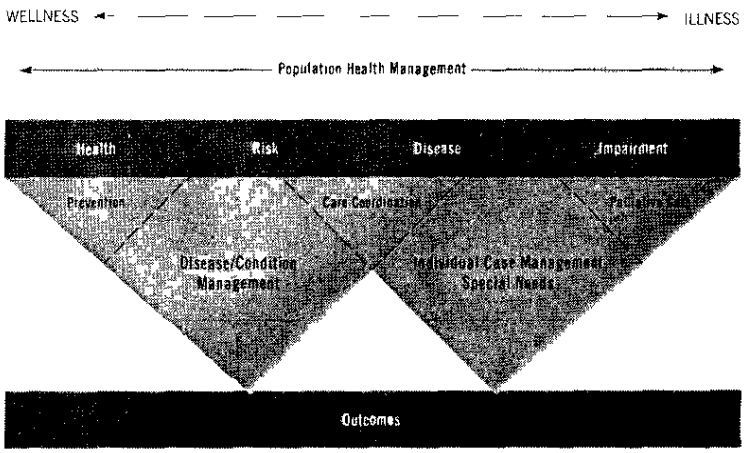
As part of its charge, the Task Force was asked to assess "wellness initiatives and disease management programs of the Department of Defense, including health risk tracking and the use of rewards for wellness." In addition, it was asked to review "education programs focused on prevention awareness and patient-initiated health care."

The health care continuum covers everything from prevention to serious illness and includes the provision of ongoing patient education programs, clinical and administrative interventions, and expert care coordination/case management at the appropriate times. TMA addresses this continuum of care in its Population Health and Medical Management Model and designed the DoD Medical Management program to support the model (see Figure 1).

However, to achieve the desired outcome of a healthy population and to optimize the use of scarce health care resources, there must be an emphasis on wellness and prevention education programs that support these objectives.

18 National Defense Authorization Act for Fiscal Year 2007, P.L. 109-364, § 711(c)(3)(C), 120 Stat. 2083, 2286 (2006).

POPULATION HEALTH AND MEDICAL MANAGEMENT MODEL



Source: Military Health System Briefing, Medical Care Management Model, Health Care Delivery Integration Board, July 11, 2007, Slide 4

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DoD Wellness and Prevention Initiatives

The services, in accordance with the medical management program outlined by TMA, have implemented service-specific wellness and disease prevention programs that are generally consistent with HHS's Healthy People 2010 goals and consistent with Partnership for Prevention's National Commission on Prevention Priorities (NCPP).[49] NCPP evaluated and ranked preventive services on a 2- to 10-point scale based on clinically preventable burden (CPB) and cost-effectiveness. CPB is measured as quality-adjusted life years (QALYs) gained.

MHS literature indicates that the preventive services being monitored are generally consistent with NCPP's priorities and that the services have elevated the priorities of suicide prevention and stress management and also have implemented programs unique to MTF locations or designated populations that are not covered in the current MHS literature. The clinical outcomes of selected preventive services are monitored in the MHS Balanced Score Card Metric Panel.

TMA's research indicates that unhealthy lifestyles significantly increase the cost of health care,[50, 51] and that tobacco adversely impacts readiness by increasing the likelihood of injury and lost productivity, decreasing night vision, exacerbating noise-induced hearing loss, and slowing wound healing.

49 Partnership for Prevention, "Priorities for America's Health: Capitalizing on Life Saving, Cost-Effective Preventive Services," 2006. See www.prevention.org/ncpp.
50 DoD spends an estimated $2.1 billion per year for medical care associated with tobacco use, obesity, and alcohol consumption (referred to as TOBESAHOL), with tobacco use accounting for $564 million of those costs. DoD also incurs nonmedical-related costs of $965 million.
51 Timothy Doll, Yidna Zhang, Yao-hu Chen, Rachel Ackermann Wagner, Paul Hogan, Nancy Fagan, Samuel Olaiya, David Tornberg, "Cost Associated With Being Overweight and with Obesity, High Alcohol Consumption, and Tobacco Use within the Military Health System TRICARE Prime Enrolled Population," Accepted for publication August 2007, American Journal of Health Promotion.
52 Jack Smith, MD, MMM, Acting Deputy Assistant Secretary of Defense for Clinical and Program Policy, Chief Medical Officer, TRICARE Management Activity, Brief to the Task Force, July 11, 2007, Slide 23.

The August 2007 MHS Balanced Score Card Metrics Panel indicated that the services are not meeting the Healthy People 2010 goal of an 88 percent nonsmoking rate. The Active Duty population scores lower in this area than all beneficiary populations and the U.S. population generally. But the Active Duty population consistently surpasses the Healthy People 2010 goal and the U.S. population rates generally in preventing obesity. Other TRICARE beneficiary populations surpass the U.S. population in lower rates of obesity, but do not meet the Healthy People 2010 goal of 85 percent. The MHS 2005 binge drinking rate ranges between 33.9 and 53.2 percent, while the DoD rate is 44.5 percent. Five additional DoD preventive services fail to meet Healthy People 2010 standards.[53]

TMA sponsors a number of demonstration and pilot programs, such as Tobacco-Free Me, the Make Everyone Proud Tobacco Use Counter Marketing Campaign, and That Guy, an alcohol abuse reduction campaign for Active Duty service members. TMA, however, does not reimburse beneficiaries for some preventive services, such as smoking cessation interventions. Smoking cessation is covered in the MTF at the discretion of the commander and with facility funds, but there is nothing in the current regulations that allows for network reimbursement for smoking cessation programs. TMA will reevaluate the policy after its current smoking cessation demonstration project ends in September 2008 and will use the demonstration results to determine the feasibility of a comprehensive tobacco cessation benefit for its beneficiaries.[54] The NCPP scores smoking cessation as a "10" on a 2- to 10-point scale, this underutilized service has the highest potential for additional QALYs (1,800,000) saved if utilization were increased to 90 percent. (See Appendix F for additional information on DoD's wellness programs.)

Prevention-Focused Beneficiary Education

The promotion of wellness through behavioral change requires basic health and prevention education, personal interaction with licensed health care personnel and point-of-service education with follow-up. Additionally, education must continue along the continuum of care. To this end, TMA has funded evidenced-based demonstration and pilot projects to address the leading causes of preventable illnesses and death among its beneficiaries. These projects, all of which incorporate educational programs, will help in evaluating the feasibility and effectiveness of new interventions that could encourage healthier lifestyles.

DoD programs are executed at the service level: the Navy through its Navy Environmental Health Center, the Army through its Center for Health Promotion and Preventive Medicine, and the Air Force through its Population Health Support Division. Educational components are incorporated into programs using the appropriate media.

TRICARE's Health Promotion & Prevention website supports education through a series of links to military and other health promotion sites and through educational programs. TRICARE's website hosts a comprehensive body of detailed information related to TRICARE, which is accessible to all who are computer literate. The TRICARE for Life plan also is comprehensively outlined in a 36-page handbook.[55] Patients who do not have electronic access or who have cognitive limitations depend on the direct and purchased care environments for plan and health education.

53 *TRICARE Management Activity Health Policy Analysis and Evaluation, Evaluation of the TRICARE Program, FY 2007 Report to Congress, February 2007. See www.tricare.mil.*
54 *Jack Smith, MD, MMM, Acting Deputy Assistant Secretary of Defense for Clinical and Program Policy, Chief Medical Officer, TRICARE Management Activity, Brief to the Task Force, July 11, 2007, Slide 25.*
55 *TRICARE for Life Handbook, at www.tricare.mil.*

The success of any educational program is contingent upon beneficiary compliance with stated care regimens and compliance is either intrinsically or extrinsically motivated. Private sector programs, while consistent with industry best practices and DoD's approach to prevention, are moving toward different approaches to accomplish patient compliance and personal responsibility for health and wellness. A foundation for these programs is patient education. Programs are structured around worksite wellness teams used by the Wellness Councils of America, financial incentives/bonuses for practicing healthy habits and behaviors as outlined by Clarian Health, and discounts in deductibles for healthy outcomes on screenings and abstinence from tobacco use provided by UnitedHealthcare Group.[56] [57] DoD is constrained in its ability to provide such incentives, but is exploring avenues to address these constraints.

Although it is evident that the services offer and sometimes even mandate wellness education and disease prevention services, a standardized approach is lacking. To consolidate and standardize wellness education and wellness program implementation, the Air Force's Health and Wellness Centers could be used as the MHS model. Once fully implemented and resourced, this model would facilitate comprehensive program evaluation, the documentation of outputs, and the cost analyses that would be needed to determine return on investment in terms of QALYs saved in the long term.

DoD Case Management

TMA's Medical Management Guide outlines case management for the services as "a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options and services to meet complex health needs through communication and available resources to promote quality, cost effective outcomes."[58] This is consistent with the American Case Management Association definition of case management as a collaborative practice model that includes patients, nurses, social workers, other practitioners, caregivers, and the community. The process encompasses communication and facilitates care along a continuum through effective resource coordination. The goals of case management include the achievement of optimal health, access to care, and appropriate utilization of resources, balanced with the patient's right to self-determination. As such, effective case management underpins the continuum of care in relation to prevention and disease management."[59]

56 *David Hunnicutt, The 10 Secrets of Successful Worksite Wellness Teams, 2007 Wellness Councils of America Absolute Advantage Magazine, 2007 6(5) 6-15*
57 *Daniel Lee, Clarian Won't Dock Workers Who Fail to Meet Health Standards, The Indiana Star, November 1, 2007. See www.indystar.com/apps/pbcs.dll/article*
58 *The Case Management Society of America, at www.cmsa.com*
59 *American Case Management Association, at www.acmaweb.org/section.asp*

Of particular concern is the transition of patients from the MHS to the VA health systems. To improve DoD and VA clinical case management services provided to service members, families, and other beneficiaries, the VA/DoD Health Executive Council established the DoD/VA Seamless Transition Clinical Case Management Work Group.[60] The group is charged with

- identifying key clinical case management concepts, processes, and subject matter experts
- identifying and defining policies, regulations, key concepts, clinical processes, and business procedures that guide the seamless transition of service members and other beneficiaries,
- assisting in developing and sustaining standardized qualifications, education, and resources for clinical case management in support of seamless transition of service members and other beneficiaries,
- reviewing and recommending clinical case management functions and work flow for effective case management related to the integration of information systems and policies that directly support the seamless transition of service members and beneficiaries
- developing a joint process for ensuring seamless transitional care of the Wounded Warrior using relevant DoD and VA documents and guidance and industry standards, and
- identifying potential gaps in the tracking of severely wounded Warriors

Additionally, the Dole-Shalala Commission recommended the development and implementation of federal recovery coordinators to oversee the care of severely wounded service members across federal agencies.[61] This role is intended to complement the services' case management approaches. In conjunction with the DoD/VA Senior Oversight Committee, the Army's approach to improving case management includes U.S. Warrior Transition Units to which seriously wounded service members would be assigned.[62] These initiatives should address the need for standardized case management in both the inpatient and outpatient health communities and would serve to support care coordination across the health care continuum.

GAO report number GAS-07-12567 states that work continues on determining the number of federal recovery coordinators needed. This is due in part to a lack of clarity regarding the portion of returning Service members' these recovery coordinators will serve. The report further states that more than half of the U.S. Warrior Transition Units had "significant shortfalls" in one or more of the required critical positions. Seventeen of 32 units had less than 50 percent of "critical staff members in place."[63] Because inpatient and outpatient case management are inextricably linked, case management reform will affect current MHS case management programs.

60 Charter, DoD/VA Seamless Transition Clinical Case Management Work Group (5-9 May 2007). Received 19 October 2007 by electronic mail from Lieutenant Colonel Glenda Mitchell, Office of the Chief Medical Officer, TMA in response to an RFI from Lieutenant Colonel Glenda Mitchell, Office of the Chief Medical Officer, TMA.

61 The Commission on Care for Returning Wounded Warriors, Serve, Support, Simplify: Report of the President's Commission on Care for America's Returning Wounded Warriors, July 2007.

62 U.S. Warrior Transition Units require that each service member be assigned to a team of three key staff—a physician case manager, a nurse case manager, and a squad leader.

63 DoD and VA, Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Service Members, GAO-07-12567, September 26, 2007.

DoD Disease Management

The services have implemented disease management programs in a resource-constrained environment that include the reporting of select Health Employer Data Information System (HEDIS) metrics through the business planning process and through service-specific systems and venues—the Army through the Command Management System, the Air Force through the Executive Global Look, and the Navy through the Population Health Navigator. Service programs are supported by the Military Health System Population Health Portal (MHSPHP), a centralized, secure, web based population health management system that transforms DoD and network health care administrative data into actionable information. DoD is working to establish a relevant disease management program for the MHS.

MHSPHP methodologies are based on HEDIS measures and methodologies. The MHSPHP has four primary sections: demographics, preventive services, disease/condition management, and administration. It provides aggregate reports, provider-level patient action lists, and administrative data and contact information.[64] The services have concurred on making disease management a critical initiative in the Tri-Service Business Planning Process. However, there is no consolidated report of MHS performance, and the metrics are not reported in the MHS Balanced Score Card Metric Panel. Except for a piloted Army Medical Department (AMEDD) provider score card, clinical providers have no efficient and timely way to monitor their performance in relation to peers.[65] Likewise, beneficiaries, MTFs, regions, and respective service commands do not have this capability.

Recognizing the need for a comprehensive disease management program, TMA, based on the September 8, 2005 MHS Disease Management Summit, adopted a unified approach to disease management across TRICARE regions in accordance with Assistant Secretary of Defense for Health Affairs guidance. Three disease states currently are being monitored: congestive heart failure, asthma, and diabetes. A phased implementation began on September 1, 2006. An evaluation of clinical outcomes, utilization, and financial outcome measures is due in December 2007.

Work is in progress to meet National Defense Authorization Act 2007 requirements to address specific disease conditions in disease management. Programs must meet nationally recognized accreditation standards, specify outcome measures and objectives, include strategies for all beneficiaries (including Medicare), and conform to the Health Insurance Portability and Accountability Act of 1996 laws and regulations. A report on design and implementation planning is due to Congress on March 1, 2008.[66]

64 Air Force Medical Support Agency, Population Health Support Division, MHS Population Health Portal Methods, July 2007.

65 The AMEDD Provider Score Card is an automated tool that allows personnel to quickly gauge the performance of a provider clinic, MTF, region, or command on clinical quality metrics, satisfaction, productivity, and data quality in a snapshot format. The tool provides graphs and charts for a rolling 12 month period. Paul Cordts, Army Medical Department Changes to Improve Healthcare Outcomes, brief to the Task Force, July 11, 2007.

66 Jack Smith, MD, MMM, Acting Deputy Assistant Secretary of Defense for Clinical and Program Policy, Chief Medical Officer, TRICARE Management Activity, Brief to the Task Force, July 11, 2007, Slides 14–15.

Findings and Recommendations

The services are conducting wellness and prevention programs generally in accordance with recommendations of NCPP. In addition, they have prioritized suicide prevention and stress management, however, overcoming stigma in seeking early low-level stress counseling remains an important problem. TMA does not cover smoking cessation intervention in the Purchased Care System, rather, it is covered in the Direct Care System at the discretion of the MTF commanders. DoD currently is evaluating the feasibility of paying for smoking cessation interventions in the Purchased Care System. Although DoD and TMA prevention efforts are extensive, they appear to be of limited effectiveness in the areas of weight management and smoking cessation, and they lack transparency and DoD-wide coordination.

Recommendation 4

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 MHS to ensure military readiness and optimal beneficiary health.

Action Items

- To promote accountability and transparency in fiscal management and quality of services, DoD should
  - continue to prioritize prevention programs in accordance with NCPP,
  - implement and resource standardized case management and care coordination that extends beyond the Wounded Warrior to other beneficiary groups across the spectrum of care,
  - ensure timely performance feedback to clinical providers, managers, and the chain of command through a timely and easily accessible reporting system such as a provider score card, and
  - maintain high-level visibility of business and clinical performance for the entire enterprise via the Tri-Service Business Planning Process and the MHS Balanced Score Card Metric Panel.

In the area of disease management, MTFs are monitoring HEDIS metrics using the MHS Population Health Portal and reporting in the service systems and the Tri-Service Business Planning tool. DoD has several initiatives in place to improve its disease management program and is currently awaiting findings and recommendations from an external study of the effectiveness of its disease management programs.

Case management is essential to the delivery of safe, high-quality, and timely medical care to injured as well as ill service members and beneficiaries through the seamless provision of case management services. However, case management in the MHS is not standardized across the spectrum of the system and, therefore, does not optimize the opportunity for better health care coordination.

Military Health Care Procurement System and Contracts for Support and Staffing Services

The Task Force was charged to assess

"The adequacy of the military health care procurement system, including methods to streamline existing procurement activities"

"Efficient and cost-effective contracts for health care support and staffing services, including performance-based requirements for health care provider reimbursement"

Acquiring health care services for the Military Health System (MHS) is big business. Sixty-five percent of beneficiary care is provided through a network of contracted private sector providers.[1] According to *Government Executive*, Humana is DoD's 13th largest contractor ($2.6 billion), followed by HealthNet at 14th ($2.1 billion), and TriWest Healthcare Alliance at 15th ($2 billion), indicating a significant expenditure of the DoD budget on contracted health care services.[2] A review of outpatient workload, inpatient workload, and MHS funding indicates that substantially more health care delivery is being provided in the private sector by TRICARE network providers than is being provided through direct care in the MHS. Given this reality, it is imperative that the MHS properly plan, adequately compete, and prudently manage its health care service acquisitions.

In 1996, the DoD obligation for medical service contracts was $1.6 billion, and by 2005 this obligation had increased to $8 billion—a 412 percent increase.[3] This growth in service acquisition spending has resulted, in part, from recent trends and changes, including military and civilian workforce downsizing, outsourcing initiatives, the expansion of the TRICARE benefit, and the need to meet new requirements and demands. To minimize growth in the cost of medical service contracts, DoD has initiated some activities to streamline acquisition management and performance-based service contracts; however, more can be done to contain costs.

Best Practices

Framework for Assessing the Acquisition Function at Federal Agencies

In a 2005 report, GAO identified a framework to assess the strengths and weaknesses of DoD's acquisition functions. This framework comprises four interrelated cornerstones that GAO's work has shown promote an efficient, effective, and accountable acquisition function: 1) organizational alignment and leadership, 2) policies and processes, 3) human capital, and 4) knowledge and information management.[4] Applying this framework reveals several opportunities for improvement in MHS acquisition procedures.

1 Michael Dinneen, Military Health System Governance Initiative: Status Update for the DoD Task Force on the Future of Military Health Care, September 5, 2007, Slide 7.
2 See www.govexec.com/features/0807-15/0807-15s2s1.htm
3 Defense Acquisitions: Tailored Approach Needed to Improve Service Acquisition Outcomes, GAO-07-20, November 2006, p. 5.
4 Framework for Assessing the Acquisition Function at Federal Agencies, GAO-05-218G, September 2005, p. vii.
See www.gao.gov/new.items/d05218g.pdf

The GAO report states the following

> Traditionally, the acquisition function has been fragmented among business units, as each was responsible for its own acquisition activities. We found that leading organizations transformed the acquisition function from one focused on supporting various business units to one that is strategically important to the bottom line of the whole company.

Although consolidation and centralization are occurring at the service level, fragmentation still exists at the MHS enterprise level. As GAO has stated, the "lack of coordination across the acquisition function results in redundancy, inconsistency, and an inability to leverage resources to meet common or shared requirements."[5]

The GAO report also cautions against situations where "there is no chief acquisition officer, or the officer has other significant responsibilities and may not have management of acquisition as his or her primary responsibility."[7] The MHS does not have a chief acquisition officer who "defines a common direction or vision for the acquisition function" across the whole enterprise.

The Task Force focused on acquisition processes of the TRICARE Management Activity (TMA). Service-specific acquisition processes are addressed in Appendix G.

In recommending monitoring and oversight of acquisition, GAO also cites the following goal for organizations: "The agency has undertaken a workforce planning effort to ensure that individuals who award, manage, and monitor contracts have clearly defined roles and responsibilities and have the appropriate workload, skills and training to perform their jobs effectively." Many acquisition billets require that the incumbent possess a certain level of acquisition certification through the Defense Acquisition University.

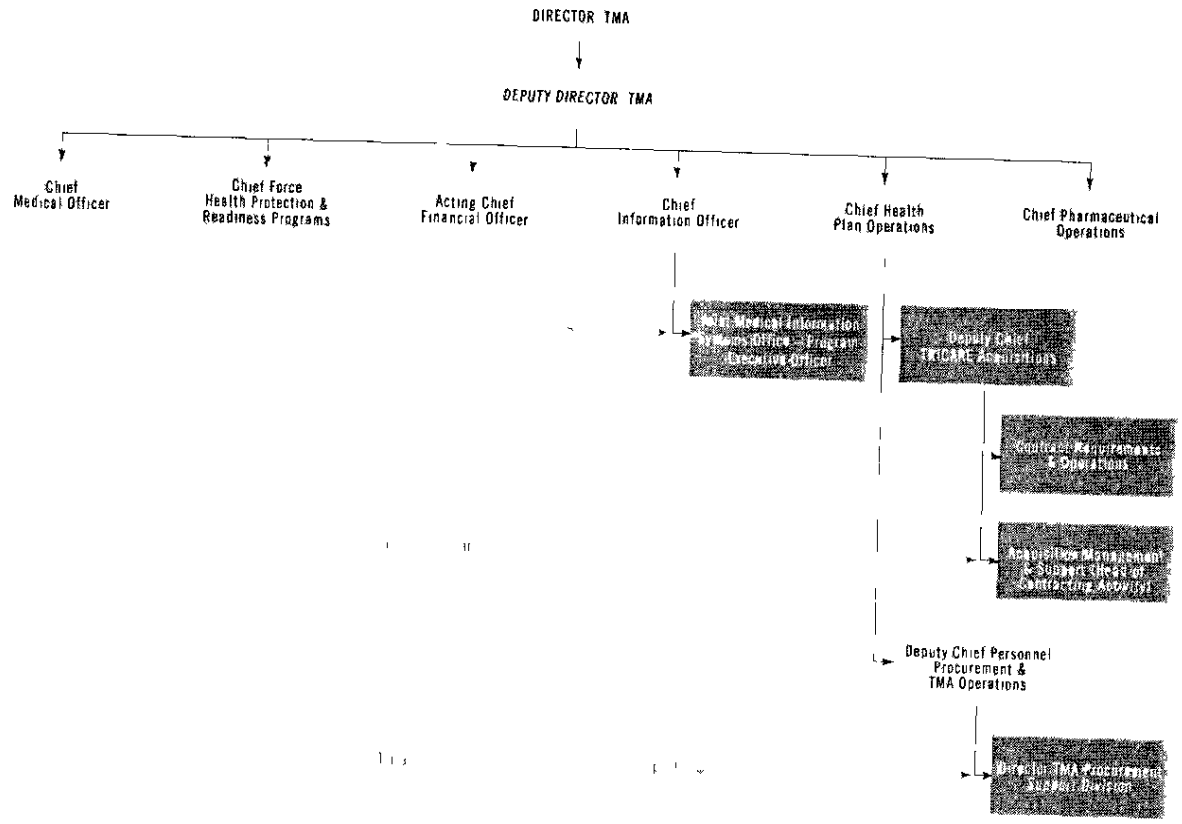
The TMA Procurement System

Structure

TMA acquisition structures are the responsibility of the Chief of Health Plan Operations and Chief Information Officer/Director, Information Management, Technology & Reengineering. TMA's acquisition activities include three areas of requirements: purchased care (Acquisition Management & Support), information technology for the MHS (Joint Medical Information Systems Office), and management consulting, and program support (TMA Procurement Support Division) (see Figure 1).

5 *Ibid., p. 1*
6 *Ibid.*
7 *Ibid., p. 5*
8 *Ibid.*
9 *Jean Storck, Brief to the Task Force, TRICARE Management Activity, July 25, 2007, Slide 7*

TMA ACQUISITION ACTIVITIES



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Managed Care Support Contract-Specific Acquisition

TMA awarded its first TRICARE contract in 1994. In its first generation of TRICARE contracts, TMA awarded 7 contracts covering 11 geographic TRICARE regions. They were competitively bid and awarded as fixed-price (i.e., contractor at-risk) contracts. Nonetheless, DoD designed them to include adjustments for health care cost increases beyond contractors' control, while other costs, such as administrative, remain fixed. All of the contracts were awarded for a base period and five option years.

GAO declared that TMA's contracting approach for TRICARE posed several administrative challenges and contributed to significant funding shortfalls.[10] To be considered for a contract award, offerors were required, in effect, to submit voluminous, expensive-to-produce proposals, which limited competition. Offerors told GAO that DoD's overly prescriptive requirements restricted their ability to use best practices to achieve the same results with greater cost efficiency.[11]

10 Defense Health Care: Lessons Learned from TRICARE Contracts and Implications for the Future, GAO-01-742T, May 17, 2001, p. 4. See www.gao.gov/new.items/d01742t.pdf
11 Ibid., p. 4-5

The TRICARE contracts were implemented while DoD was realigning and reducing its Military Treatment Facility (MTF) capability, resulting in greater reliance on civilian providers and numerous adjustments to the TRICARE contracts causing some instability and cost escalation GAO advised TMA "to carefully weigh the impact of its decisions on competition, including whether to carve out elements of TRICARE such as pharmacy or enrollment for separate, national contracts"[12] and suggested that their "continued partnering with private industry to reach agreement on the degree of prescriptiveness needed, by identifying the specific functions in which the use of best practice techniques would be most practical "[13]

In August 2002, TMA announced extensive changes to its second generation of TRICARE contracts that included consolidating the number of health care regions from 11 to 8 and correspondingly reducing the number of health care delivery contracts to 3 (see Figure 2) This contracting simplification led to significant administrative savings purportedly, $190 million in Fiscal Year 2005[14]

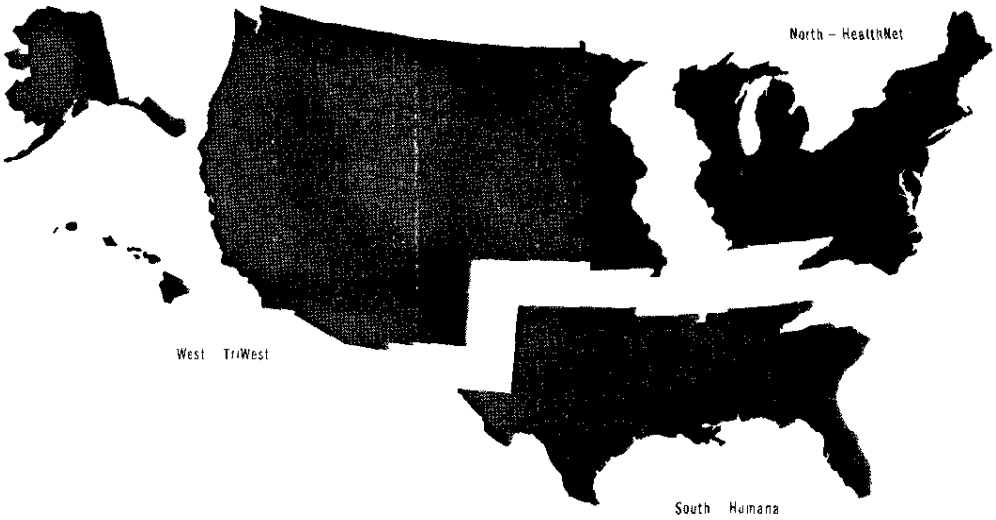
Additionally, TMA removed from the new health care delivery contracts some of the health care functions normally associated with delivering integrated health plan offerings that had been included in the previous TRICARE contracts, such as retail pharmacy services MTF appointments, marketing/education, and TRICARE for Life (TFL) claim processing These functions were either separately awarded as national contracts (retail pharmacy services, marketing and education services, and the adjudication of Medicare-eligible retiree claims) or were given to the military services to manage (MTF appointment setting, resource-sharing agreements, health care information line, and medical necessity reviews) In testimony to the Task Force, Humana said that such 'carve-outs do not represent current industry best practices Rather, they impact operational effectiveness and they appear to drive additional overhead costs including separate procurement and oversight expenses "[15] Echoing these concerns, HealthNet cited in its testimony[16] what it views as the problems with a nonintegrated approach

- 'Dis-integration' diminishes the ability of the managed care support contractor to effectively coordinate the range of services needed to ensure high quality, end-to-end care for beneficiaries
- A lack of integration introduces risk by creating unnecessary communications and operational barriers
- Prior industry and government attempts to dis-integrate key aspects of the managed care program have been problematic

TMA awarded its current TRICARE health care delivery contracts on August 21 2003 The contracts specify five option years, all due to expire on March 31, 2009 In its testimony, Humana urged DoD to promote stability and minimize disruption in the delivery of health care by using "its authority to extend the duration of the current contracts In the future, we also recommend that DoD consider longer duration "[17] HealthNet suggested that DoD "implement a 7 to 10 year term for managed care support contracts' because it 'provides [the] opportunity for Government and MCS contractors to jointly work on significant program issues over sustained periods of time" and it 'allows for collaboration of refinement of current operations/activities "[18]

12 Ibid p 10
13 Ibid p 11
14 The Military Health System Overview Statement by the Honorable David S C Chu Under Secretary of Defense for Personnel and Readiness and the Honorable William Winkenwerder Jr Assistant Secretary of Defense for Health Affairs before the Committee on Armed Services Subcommittee on Personnel United States Senate April 4 2006 p 4
15 Humana Military Healthcare Services Response to Questions of the DoD Task Force on the Future of Military Health Care March 21 2007 p 1
16 Steven Tough Brief to the Task Force March 28 2007 Slide 16
17 Humana Military Healthcare Services Response to Questions of the DoD Task Force on the Future of Military Health Care March 21 2007 p 4
18 Steven Tough Brief to the Task Force March 28 2007 Slide 19

HEALTH CARE REGIONS



Source: [illegible] contracting health care [illegible]

Figure 2

These contracts are designed to be performance based and focusing on desired outcomes—usually based on common industry practices—allowing the contractor latitude in how to achieve them. TMA based its current contracts on five overarching objectives:

1) ensure optimal use of MTFs,
2) attain the highest possible level of beneficiary satisfaction,
3) attain best-value health care by utilizing commercial practices, when possible,
4) have fully operational services and systems at the start of health care delivery so that disruption to beneficiaries and MTFs is minimal, and
5) ensure that TMA has ready access to contractor-maintained data.[19]

Along with the second generation TRICARE contracts, TMA and the military services also made substantial changes to the management and oversight of TRICARE's purchased and direct care systems through the joint development of a governance plan. This plan established a new regional governance structure, including the creation of TRICARE Regional Offices (TROs) to manage each of the three TRICARE regions (North [Falls Church, Virginia], South [San Antonio, Texas], and West [San Diego, California]) and was implemented in 2004.[20]

19 Defense Health Care: Implementation Issues for New TRICARE Contracts and Regional Structure, GAO-05-773, July 2005, p. 28. See www.gao.gov/new.items/d05773.pdf.
20 Defense Health Care: Implementation Issues for New TRICARE Contracts and Regional Structure, GAO-05-773, July 2005. See www.gao.gov/new.items/d05773.pdf.

Each TRO has some unique features. TRO-West has a TRICARE Regional Advisory Committee with representatives from major West Region direct care components, TRO-West and TriWest that meets regularly to discuss regional and national challenges faced by the program and by customers "to develop collective solutions that best respond to these concerns."[21] TRO-South has defined a total of 162 separate operational metrics with defined standards of performance. Monthly, Humana reports actual results against the standards. Humana believes "TRO-South is effectively accomplishing its mission"[22] to hold them accountable for operational service delivery across a broad spectrum of contractual requirements. Furthermore, from Humana's perspective, "the creation of the TRO structure seems to have achieved administrative efficiencies by eliminating three separate 'Lead Agent' offices, which previously existed in the South Region under legacy TRICARE contracts."[23] HealthNet reported in its testimony that TRO-North "has been proven critical to effective development of relationships at the local level, ensuring on-going linkage to field priorities and channeling information, facilitating key interactions, and focusing on regional distinctions."[24]

In planning for the next generation of contracts (T3) in early 2007, TMA has taken a number of actions to streamline the procurement process and encourage and stimulate industry involvement. TMA communicated early with potential offerors by using FedBizOpps[25] notices and the TMA website. TMA held Request for Information (RFI) meetings to obtain input from potential prime contractors and subcontractors. Further industry participation was obtained after TMA issued a draft Request for Proposal (RFP) in early 2007. The comment period closed July 19, 2007, with 300 comments filed from industry.[26] TMA expects to award the T3 contracts in 2008 with the "transition in" base period (planned for 10 months) starting upon award. There will be six one-year option periods, with the first starting April 1, 2009.[27]

Future contracts offer more opportunities for improvement. GAO wrote that TMA

> should recognize the effect that the complexity of earlier contracts, with the resulting high contractor proposal costs, had on competition and simplify the contracts as much as feasible. The challenge for DOD, in other words, is to decide whether to continue to use fewer large and complex contracts versus managing smaller and potentially simpler contracts, each of which has unique management challenges.[28]

In 2005 the Office of Management and Budget (OMB) directed federal agencies to leverage spending to the maximum extent possible through strategic sourcing. Strategic sourcing is a collaborative and structured process of analyzing an organization's spend to use the information to make business decisions about acquiring commodities and services more effectively and efficiently.[29] This approach would enable the MHS to capitalize on health care market trends, for example, specialized vendors who offer integrated programs of chronic disease management.

21 David McIntyre, Written Testimony to the Task Force on the Future of Military Health Care, March 28, 2007, p. 6
22 Humana Military Healthcare Services, Response to Questions of the DoD Task Force on the Future of Military Health Care, March 21, 2007, p. 4
23 Ibid., p. 5
24 Steven Tough, Brief to the Task Force, March 28, 2007, Slide 24
25 FedBizOpps.gov is the single government point of entry for federal government procurement opportunities over $25,000. Government buyers are able to publicize their business opportunities by posting information directly to FedBizOpps via the Internet.
26 Peggy Cox, Senior Program Analyst, TMA Office of Chief Health Plan Operations, TMA Response to Memo, Subject: Request for Information on T3 and TPharm Contract Activities, October 5, 2007, p. 4
27 Bruce Mutzner, Contracting Officer, TMA Office of Chief Health Plan Operations, Response to Task Force RFI, November 20, 2007
28 Defense Health Care: Lessons Learned from TRICARE Contracts and Implications for the Future, GAO-01-742T, p. 10-11
29 Office of Management and Budget, Implementing Strategic Sourcing Memorandum, May 20, 2005

Pharmacy-Specific Acquisition

Historically, managed care support contracts provided pharmacy services. However, in order to realize the significant cost benefit available to DoD, senior leaders decided in 1996 to implement a single mail order pharmacy program. Much of the cost benefit was derived by Big Four Federal Supply Schedule (FSS) pricing,[30] which was made available for pharmaceuticals purchased through the DoD prime vendor program operated by Defense Supply Center Philadelphia (DSCP) and dispensed at a contracted mail order pharmacy. Additional benefits included full government visibility to all mail order pharmaceutical and administrative costs and the elimination of duplicated administrative and customer support costs at multiple managed care support contracts.[31]

As part of the implementation of the 1996 TRICARE mail order pharmacy decision, the National Mail Order Pharmacy (NMOP) contract was awarded by DSCP to Merck-Medco on August 5, 1997, with prescription deliveries beginning on October 6, 1997. The contract had a one year base period with four one year options. DoD deleted the mail order pharmacy requirements from the managed care support contracts, effective at the start-up of NMOP.

Federal law requires the Secretary of Defense to establish an effective, efficient, and integrated pharmacy benefits program.[32] Under this pharmacy benefits program, the Secretary must ensure the availability of pharmaceutical agents for all therapeutic classes, establish a uniform formulary based on clinical effectiveness and cost-effectiveness, and assure the availability of clinically appropriate pharmaceutical agents to members of the Uniformed Services. The Secretary of Defense implemented this key component of the TRICARE program, the current TRICARE Pharmacy Program, effective May 3, 2004.[33]

Senior MHS leadership considered a strategy in October 2001 to procure pharmacy benefit management services for both mail order and retail network delivery of prescriptions from a single contractor.[34] The strategy also entailed a breakout of retail pharmacy services previously furnished under the various managed care support contracts in order to fully implement a single uniform and portable pharmacy benefit for all MHS-eligible beneficiaries envisioned by Congress in the National Defense Authorization Act (NDAA) for Fiscal Year 2000. Because of acquisition cycle considerations, DoD ultimately decided in late 2001 to reprocure a single mail order pharmacy separately from retail in order to minimize the length of any sole source extension of NMOP and more closely align the breakout of retail pharmacy services with the start of the next generation of managed care support contracts. Thus, with the implementation of its next generation of TRICARE contracts in 2003, TMA removed pharmacy services from these health care delivery contracts and separately awarded these functions as national contracts: TRICARE Retail Pharmacy (TRRx) and TRICARE Mail Order Pharmacy (TMOP).

30 The Veterans Health Care Act of 1992 (P.L. 102-585, 106 Stat. 4943) §605 amended 38 U.S.C. by adding §8126, which allowed the federal agencies, including DoD, to avail themselves of FSS pricing.
31 Ibid., p. 7.
32 10 U.S.C. §1074g (a)(1) (2005).
33 See 69 Fed. Reg. 17035 (April 1, 2004) (noting that the final rule becomes effective May 3, 2004).
34 Ibid.

The TRRx contract provides comprehensive retail pharmacy services to all DoD beneficiaries living in the United States and U S territories DoD awarded the contract to Express Scripts, Inc , on September 26 2003, and it began health care service delivery on June 1 2004 [35] This contract provided improvement over the prior contracting arrangement by centralizing pharmacy claims processing, eliminating portability issues, providing future access to discounted federal ceiling prices,[36] implementing a uniform formulary, and implementing online coordination of benefits

The TMOP contract provides for the operation of a full-service mail order pharmacy available to TRICARE eligible beneficiaries worldwide DoD awarded this contract to Express Scripts, Inc , on September 10, 2002, and it began health care service delivery on March 1, 2003 Express Scripts Inc , operates a dedicated distribution center in Tempe, Arizona from which it has filled more than 26 million prescriptions In calendar year 2006, Express Scripts Inc , shipped 670,041 prescriptions and handled 117,546 beneficiary telephone inquiries on average each month [37] Given these changes in contract structure some managed care support contractor officials have told GAO that assigning responsibility for retail pharmacy services to a separate contractor impeded their ability to adequately monitor beneficiaries drug use because they no longer have access to this information [38] One managed care support contractor told GAO that under the previous health care delivery contracts, it mined pharmacy data in order to direct individualized mailings to providers and beneficiaries to ensure that they followed medical best practices related to pharmaceuticals [39] However, managed care support contractors can obtain beneficiary pharmacy data case-by-case from TMA s centralized pharmacy database Another managed care support contractor told GAO that the pharmacy carve-out contract eliminates any financial incentives for the managed care support contractors to manage beneficiaries' drug use [40]

In the acquisition cycle TMA plans to combine the operations of both TMOP and TRRx under a single contract known as the TRICARE Pharmacy (TPharm) contract with the expectation that one contract will save costs by eliminating duplicate contractor and government administrative services, result in a more consistent application of the benefit and enhance coordination between the managed care support contractors and the single pharmacy contractor

Recently, TMA modified its current pharmacy contract, and this led to the August 29, 2007 opening of the Member Choice Center (MCC), which incorporates streamlined telephone and website processes to enable beneficiaries to switch from the most costly retail point of service to the less costly mail order point of service

35 *Jean Storck Brief to the Task Force February 6 2007 Slide 6*
36 *70 Fed Reg 19647 (April 12 2005)*
37 *Jean Storck Brief to the Task Force February 6 2007 Slide 5*
38 *TRICARE Implementation Issues GAO 05 773 p 58 See www gao gov /new items/d05773 pdf*
39 *Ibid*
40 *Ibid*

Interim Report

The Task Force, in its review of the DoD pharmacy contract process in its interim report (which recommended that particular attention be given to the pharmacy benefit), offered the following

> Current practices in the DoD pharmacy procurement process appear to pose obstacles to negotiating both best price and best use. Additionally, some have interpreted legal provisions governing beneficiary contact as prohibiting multiple targeted programs to increase home delivery that have been used successfully in the private sector. The last iteration of TRICARE contracts promoted a contract environment that focused on outcomes and best business practices. The Task Force heard from several current TRICARE contractors who spoke of their inability to implement their best business practices because of government regulations and/or strict interpretation of requirements.
>
> DoD should review its pharmacy acquisition strategies to determine if changes can be made to effect greater reductions in the cost of drugs and to foster improvements in effective utilization. In doing so, DoD should consider pursuing policy, regulatory, and/or statutory changes that would allow for alternative commercial best practices to be implemented when in the best interests of the government.[41]

The Task Force further pledged to examine best practices that produce efficiencies in the public and private health care sectors, including those for procurement practices, and offer strategies for modifying the pharmacy acquisition process in order to achieve greater savings and improved utilization.

Since the publication of the interim report, the Task Force has continued to assess MHS acquisition and procurement activities and processes through the following mechanisms:

- over the summer, a member of the Task Force with expertise in acquisition met with the Chief, Health Plan Operations; Chief, Pharmaceutical Operations; Director, Acquisition Management and Support (AM&S), and Director, TMA Office of General Counsel;
- held hearings on July 25, 2007, dedicated to the topic of acquisition and procurement;
- analyzed TMA and service responses to various RFIs, and
- held meetings and a teleconference in October 2007 to review the Performance Assessment Tool and the Performance Assessment Plan for managed care support contractors.

As a result of this review and analysis, the Task Force offers findings and recommendations in the following areas: reorganize TMA to place a greater emphasis on the acquisition role; aggressively look for and incorporate best practices in the public and private sectors with respect to health care purchasing; and reassess requirements for purchased care contracts to determine if more effective strategies can be implemented to obtain those services and capabilities.

41 DoD Task Force on the Future of Military Health Care Interim Report at www.dodfuturehealthcare.net/images/103 06 1 Home Task_Force_Interim_Report_053107.pdf p. 31-32

Final Findings and Recommendations

In September 2006, the Defense Business Board recommended the following "Re-align the current activities of the TRICARE Management Activity to function alongside the unified command and streamline its management functions to concentrate on policy and oversight of health plan management."[42]

The Task Force agrees that TMA should be realigned to place greater emphasis on the acquisition role, as the original charter of the organization intended. DoD Directive 5105.46, dated July 31, 1997, established the mission, organization, responsibilities, functions, relationships, and authorities of the "TRICARE Support Office (TSO)," which replaced the Office of the Civilian Health and Medical Program of the Uniformed Services. The directive stated the mission of the TSO is to provide operational support for the Uniformed Services in the management and administration of the TRICARE program, administer the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and serve as the primary contracting activity for TRICARE managed care support contracts and other related health care services contracts.

Recommendation 5

DoD should restructure TMA to place greater emphasis on its acquisition role.

Action Items

- DoD should
  - elevate the level of the Head of Contracting Activity (e.g., to the level of the Military Deputy Director of TMA),
  - ensure acquisition personnel are certified according to the Defense Acquisition Workforce Improvement Act[43] and have strong competencies in health care procurement,
  - ensure that the management of acquisition programs is consistent with the Defense Acquisition System process,
  - clearly delineate program managers and program executive offices,
  - ensure compliance with DoD Directive 5000.1, The Defense Acquisition System,[44] and DoD Instruction 5000.2, Operation of the Defense Acquisition System,[45]
  - create a system of checks and balances by separating the acquisition functions from the requirements/operations and the budget/finance functions and placing them under a Chief Acquisition Officer-equivalent who operates independently and is on the same level in the organization as the Chief of Health Plan Operations and Chief Financial Officer, and
  - implement a study to determine if it is in the best interests of the government to colocate the TRICARE Deputy Chief TRICARE Acquisitions organization (located in Aurora, Colorado) and its acquisition counterparts (located in the National Capital Region).

42 Defense Business Board Report to the Secretary of Defense, "Military Health System—Governance, Alignment and Configuration of Business Activities Task Group Report," Report FY06-5, at www.defenselink.mil/dbb/pdf/MHS%20Final%20Report.pdf.

43 The Defense Acquisition Workforce Improvement Act was signed into law in November 1990 and requires the Secretary of Defense to establish education and training standards, requirements, and courses for the civilian and military acquisition workforce. The requirements are based on the complexities of the job and are listed in DoD 5000.52-M, Career Development Program for Acquisition Personnel. Civilian positions and military billets in the acquisition system have acquisition duties that fall into 14 career fields/paths. The Act has been amended a few times since its enactment, with extensive changes in 2003. See http://library.dau.mil/DAWIA_FI_FO_09092007_FINAL.pdf.

44 See https://akss.dau.mil/dag/DoD5000.1/References.asp.

45 See https://akss.dau.mil/dag/DoD5000.2/Subject.asp.

Recommendation 6

DoD should aggressively look for and incorporate best practices from the public and private sectors with respect to health care purchasing

Action Items

- DoD should
  - examine and implement strategies to ensure compliance with the principles of value-driven health care consistent with Executive Order 13410, "Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs"
    - > Health Information Technology Require in contracts or agreements with health care providers, health plans, or health insurance issuers that as each provider, plan or issuer implements acquires, or upgrades health information technology systems it should use where available health information technology systems and products that meet recognized interoperability standards
    - > Transparency of Quality Measurements Implement programs measuring the quality of services supplied by health care providers to the beneficiaries or enrollees of the TRICARE health care programs
    - > Transparency of Pricing Information Make available to the beneficiaries the prices that TMA pays for procedures to providers in the health care program with which the agency issuer or plan contracts

Recommendation 7

DoD should reassess requirements for purchased care contracts to determine whether more effective strategies can be implemented to obtain those services and capabilities

To enhance competition efficiency cost-effectiveness, and innovation, TMA should examine requirements in existing contracts to determine if they are necessary, thus reducing the differences between government contracts and commercial contracts as much as reasonably possible

Action Items

- DoD should
  - examine whether the benefits from waiving cost accounting standards outweigh the risks associated with the waiver,
  - examine the 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,
  - test and evaluate through pilot or demonstration projects the effectiveness of carved out chronic disease management programs, and
  - examine the overarching contracting strategy for purchased care to consider whether certain functions should be
    - > added to managed care support contracts (e g , marketing/education and TRICARE for Life claim processing), and/or
    - > carved out from managed care support contracts (e g , specialized contracts to enhance disease management or other innovative pilot programs)

Efficient and Cost-Effective Contracts for Health Care Support and Staffing Services

To help fill needs that cannot be satisfied through DoD MTF personnel or through purchased care contracts under TRICARE, the services issue direct care medical services contracts. Each service has its own organizational structure for acquiring non-TRICARE medical services. The service Surgeons General have delegated responsibility for health care services acquisitions. The Army uses the Army Health Care Acquisition Activity, and the Navy uses the Naval Medical Logistics Command. The Air Force uses the Commodity Council as its new preferred source for contracting; however, MTFs and Major Commands also use the line of the Air Force and other contracting activities. The organizational structure and operation of those offices vary, as do the number and size of the contracting offices reporting to them. Table 1 displays the medical services contracting workload of these organizations.

Table 1 Services Health Services Spending (in millions)

SERVICE		FY 04	FY 05	FY 06
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
	[illegible]	[illegible]	[illegible]	[illegible]

[illegible]

Achieving Best Practices in Support and Staffing Acquisitions

GAO has studied how leading companies have changed their approach to improve the management of services acquisitions. It found that these companies adopted "a more strategic perspective to service spending, that is, each company focused more on what was good for the company as a whole rather than just individual business units, and each began making decisions based on enhanced knowledge about service spending."[16] To employ a strategic approach, GAO found that these companies "elevated or expanded the role of the company's procurement organization, designated 'commodity' managers to oversee key services, and/or made extensive use of cross functional teams to help identify their services needs, conduct market research, evaluate and select providers, and manage performance."[17] Furthermore, they took measures to achieve better services acquisition outcomes, such as "developing a reliable and accurate picture of services spending, developing new structures, mechanisms, and metrics to foster a strategic approach, and providing strong leadership to carry out these changes."[18]

16 *Contract Management: Taking a Strategic Approach to Improving Service Acquisitions*, GAO-02-499T, March 7, 2002, p. 2.
17 Ibid., p. 4.
18 Ibid., p. 9.

The National Defense Authorization Act for Fiscal Year 2007[49] stipulates that "the Regional Director of each region under the TRICARE program shall develop each year integrated, comprehensive requirements for the support of military treatment facilities in such region that is provided by contract civilian health care and administrative personnel under the TRICARE program"[50] with the following purpose

(1) To ensure consistent standards of quality in the support of military treatment facilities by contract civilian health care personnel under the TRICARE program

(2) To identify targeted, actionable opportunities throughout each region of the TRICARE program for the most efficient and cost-effective delivery of health care and support of military treatment facilities

(3) To ensure the most effective use of various available contracting methods in securing support of military treatment facilities by civilian health care personnel under the TRICARE program including resource-sharing and clinical support agreements, direct contracting, and venture capital investments [51]

DoD and Performance-Based Requirements for Health Care Provider Reimbursement

More than half of American health maintenance organizations (HMOs) used pay-for-performance programs in their contracts with doctors and hospitals in 2005 [52] In addition, 90 percent of those organizations included pay-for-performance provisions for physician compensation and 38 percent of HMOs with these programs included pay-for performance policies in their contracts with hospitals [53] Medicare also has implemented various initiatives to encourage improved quality of care in all health care settings where Medicare beneficiaries receive services, including physicians offices, ambulatory care facilities, hospitals, nursing homes, home health care agencies, and dialysis facilities [54]

By shifting the focus from process to results, performance-based services acquisitions hold the promise of better outcomes and reduced costs In view of the potential benefits, Congress has been encouraging greater use of performance-based contracting and the administration has set a general goal that 20 percent of eligible services contracts should be performance based DoD had a goal that 50 percent of its services contracts would be performance based by 2005 [55]

DoD and its entities have used performance-based requirements to varying degrees, but have used few if any, performance-based requirements that address health care provider reimbursement TMA employs assorted performance-based requirements in its managed care contracts in the forms of performance guarantees for claims processing, underwriting incentives in network usage, performance incentives based on clinical quality measures, and an award fee based on items of interest to induce optimum contractor performance [56]

49 National Defense Authorization Act for Fiscal Year 2007 (P L 109 364 120 Stat 2083 2296) §732(a)
50 Ibid 120 Stat 229
51 Ibid 120 Stat at 2297
52 Meredith Rosenthal Bruce Landon Sharon Lise Normand Richard Frank Arnold Epstein Pay for Performance in Commercial HMOs New England Journal of Medicine 2006 355 1895 1902 1895
53 Ibid
54 Center for Medicare & Medicaid Services Press Release January 31 2005 Medicare Pay for Performance Initiatives See www cms hhs gov/apps/media/press/release asp?Counter=1343
55 GAO Use of Legislative Incentive for Performance Based Contracting Unknown (GAO 03 674R Washington DC May 22 2003
p 2 See also Memorandum from Under Secretary of Defense Acquisition Technology & Logistics (USD(AT&L)) to Secretaries of Military Departments Subject Performance Based Acquisitions August 19 2000
56 Jean Storck Brief to the Task Force July 25 2007 Slide 16

TMA also uses pay-for-performance measures in its nonpurchased care contracts. In fact, 45 percent of TMA's information management/information technology contracts are performance based, and 57 percent of its operational support services are performance based.[57] TMA has found that its high customer service ratings are based on pay for performance measures.[58] TMA reviewed inputs from its regional offices regarding current pay-for-performance measurements to determine what has worked well and what can be improved, and has incorporated that analysis into the RFP.[59]

Contracting for Additional Staff

Despite the presence of large purchased care networks, purchased care budget constraints and increased operational requirements are driving the services to obtain additional clinical staff to meet patient demand for health care at MTFs. Additional staff are acquired by issuing direct medical care services contracts through service-unique processes.[60] Funds expended are significant, the services spent more than $1 billion in acquiring additional direct care medical services in Fiscal Year 2006.[61, 62, 63]

When acquiring additional direct medical care staff, the services by and large do not use performance-based requirements in their contracts as a basis to reimburse health care providers. The services acquire health care services through personal[64] or nonpersonal services contracts.[65, 66] There are major differences between these two kinds of contracts with respect to salary, the liability of contract workers, and the government's ability to control the physical details of the contract employee's work. Unlike the arrangement for personal services, compensation limits do not exist for nonpersonal services contracts, and the government cannot control the details through which those who are employed under a nonpersonal services contract render services.[67]

Congress granted the services the authority to enter into personal services contracts to carry out health care responsibilities.[68] But by using personal services contracts, compensation limits hinder the ability of the services to hire personnel and to construct performance-based requirements for reimbursement in cases in which a medical specialty provider's performance-based compensation could exceed the statutory limit. Compensation limits do not just affect the services' ability to hire and pay high earners in the medical profession, they also affect the services' ability to hire and pay those in lower-earning medical specialties.

57 *Ibid.*, Slide 17.
58 *Jean Stoel, Brief to the Task Force, Official Transcript, July 25, 2007, p. 35.*
59 *Ibid., p. 35-36.*
60 *Defense Procurement: DoD Wide Strategy Council for Acquiring Direct Care Medical Services, Final Report to the U.S. Department of Defense, Assistant Secretary of Defense (Health Affairs), Censio Consulting Group, June 2005, p. 5.*
61 *Col. Turk Smith II, Brief to the Task Force, July 25, 2007, Slide 9.*
62 *Terry Horst, Andrew Muenfeld, Brief to the Task Force, July 25, 2007, Slide 9.*
63 *Lt. Col. Joe Munro, Brief to the Task Force, July 25, 2007, Slide 12.*
64 *Federal Acquisition Regulation (FAR) §37.104 (2007).*
65 *FAR §36.102.*
66 *Ibid., §37.101.*
67 *Ibid., §37.104.*
68 *10 U.S.C. §1091(a) (2006).*

Nonpersonal services contracts could be used to circumvent personal services contract compensation limits. However, this approach is problematic for a number of reasons. First, nonpersonal services contracts limit medical providers to provide services only in the state in which they are licensed. Second, nonpersonal services contracts limits the government's ability to control how the contractor provides the service, because under nonpersonal services contracting, the government is not allowed to exert direct supervision of the health care provider. Third, nonpersonal services contracts create some uncertainty regarding how the private provider's insurance company will respond when a medical malpractice claim is asserted based on the adequacy of the government's protocol.[69] Finally, the government may be tempted to treat nonpersonal services providers as though they are personal services providers, in violation of federal law.[70]

DoD's ongoing goal of having 50 percent of contract dollars awarded be performance based[71] creates another impediment to fashioning efficient and cost-effective contracts for health care services.[72] A partial exemption exists for services with low opportunities for utilizing performance-based contracting, such as medical research and development and nonfacility related medical services.[73] This partial exemption forces the services to use more nonpersonal services contracts to meet DoD's overall performance-based goals.[74]

Still another obstacle the services face is that they cannot avail themselves of Department of Veterans Affairs FSS contracts for personal services, because the medical liability coverage of Title 10 is limited to DoD contracts.[75] These schedules provide federal agencies with a simplified process for obtaining commercial supplies and services at prices associated with volume buying,[76] and this obstacle limits the services surge capability to care for wounded service personnel. Also, it increases the time required to procure medical services in the face of personnel deployments and reduces the potential supply of medical professionals that the services can tap to meet increased demand for health care services.[77]

Conclusions Regarding Health Care Support and Staffing

The Task Force found several systemic obstacles to the use of more efficient and cost-effective contracting strategies for health care support and staffing services, many of which are being addressed through current initiatives, such as using strategic sourcing, establishing multiple award task orders, and implementing other strategies for streamlining the process. Appendix G contains more detail. In its review of the adequacy of the military health procurement system, including methods to streamline existing procurement activities (see above), the Task Force offers a number of general recommendations, all of which are applicable to contracting for health care support and staffing services.

69 All nonpersonal services contracts "[r]equire that the contractor indemnify the Government for any liability producing act or omission by the contractor, its employees and agents occurring during contract performance." FAR §37.401(c) (2007).
70 Eugene J. Smith, Testimony to the Task Force, Official Transcript, July 25, 2007, p. 88-89.
71 Memorandum from Under Secretary of Defense, Acquisition, Technology, & Logistics (USD(AT&L)) to Secretaries of Military Departments, Subject: Performance Based Acquisitions, August 19, 2003.
72 Eugene J. Smith, Testimony to the Task Force, Official Transcript, July 25, 2007, p. 96.
73 Memorandum from Under Secretary of Defense, Acquisition, Technology, & Logistics (USD(AT&L)) to Secretaries of Military Departments, Subject: Performance Based Acquisitions, August 19, 2003.
74 Eugene J. Smith, Testimony to the Task Force, Official Transcript, July 25, 2007, p. 95-96.
75 10 U.S.C. §1089 et seq. (2005).
76 FAR §8.402(a) (2007).
77 Col. Earle Smith II, Brief to the Task Force, July 25, 2007, Slide 15.

The Reserve Component and Its Health Care Benefit

The roles and missions of the Reserve Component have changed since the end of the Cold War In the post-World War II era, DoD's Reserve operated primarily as a "strategic reserve" For example, from 1945 to 1989, reservists were called to active duty as part of a mobilization by the federal government only four times, an average of less than once per decade [1] Since 1990, reservists have been mobilized by the federal government six times, an average of nearly once every three years [2] Since 2002, approximately 500,000 reservists have been mobilized, primarily for contingency operations in Afghanistan and Iraq Reserve mobilizations have increased the demands on the Military Health System (MHS), with subsequent increases in health care expenditures (see Table 1) [3]

Table 1 Reserve Component Defense Health Care Costs

	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible] Cost Estimate for FY 2008
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	

[illegible]

[illegible]

At the end of Fiscal Year 2006, there were approximately 1 1 million Guard and Reserve members in the DoD Ready Reserve [4] As of Fiscal Year 2006, the Selected Reserve[6] had a total of about 826,000 members [7] Part-time reservists are entitled to a premium-based health care benefit for themselves and their dependents Mobilized reservists are eligible for full TRICARE health care benefits for themselves and their families

1 GAO Military Personnel DoD Needs to Establish a Strategy and Improve Transparency over Reserve and National Guard Compensation to Manage Significant Growth in Cost GAO 07 828 2007 p 11
2 Ibid
3 William Carley Operations Office TMA Office of Chief Financial Officer Response to Task Force RTI August 17 2007
4 GAO Military Personnel DoD Needs to Establish a Strategy and Improve Transparency over Reserve and National Guard Compensation to Manage Significant Growth in Cost GAO 07 828 p 9
5 The Ready Reserve includes the Selected Reserve the Individual Ready Reserve and the Inactive National Guard
6 The Selected Reserve largely consist of units and individuals designated by their respective services that serve in an active drilling status
7 GAO Military Personnel DoD Needs to Establish a Strategy and Improve Transparency over Reserve and National Guard Compensation to Manage Significant Growth in Cost GAO 07 828 2007 p 10

From Fiscal Year 2000 to Fiscal Year 2006 deferred compensation costs for part-time and full-time reservists more than tripled, increasing from $1 7 billion to $5 8 billion [8] This represents an increase from 12 percent of Reserve compensation costs in Fiscal Year 2000 to 28 percent in Fiscal Year 2006 [9] This growth is largely attributed to additional health care benefits that have been set aside for future Reserve retirees and their families, known as TRICARE for Life These increases in cost mainly are driven by entitlements that are unlikely to subside at the end of the ongoing military operations in Iraq and Afghanistan [10]

Noncash benefits also increased—to about 29 percent of Reserve compensation costs in Fiscal Year 2006—primarily as a result of increased costs for full-time reservists health care benefits and expanded health care benefits for part-time reservists and their families [11]

Establishing Readiness

DoD Directive 6200 04 states, "Commanders, supervisors individual Service members and the MHS shall promote improve, conserve, and restore the physical and mental well being of members of the Armed Forces across the full range of military activities and operations" [12] Today's operational tempo raises the importance of all responsible parties doing their part to ensure that Individual Medical Readiness (IMR)[13] requirements are satisfied to facilitate maximum deployability of our forces

Eighty percent of reservists have civilian health insurance, which greatly enhances readiness [14] Members of the Selected Reserve except for those eligible for Federal Employee Health Benefits Program (FEHBP) coverage, are now afforded the opportunity to purchase TRICARE Reserve Select (TRS) coverage

Congress has recognized the impact dental readiness has on deployment capability and clarified in the Fiscal Year 2006 National Defense Authorization Act (NDAA) that "dental care is included in the medical readiness tracking and health surveillance program" [15] Dental readiness continues to be the greatest obstacle to medical readiness for most of the Reserve Component (see Table 2)

8 Ibid p 5 6
9 Ibid p 18
10 Ibid p 6
11 Ibid p 19
12 DOD Directive 6200 04 Force Health Protection See www dtic mil/whs/directives/corres/pdf/620004p pdf p 2
13 IMR is a means to assess an individual service member or larger cohorts readiness level against established metrics applied to key elements of health and fitness to determine medical deployability in support of contingency operations See www dtic mil/whs/directives/corres/pdf/602519p pdf
14 GAO Military Health Increased TRICARE Eligibility for Reservists Presents Educational Challenges GAO 07 195 2007 p 3
15 National Defense Authorization Act for Fiscal Year 2006 P L 109 163 § 745 119 Stat 3136 3362 (2006)

Table 2 Individual Medical Readiness, Reserve Component, Q4 Fiscal Year 2007

ELEMENT	ARMY	NAVY	AIR FORCE	MARINE CORPS	AIR GUARD	ARMY GUARD	COAST GUARD
Dental Class 1 [illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Immunizations	[illegible]	88.3	87.2	[illegible]	92.6	57.7%	[illegible]
Medical Readiness Labs	94.1	82.1%	[illegible]	75.1	[illegible]	93.3%	[illegible]
Not Deployment Limiting Conditions	86.9	94.5%	[illegible]	94.5%	[illegible]	88.8%	79.0%
Health Assessment	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	88.8%	[illegible]
Medical Equipment	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

[illegible]

Source: DoD Background Statistics [illegible] Medical Readiness Metrics, Q4 FY 2007 Source [illegible]

For dental readiness, reservists can participate in the TRICARE Dental Program which is a voluntary premium-based dental insurance plan administered by United Concordia Companies, Inc. (United Concordia).[16] This program replaced the TRICARE Selected Reserve Dental Program on February 1, 2001,[17] and provides a way for reservists to meet and maintain their dental requirements prior to being called to active duty.[18] However, the take rate, reviewed monthly by TRICARE Management Activity (TMA), is approximately 9 to 11 percent, varying by service and pay grade.[19]

Further supplementing their available resources to meet IMR requirements for deployment, reservists can leverage the "just-in-time" health services provided through the Federal Strategic Health Alliance (FEDS_HEAL) Program.

The Federal Strategic Health Alliance

IMR requirements necessary to ensure the deployability of an Active Component service member are satisfied through Military Treatment Facility (MTF) health care and are funded through the Defense Health Program. However, this is not the case for Reserve Component service members. By policy, IMR services are planned and allocated from service line budgets to ensure Reserve Component service members are deployable.

FEDS_HEAL[20] is a joint program designed to enhance rapid deployability of Reserve service members by ensuring medical fitness to deploy. It provides medical support services to Reserve units to help them meet the medical standards for readiness. It derives from a joint agreement of interagency support among DoD, the Veterans Health Administration, Federal Occupational Health, and the Reserve Component to provide access to nearly 10,000 points of service nationally for required medical and dental exams, limited dental treatment, and immunizations. All medical service requests are coordinated through the FEDS_HEAL Program Office, which is responsible for scheduling medical services and generating management reports for specified military oversight agents.

16 See www.tricare.mil/mybenefit/home/Dental/DentalProgram
17 Kathleen Rhem, New TRICARE Program to Boost Dental Readiness of Reserves, March 21, 2001. See www.defenselink.mil/news/newsarticle.aspx?id=15767
18 TRICARE News Release No. 06-09, TRICARE Dental Program Helps National Guard and Reserve Members Maintain Deployable Status, April 04, 2006. See www.tricare.mil/news/news.aspx?id=201
19 Col. Cary C. Martin, Director/Dental Care Division, TRICARE Operations Division, TMA, Response to Task Force RFI, November 28, 2007
20 See www.hooah4health.com/deployment/benefits/fedsheal.htm

Servicemembers Civil Relief Act of 2003 and the Uniformed Services Employment and Reemployment Rights Act

Reservists' private health insurance coverage is protected by the Servicemembers Civil Relief Act (SCRA) of 2003 and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If a reservist's individual coverage is terminated while on active duty, when the reservist returns from active duty, SCRA requires private insurance companies to reinstate coverage at the premium rate the reservist would have been paying had coverage not been terminated.[21] It also requires insurance companies to cover most pre-existing conditions after a reservist's insurance is reinstated.

USERRA[22] allows reservists to elect to keep employer-provided health benefits while absent from employment on active duty, up to a maximum period of 24 months. For absences of 30 days or less, the employer must continue to pay its share of the premium. For absences of 31 days or more, the reservist may elect to continue the civilian coverage, but the employer may charge the reservist up to 102 percent of the full premium under the plan, which represents the employer's share plus the employee's share, plus 2 percent for administrative costs.[23] In addition, under USERRA, employers generally must reinstate reservists' health coverage upon their re-employment, and no waiting period or exclusions may be imposed in connection with that reinstatement.

If a reservist's dependents were covered under the reservist's policy prior to his or her active duty service, the protections found in SCRA and USERRA also apply to their health benefits.

TRICARE Reserve Select

TRS is a congressionally authorized, premium-based health care coverage plan for Guard members, reservists, and their families. TRS allows members of the Selected Reserve to purchase comprehensive TRICARE health care coverage for themselves and their families (see Appendix H for further discussion). Effective October 1, 2007, eligibility for TRS ceased to be dependent on a service member's mobilization status or access to an employer-sponsored health insurance plan, and the current, tiered eligibility structure was eliminated. TRS access is available to all active drilling reservists, except those who are eligible for FEHBP. TRS members and their covered family members may access care from any TRICARE-authorized provider, hospital or pharmacy as well as from a military clinic or hospital on a space-available basis.

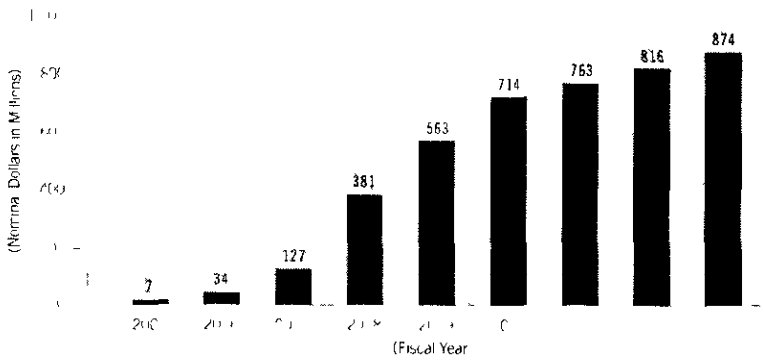
There is no requirement for TRICARE to develop a network of providers for beneficiaries choosing to utilize TRS.[24] However, TMA actively monitors access to care and takes steps in accordance with its statutory authority to increase payment rates if access is impaired in a location. For the last three years, TMA has been conducting surveys of physicians all over the country to determine their knowledge of and acceptance of TRICARE. In addition, TMA has made special efforts, in cooperation with State Adjutants General, to enlist the support of State Medical Societies to urge their members to treat TRICARE patients, particularly reservists and Guard members and their families.[25]

21 See www.military.com/benefits/legal-matter/crra-overview/
22 See http://esgr.org/userra.asp
23 See http://esgr.org/userra/faq.asp?p=d#sec2
24 Peggy Cox, Senior Program Analyst, TMA Office of Chief Health Plan Operations, Response to Task Force RFI, November 5, 2007
25 Ibid.

Service members pay a monthly premium rate based on the type of coverage purchased TRS Member-Only or TRS Member-and-Family TRS premiums are adjusted annually effective January 1 The regulations governing TRS call for the premiums to be indexed according to increases in costs of FEHBP Blue Cross and Blue Shield premiums and to be rebased as appropriate (rates are to be determined on an "appropriate actuarial basis" according to statute) However the NDAA has frozen the rates for 2007 and 2008 [26, 27] (See Appendix H for more detail)

DoD projects TRS costs to rise from $7 million in Fiscal Year 2005 to $874 million by Fiscal Year 2013 (see Figure 1)

DoD's ESTIMATED COST TO THE GOVERNMENT FOR TRICARE RESERVE SELECT, FY05–13



Source: GAO, Military Personnel: DoD Needs to Establish a Strategic Approach to Transparency for Reserve and National Guard Compensation to Manage Significant Growth in Costs, GAO 07-828, 2007, p. 2

Figure 1

Since the publication of the Task Force's interim report, TMA has implemented its restructured TRS benefit plan [28] As of October 1, 2007, TRS has

- expanded eligibility the benefit is now available to all members of the Selected Reserve, regardless of any active duty served, with the exception of those who are ineligible for it or who are currently covered under FEHBP,
- provided only one premium amount for each type of coverage
  - Member-Only, $81/month,
  - Member-and-Family, $253/month, and
- ensured that eligible members are no longer limited to purchasing the insurance immediately following activation or during the annual open season, the new TRS plan allows eligible members to purchase the insurance at any time throughout the year

26 Ibid
27 See www.tricare.mil/mybenefit/Download/Forms/TRS_Flyer_07.pdf
28 See www.tricare.mil/mybenefit/Download/Forms/TRS_Flyer_2007.pdf

As of November 5, 2007, enrollment was as follows

- 5,493 TRS Member Only plans,
- 10,922 TRS Member and Family plans, and
- 16,415 total TRS plans [29]

With the October 1, 2007 changes to the TRS benefit comes the increased need for education to inform the eligible population about TRS and TRICARE. Primary educational tools are TRICARE briefings provided at mobilization and demobilization sites. However, the consensus among personnel with whom the Task Force spoke is that this strategy is not adequate. Even though TMA supplements these briefings through family support groups, websites, 1-800 customer assistance numbers, and print materials, feedback from reservists suggests that more needs to be done.

Task Force Approach

In its interim report, the Task Force noted that the transition of the Guard and the Reserve from a strategic reserve to an operational force has placed additional demands on the MHS from the readiness and health benefit perspectives. It is important to understand the nuances of Guard and Reserve regulations, policies, activities, and culture and how they affect the military health care system. It also is important to consider these nuances in relationship to the goal of achieving a Total Force military capability.

The Task Force pledged to explore "the effects of the transition of the Guard and Reserve from a strategic force to an operational force—specifically the effects of mobilizations and demobilizations on beneficiaries as they access the health care system and on DoD health care costs."[30] It received and analyzed information from panels in San Antonio, Texas, and Virginia Beach, Virginia. (See Appendix D.) Additionally, several members met with the Reserve Chiefs and the Reserve Enlisted Advisors. The following concerns were noted:

- the need for a Total Force solution set that addresses both readiness and health care as a benefit,
- the need for a seamless health benefit to promote medical readiness and family stability, which enhances deployability,
- the need for improved education and information dissemination to reservists about their health care benefit options and how to use the military health care system,
- the need for streamlining the Medical Evaluation Board/Physical Evaluation Board (MEB/PEB) processes used for determining fitness for duty and percentage of physical disability,
- the need for an expansion of the TRICARE provider network, and
- the need for maintaining a medical benefit for the Reserve Component to encourage retention.

29 TRICARE Health Care Transparency Initiative: TRICARE Reserve Select Program, at www.tricare.mil/transparency/index.cfm?id=1
30 DoD Task Force on the Future of Military Health Care Interim Report, at www.dodfutureshealthcare.net/images/103_06_1_Home/Task_Force_Interim_Report_053107.pdf, p. 35.

The Task Force took note of a 2007 GAO survey that assessed increased TRICARE eligibility for reservists and revealed difficulties in many of the same areas

- lack of understanding of the TRICARE program (58 percent of survey respondents)
- difficulty establishing TRICARE eligibility (nearly half of survey respondents),
- difficulty obtaining TRICARE assistance (almost one-third of survey respondents), and
- finding a participating health care provider (more than one-fourth of survey respondents) [31]

Officers and enlisted leaders of the Guard/Reserves view the MHS from two key perspectives readiness and value First and foremost is readiness They said that the typical reservist/guardsman faces a changing environment with many trends that influence readiness and readiness determinations, including

- recurring mobilizations—not just for deployments abroad in support of GWOT, but also to provide security at home and to respond to domestic disasters—and transition to an operational force,
- three to four deployments in a career, and
- a requirement for 100 percent readiness—including medical readiness—versus the more traditional goal of 70 percent readiness

The second perspective focuses on the value of the health care benefit Task Force discussions with Reserve Senior Enlisted Advisors revealed that, in general, they see TRICARE and TRS as a 'pretty good benefit not just for them but also for their families '[32] GAO reports that 70 percent of reservists think that TRICARE is equal to or better than their civilian health insurance plan [33]

Finally, it is important to note that several other commissions, task forces, and review groups have examined or are examining issues surrounding military health care, including care for the Wounded Warrior (both in the Active Duty Component and the Reserve Component), the transition between the DoD and Department of Veterans Affairs (VA) systems and the determination of eligibility and benefits The recommendations of these groups were considered by the Task Force in its deliberations (see Appendix F)

Recommendation 8

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

As the Task Force considered the issues specifically raised by members of the Reserve Component, it realized that many of these issues also apply to subsets of the Active Component, although they are magnified for the Reserves Strategies that are implemented to enhance readiness and improve the benefit for the Reserve Component will improve conditions for other subsets of the Total Force and will thereby enhance overall Total Force readiness

31 GAO *Military Health Increased TRICARE Eligibility for Reservists Presents Educational Challenges* GAO 07 195 2007 p 22 25
32 *Meeting with Reserve Senior Enlisted Advisors other personal communication* October 2 2007
33 GAO *Military Health Increased TRICARE Eligibility for Reservists Presents Educational Challenges* GAO 07 195 2007 p 22

Action Items

- DoD should
  - after three to five years, assess the impact of recent changes in TRICARE Reserve Select eligibility on readiness issues. This assessment should include examining the adequacy of the provider network to absorb the additional workload and to provide sufficient geographic coverage for the dispersed beneficiary population
  - improve information dissemination about the health benefit program to both the service member and his/her family members, particularly at times not associated with mobilization/demobilization,
  - harmonize and leverage the work of other review groups to streamline processes to promote better "hand offs" from the DoD to the Veterans Affairs health system, and reduce administrative "seams" in the Military Health System to ensure beneficiaries receive adequate service, and
  - expand efforts to promote provider participation in the network in nonprime service areas to improve access

Managing the Health Care Needs of Medicare-Eligible Military Beneficiaries

The Task Force was charged to address

"Programs focused on managing the health care needs of Medicare-eligible military beneficiaries."

Historically, the primary mission of the medical departments of the Army and Navy was to provide medical care to Active Duty personnel, and as more of those personnel came to have dependents, "space-available" medical care was extended to their dependents. When military personnel retired from active service, it was understood that they were subject to recall in time of national need; therefore, medical care was made available to them as well. Family members of Active Duty personnel and retirees and their dependents received medical care from military medical facilities on a space-available basis.[1]

After World War II, and especially after the Korean War, a larger standing armed force for the Cold War resulted in larger dependent and retiree communities. Their medical care in military medical facilities was limited and space-available care became increasingly unavailable. Many retirees had to seek medical care in the civilian economy, and, at least until they became eligible for Medicare after 1966, retirees had to pay for health care on their own. Dependents of Active Duty personnel were given a higher priority for receiving health care services than some retirees, because capacity was finite.[2]

To address the adverse effects on morale of the rationing of medical care in military medical facilities for Active Duty dependents and retirees (and their dependents), Congress acted to provide alternative sources of medical care to those communities, if their needs could not be met in the space-available military medical facilities. The Civilian Health and Medical Program of the Uniformed Services, or CHAMPUS, was developed to provide this civilian care. It became one of the fastest growing parts of the military manpower budget, as has its successor program, TRICARE.[3]

The Dependents Medical Care Act[4] is the statutory basis for military retirees and their dependents to receive care in military medical facilities based on the "availability of space and facilities and the capabilities of the medical and dental staff," and it gave the Secretary of Defense the authority to contract with civilian medical care sources for the care of spouses and children of Active Duty members of the Uniformed Services, but not for retirees and their dependents.[5]

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1 DoD Under Secretary for Personnel and Readiness, Military Compensation Background Papers, Sixth Edition, May 2005, p. 1130.
2 Ibid., p. 1131.
3 Ibid.
4 The Dependents Medical Care Act, P.L. 84-569, 70 Stat. 250 (1956).
5 DoD Under Secretary for Personnel and Readiness, Military Compensation Background Papers, Sixth Edition, May 2005, p. 1131-1132.

Subsequent to the passage of the legislation that created Medicare, in 1966 Congress amended Title 10, authorizing DoD, pursuant to this authority under the Military Medical Benefits Amendments of 1966,[6] to create CHAMPUS.[7]

CHAMPUS used the Blue Cross-Blue Shield High Option Plan of the Federal Employees Health Benefits Program (FEHBP) as a model, providing for partial government payment for new and expanded inpatient and outpatient care at civilian sources for designated beneficiaries. The CHAMPUS benefits were limited when compared to those authorized in military medical facilities, and they did not extend to those over 65 years of age (unlike FEHBP). Those with only Military Treatment Facility (MTF) eligibility were primarily retirees and their dependents and the dependents of deceased members and former members who lost their eligibility for CHAMPUS when they became eligible for Medicare because of age or disability. The eligibility of parents and parents-in-law of Active Duty and retired service members also is limited to MTFs.[8]

Another difference between CHAMPUS and FEHBP was that civilians had to pay a part of the monthly premium, but could choose from a variety of plans with different annual benefit structures. CHAMPUS eligible individuals did not have to pay a premium but had no plan choice. CHAMPUS and its successor program, TRICARE Standard, also differ from FEHBP in that beneficiaries generally are required to obtain nonemergency inpatient care from nearby MTFs, if such care is available there. Thus, CHAMPUS and TRICARE Standard are not directly comparable to the various plans available to participants in FEHBP.[9]

At the end of the Vietnam War and the subsequent drawdown of military forces, the Nation ended the military draft and converted to an All-Volunteer Force. This policy change had many practical effects, including increasing the complexity of the military compensation system by deferring benefits that originally were designed to entice members to choose the military as a career, based on 20 years of service.

In an attempt to improve the quality of health care for service families while at the same time controlling health care program costs, Congress supported DoD initiatives to change the CHAMPUS program through the enactment of a number of new provisions in U.S. Code, Title 10.[10] These provisions, while authorizing the Secretary of Defense to prescribe premiums, deductibles, copayments, and more, also specifically authorized the Secretary of Defense to waive beneficiary financial liabilities. The Secretary may waive such payments, or may waive limitations on the kinds of health care services that may be provided, as an inducement to beneficiaries of the military health care system to enroll in alternative health care programs that offer equal or better services at equal or lower cost.[11]

In addition, the Department of Defense Authorization Act of 1987 required the Secretary of Defense to establish a health care enrollment system for beneficiaries of the military health care program. Under the enrollment system, beneficiaries would be permitted to choose a health care plan from a number of alternative plans designated by the Secretary of Defense. Eligible plans would include Uniformed Services medical facilities, CHAMPUS providers, all health care plans contracted for by the Secretary of Defense, or any combination of such plans. Freedom to choose from among available plans could be limited out of necessity to assign beneficiaries to Uniformed Services MTFs in order to assure their full use in a given area.[12]

6 The Military Medical Benefits Amendments of 1966, P.L. 89-614, 80 Stat. 862 (1966).
7 DoD, Under Secretary for Personnel and Readiness, Military Compensation Background Papers, Sixth Edition, May 2005, p. 1132.
8 Ibid.
9 Ibid., p. 1132-1133.
10 Department of Defense Authorization Act of 1987, P.L. 99-661, §§ 701-702, 100 Stat. 3331, 3891-3900 (1986).
11 DoD, Under Secretary for Personnel and Readiness, Military Compensation Background Papers, Sixth Edition, May 2005, p. 1136-1137.
12 Ibid., p. 1137.

The success of various demonstration projects led DoD in 1994 to embark on a new program, known as TRICARE, to improve the quality, cost, and accessibility of services for its beneficiaries. Because of the size and complexity of the Military Health System (MHS), TRICARE implementation was phased in over a period of several years. The principal mechanisms for the implementation of TRICARE were the designation of the commanders of selected MTFs as lead agents for 12 TRICARE regions across the country, operational enhancements to the MHS, and the procurement of managed care support contracts for the provision of civilian health care services within those regions. The first region went into operation in 1995, and the final region went into operation in 1998. All MTFs in the United States have become part of the program coverage.[13]

While the health care benefit was changing, so was the composition of beneficiaries. Between 1988 and 2003, the number of eligible non-Active Duty beneficiaries for each Active Duty service member increased from 3.1 to 4.7. This growth in non-Active Duty eligibles reflected the results of the drawdown at the end of the Cold War and the first wave of retirees who had entered military service under the All-Volunteer Force.[14] Given that most retirees are between 38 and 45 years of age upon retirement,[15] the oldest members of this group will be eligible for Medicare and the TRICARE for Life (TFL) benefit beginning in 2008, and the youngest will become eligible in 2015. During the drawdown, the number of military retirees increased from 1.6 million to 2 million.

As the eligible retiree population was increasing, the opportunity for receiving inhouse care was rapidly declining. Between 1990 and 2001, base realignments and closures and MTF consolidation resulted in a 74 percent drop in the number of beds, a 76 percent decrease in bed days, and a 36 percent reduction in outpatient visits.[16] This "... amounted to a de facto decline in the level of benefits provided to Medicare-eligible retirees. They had difficulty obtaining care at military medical treatment facilities on a space-available basis."[17]

TRICARE Plus

TRICARE Plus is a special program that allows all retirees and their family members,[18] including parents and parents-in-law, who are eligible for care in specific MTFs to seek primary care on a space-available basis. This program allows these retirees to continue receiving care directly within the military health care system and also provides residency and fellowship training programs within MTFs with "a consistent supply of patients over the age of 65 to provide sufficient exposure to clinical conditions to establish competency in practice."[19]

13 Ibid., p. 1137–1138.
14 The Congress of the United States, Congressional Budget Office, A CBO Study, Growth in Medical Care Spending by the Department of Defense, September 2003, p. 4.
15 Ibid., p. 5.
16 Ibid., p. 7.
17 Ibid., p. 7.
18 See www.tricare.mil/mybenefit/home/overview/SpecialPrograms/Plus.
19 Steve Lillie, Deputy Chief for TRICARE Operations, TRICARE Management Activity, TRICARE for Life, Brief to the Task Force, October 3, 2007, p. 206.

Enrollees have the same access standards as TRICARE Prime enrollees and have no out-of pocket expense for care rendered in the facility. Participation in TRICARE Plus does not affect TFL benefits, and participation in Medicare Part B is not required.[20] If eligible for TFL, a beneficiary may enroll in both programs.[21] For all referrals outside the MTF, the beneficiary is responsible for costs at the TRICARE Standard or TFL rates, if eligible. Beneficiaries are ineligible for this program if they are enrolled in:[23]

- TRICARE Prime
- TRICARE Prime Remote
- TRICARE Prime Remote for Active Duty Family Members
- US Family Health Plan (USFHP)
- A civilian health maintenance organization (HMO)
- Medicare Advantage HMO

TRICARE Plus is offered only at specific MTFs based on space availability. There is no charge for enrollment, and it is not guaranteed or portable. A beneficiary may be disenrolled if the MTF commander discontinues the program. Currently, there are about 150,000 enrollees.[24]

The US Family Health Plan

In 1981, Congress enacted the Omnibus Reconciliation Act designating certain former U.S. Public Health facilities as Uniformed Services Treatment Facilities (USTFs).[25] The following year, DoD assumed responsibility for the USTF program from the Department of Health and Human Services. In 1993, the USTFs were reorganized in the Uniformed Services Family Health Plan as TRICARE Designated Providers—the first DoD sponsored, full-risk managed health care plan, and the first to serve the military 65 and older population.[26] The plan began offering the TRICARE Prime benefit the following year. In 2001, the name was shortened to US Family Health Plan, and copayments were eliminated for Active Duty dependents and members 65 years of age and older who had Medicare Part B coverage.

The USFHP is a DoD sponsored, fully at-risk managed care health plan offering the TRICARE Prime benefit. However, its geographic availability is limited to six metropolitan areas. Notable health plan features include comprehensive disease management, case management, and utilization management all of which contribute to very high satisfaction rates.

The plan is made available by nonprofit health care providers and serves more than 90,000 beneficiaries nationally,[28] with 37 percent 65 years of age and older.[29] Beneficiaries include military retirees, eligible retirees, and all Active Duty family members including activated reservists and National Guard family members.[30] One may enroll any time during the year. All services must be provided through the health plan's area network, no services, including pharmacy, may be obtained through other TRICARE-authorized providers or an MTF.[31] The overall national member

20 See www.tricare.mil/mybenefit/home/overview/Special Programs/Plus
21 Ibid
22 Ibid
23 Ibid
24 Steve Lillie, Deputy Chief for TRICARE Operations, TRICARE Management Activity, TRICARE for Life, Brief to the Task Force, October 3, 2007, p. 206
25 See www.usfhp.org/newsite/portal/planhistory.asp
26 Ibid
27 See www.usfhp.org/newsite/portal/factsheet.asp
28 Ibid
29 Marshall Bolyard, LTC, USA (Ret.), Executive Director, USFHP at CHRISTUS, Chair, US Family Health Plan Alliance; Linda Dunbar, Ph.D., Vice President, Care Management, Johns Hopkins HealthCare LLC, US Family Health Plan, Brief to the Task Force, May 22, 2007, Slide 20
30 See www.usfhp.org/newsite/portal/news.asp
31 See www.tricare.mil/Factsheets/

satisfaction rate with the USFHP has remained above 85 percent since 2000, and in 2006, it was 87.6 percent—22 percent higher than the national average for all health plans.[32] USFHP is a capitated plan that represents a fixed and predictable annual budget that varies only by the number of enrollees and their gender and age,[33] while TFL beneficiary costs may vary because TRICARE acts as a secondary payer and costs will fluctuate based on amount and type of services provided. While a direct comparison of the average DoD cost per beneficiary cannot easily be made between TFL and USFHP, DoD costs for the Medicare-eligible beneficiary are likely to be significantly lower in the TFL program.[34] The fact that the TFL beneficiary has Medicare as a primary payer, while the USFHP beneficiary does not, accounts for a significant portion of the difference in the DoD outlay.[35]

TRICARE for Life

TFL, which was introduced in all regions during 2004, combines TRICARE and Medicare coverage for Medicare-eligible military retirees and dependents. Under TFL, TRICARE acts as the second payer for expenses covered by both programs, covering deductibles and certain other expenses not covered by Medicare. If hospitalization exceeds 150 days, TRICARE becomes the primary payer.

The TFL plan came into existence on October 1, 2000,[36] through the National Defense Authorization Act of 2001. In Fiscal Year 2007, approximately 1.9 million beneficiaries were eligible for TFL.[37] Beneficiaries include dual eligible Medicare/TRICARE beneficiaries, regardless of age, who are eligible for Medicare Part A and who are generally enrolled in Medicare Part B. National Guard and Reserve members who receive retired pay, family members, widows/widowers, and certain former spouses are included. Dependent parents and parents-in-law are ineligible for TFL (except for the pharmacy benefit),[38] however, they are eligible for TRICARE Plus and the USFHP.[39]

This program combines TRICARE Standard with Medicare Parts A and B to provide Medicare wrap-around coverage.[40] (Statutorily, TRICARE only pays after *all* other health insurances have paid.[41]) When care is rendered that is payable under both systems, TRICARE is the secondary payer and will normally pay the actual out-of-pocket costs incurred by the beneficiary.[42] TRICARE functions as the primary payer for those services covered only by TRICARE. In the case of dual coverage, Medicare pays its portion and forwards the claim to TRICARE for processing.[43] The Medicare Eligible Retiree Health Care Fund, also known as the accrual fund, is the source of funding for this program.[44]

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32 National Committee for Quality Assurance, The State of Health Care Quality 2006, Appendix 3, CAHPS Member Satisfaction Measures, National Averages.
33 Marshall Bolyard, LTC, USA (Ret.), Executive Director, USFHP at CHRISTUS, Chair, US Family Health Plan Alliance, Brief to the Task Force, May 22, 2007, Oral testimony, certified transcript, p. 14, lines 4-8.
34 Robert J. Moss, Jr., Deputy Director, Management Control & Financial Studies Division, Office of the Chief Financial Officer, TRICARE Management Activity, TRICARE for Life, Brief to the Task Force, October 3, 2007, p. 216-219.
35 Ibid.
36 Floyd D. Spence, National Defense Authorization Act of 2001 (P.L. 106-398), §711 (114 Stat. 1654A-176-177) (2000).
37 Allen Middleton, Acting, Deputy Assistant Secretary of Defense for Health Affairs and Acting, Chief Financial Officer, TRICARE Management Activity, The Military Health System and the Defense Health Program, An Overview for the Task Force on the Future of Military Health Care, Brief to the Task Force, January 16, 2007.
38 Ibid.
39 See www.tricare.mil/mybenefit/home/overview/Eligibility/WhoIsEligible/DependentParentsAndParentsInLaw.
40 TRICARE Policy Manual 6010.54M, TRICARE for Life, Chapter 10, Section 6.1 (Change 60, July 17, 2007, to the August 1, 2002, edition).
41 See www.tricare.mil/mybenefit.
42 TRICARE Policy Manual 6010.54M, TRICARE for Life, Chapter 10, Section 6.1 (Change 60, July 17, 2007, to the August 1, 2002, edition).
43 See www.tricare.mil/.
44 Robert J. Moss, Jr., Deputy Director, Management Control & Financial Studies Division, Office of the Chief Financial Officer, TRICARE Management Activity, TRICARE for Life, Brief to the Task Force, October 3, 2007.

There are no enrollment fees for TFL but beneficiaries must, by law, purchase and maintain Medicare Part B coverage, an exception is made for Active Duty family members and only for the period prior to the sponsor's retirement [15] Beneficiaries may continue to receive care at an MTF, on a space-available basis, without subscribing to Medicare Part B

By contrast, Medicare Part B incurs a monthly premium of $93 50 for 2007 for those earning up to $80 000 as an individual or $160,000 as a couple This amount gradually increases with an increase in income TFL beneficiaries generally must purchase and maintain Part B enrollment These premiums, as well as deductibles and copayments are adjusted yearly according to formulas set by statute

When care is covered by Medicare, but not by TRICARE (e g , chiropractic care), TRICARE will not pay, regardless of Medicare's actions The beneficiary is responsible for Medicare deductibles and cost-shares

The opposite payment structure occurs when care is covered by TRICARE, but not Medicare (e g , overseas care, unlimited hospital days and the first three pints of blood) In these cases TRICARE becomes the primary payer, and the beneficiary pays the applicable TRICARE deductibles and cost-shares at TRICARE Standard and Extra rates

Pneumovax® Program

The Pneumovax Program is a preventive program especially relevant to the Medicare eligible population as it seeks to shield those most vulnerable to acquired pneumonias This population is predisposed to pneumonia as a comorbidity The Army Medical Department (AMEDD), through its Tactical Implementation Cell has implemented the "Adult Pneumovax® Immunization Strategy," with the goal of increasing the percentage of beneficiaries age 65 and older with one documented Pneumovax® in the Armed Forces Health Longitudinal Technology Application (AHLTA), decreasing hospitalization rates for pneumonia as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicator measures, and increasing the percentage of eligible hospitalized patients who have current Pneumovax® in AHLTA at the time of discharge With monitoring and compliance the AMEDD should achieve a vaccination rate of 95 percent by January 2008 In addition to lower hospitalization rates for pneumonia, the AMEDD projects savings of $500 per vaccine given [16]

Conclusions

While legislation has provided for military health care benefits, only within the last decade has Congress specifically addressed the age 65 and older beneficiary A retiree located near an MTF that offers TRICARE Plus can receive primary care, and specialty care if available, and use TFL benefits when referred to a downtown clinician When accessing the downtown clinician, the retiree's Medicare Part B pays first and TFL pays second When the retiree lives in one of the six metropolitan areas served by the USFHP, a member may choose this plan and not need to participate in Medicare Part B The full risk HMO provides the same care as TRICARE Prime with an extraordinarily high satisfaction rate among those who use it TFL , which requires participation in Medicare Part B, provides a nationwide benefit for maximum mobility As a second payer, TFL reduces the costs to DoD while ensuring a solid health benefit for the retiree

15 See www tricare mil/mybenefit/
16 Department of the Army Headquarters U S Army Medical Command OTSG/MEDCOM Policy Memo 06 023 The Adult Pneumovax® Strategy September 23 2006

The DoD Pharmacy Program

The impetus for DoD to provide a uniform program of medical and dental care for members and certain former members of the military services and for their dependents is ensconced in federal law.[1] Federal law also requires the Secretary of Defense to establish an effective, efficient and integrated pharmacy benefits program. Under this pharmacy benefits program, the Secretary must ensure the availability of pharmaceutical agents for all therapeutic classes, establish a uniform formulary based on clinical effectiveness and cost-effectiveness, and assure the availability of clinically appropriate pharmaceutical agents to members of the Uniformed Services. The Secretary of Defense implemented this key component of the TRICARE program, the current TRICARE Pharmacy Program, effective May 3, 2004.[2]

TRICARE provides a pharmacy benefit to all eligible Uniformed Services members, including TRICARE for Life (TFL) beneficiaries. TFL beneficiaries who turned age 65 on April 1, 2001, or later must be enrolled in Medicare Part B to use the TRICARE Retail Pharmacy (TRRx) Program and the TRICARE Mail Order Pharmacy (TMOP) Program.

Factors Influencing Expenditures

There are several factors contributing to the increase in pharmacy expenditures within the Military Health System (MHS):

- limited discounts at the retail point of service coupled with increasing usage,
- significant increases in pharmacy costs, since the implementation of TFL, retail prescription usage and costs have been the main cost driver contributing to the significant increases in MHS pharmacy costs. Pharmaceutical costs for those under 65 years of age average $437 per eligible beneficiary, compared to $1,784 for those who are 65 years of age or older, a difference of $1,347 per eligible beneficiary,[3]
- increased numbers of eligible beneficiaries, from 8.6 million (Fiscal Year 2002) to 9.2 million (Fiscal Year 2006), and increased numbers of users of the benefit, from 5.7 million (Fiscal Year 2002) to 6.7 million (Fiscal Year 2006),
- no change in pharmacy copayments since the inception of the TRICARE Senior Pharmacy (TSRx) Program in 2001,
- the stipulation of maximum nonformulary copayments in law, and
- limited leverage to optimize drug utilization management in the network point of service compared to the Military Treatment Facility (MTF).

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1 10 U.S.C. §§ 1071–1073 (2004).
2 See 69 Fed. Reg. 17035 (April 1, 2004) (noting that the final rule becomes effective May 3, 2004).
3 Maj. Wade Hiller, Dave Brett, Jr., DoD Pharmacoeconomic Center, PTC Brief, April 11, 2007.

Points of Service

To have a prescription filled, beneficiaries need a written prescription and a valid Uniformed Services identification card. Eligible beneficiaries may fill prescription medications at four outpatient pharmacy points of service:

1) MTFs,
2) retail network pharmacies (non-MTF pharmacies that are part of the network established for the TRRx program),
3) retail non-network pharmacies (non-MTF pharmacies that are not part of the network established for TRICARE retail pharmacy services), and
4) TMOP.

Copayment Structure

Federal law also establishes cost-sharing requirements for the pharmacy benefits program.[4] Cost-shares, when collected by the government for prescriptions dispensed through the retail network pharmacies or TMOP, help defray government costs of administering the pharmacy benefits program and can be used to encourage (or discourage) certain types of behavior. The current TRICARE Pharmacy Program covers at least a portion of a beneficiary's cost of prescription drugs when the beneficiary acquires the drugs from one of the four sources cited above. The amount of cost sharing between beneficiaries and DoD varies depending on the source of the prescription drugs obtained.

Beneficiaries currently pay the pharmacy copayment based on whether the prescription medication is classified as a formulary generic drug (Tier 1), a formulary brand name drug (Tier 2), or a nonformulary drug (Tier 3). The copayment depends on where the beneficiary chooses to fill his or her prescription.

Beneficiaries may fill their prescriptions at an MTF, through TMOP, or at one of the more than 58,650 TRRx locations in the nationwide network.[5] Beneficiaries also can fill prescriptions at non-network pharmacies, but they will pay significantly more and must meet a deductible.

Active Duty service members are not required to make copayments on their prescriptions. However, if they receive medications through an overseas pharmacy or an out-of-network pharmacy, they may need to pay out-of-pocket expenses for the total cost of the medication and then file a claim for reimbursement for the full amount.

The copayment structure applies to all TRICARE beneficiaries. Beneficiaries have no copayment when they obtain drugs from an MTF.[6] However, beneficiaries must pay a copayment when they obtain drugs from other points of service. A comparison of the point-of-service copayment and the associated quantity of medication dispensed is presented in Table 1.[7]

4 10 U.S.C. §1074g(a)(6) (2004).
5 RADM Thomas McGinnis, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity; Capt. Patricia Russ, DoD Pharmacy and Therapeutics Committee, Overview of the Department of Defense Pharmacy Program, February 6, 2007.
6 32 C.F.R. §199.21(a)(2)(i) (2006).
7 See www.tricare.mil/pharmacy/copays.cfm.

Table 1 TRICARE Pharmacy Copayments in the United States and Territories

UNIFORM FORMULARY

PLACE OF SERVICE	FORMULARY GENERIC (TIER 1)	FORMULARY BRAND NAME (TIER 2)	NONFORMULARY (TIER 3)
MTF pharmacy (up to a 90 day supply)	[illegible]		[illegible]
TMOP (up to a 90 day supply)	[illegible]	[illegible]	[illegible]
TRRx (up to [illegible] day supply)	[illegible]	[illegible]	[illegible]
Non network retail pharmacy (up to [illegible]) **Note** [illegible]	**For those who are not enrolled in TRICARE Prime** [illegible]		**For those who are not enrolled in TRICARE Prime** [illegible]
	TRICARE Prime [illegible]		**TRICARE Prime** [illegible]

BENEFICIARY COPAYMENT AT OVERSEAS LOCATIONS

	ACTIVE DUTY SERVICE MEMBERS	ACTIVE DUTY FAMILY MEMBERS (ADFMS) ENROLLED IN PRIME	ADFMS NOT ENROLLED IN PRIME	RETIREES AND FAMILY MEMBERS
Copayment	[illegible]	[illegible]	[illegible]	[illegible]

The copayment structure has not changed since 2001 The MHS does not have an index to inflation as does the Centers for Medicare & Medicaid Services (CMS) with its Part D drug benefit The maximum nonformulary copayment is a percentage of the total costs in the third tier This figure is 20 percent for Active Duty family members and 25 percent for retirees The Task Force believes that this amount ($22) does not represent a large enough difference to drive utilization into a formulary drug (Tier 2) or a generic drug (Tier 1)

The established copayments may be adjusted periodically based on experience with the uniform formulary, changes in economic circumstances, and other appropriate factors.[8] Adjustments may be made upon the recommendation of the DoD Pharmacy and Therapeutics Committee and approved by the Assistant Secretary of Defense for Health Affairs.[9] However, adjustment amounts must comply with the requirements of applicable federal law.[10] Under these requirements, the Secretary of Defense may establish cost-sharing requirements in a percentage or fixed dollar amount under the pharmacy benefits program for generic, formulary, and nonformulary agents.[11] The law limits the amount of the highest copayment category, the nonformulary, or third-tier category, to 20 or 25 percent.

TRICARE's mandatory generic drug policy requires that prescriptions be filled with a generic product if one is available. Brand name drugs that have a generic equivalent may be dispensed only if the prescribing physician is able to justify the medical need for its use. If a generic-equivalent drug does not exist, the brand name drug will be dispensed at the brand name copayment rate.

The MHS average cost for a retail prescription for 30-day equivalents is $70 as of March 2007.[12] For TMOP, the average cost is $34.[13] The retail and TMOP points of service had a generic fill rate[14] in excess of 53 percent in 2006, and this number continues to climb, resulting in a 1 percent reduction in pharmacy spend for every 1 percent increase in the generic fill rate. The MTF remains the lowest cost point at $19; it is the most cost-effective option for both the government and beneficiaries when drugs are available and accessible.[15] Overall, DoD has a 62 percent fill rate for generic medications, in line with the CMS benchmark of 60 percent.[16] Nonetheless, ExpressScripts, Inc., has suggested that an 80 percent generic fill rate is an achievable rate.[17] However, it is not clear whether these data reflect the actual costs of dispensing. 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. Moreover, cost comparisons must be made using specific medications.

Beneficiaries and Usage of the Pharmacy Benefit

Of the 9.2 million eligible beneficiaries in the MHS, 73 percent, or 6.7 million, used the pharmacy benefit in Fiscal Year 2006 (see Table 2).

8 32 C.F.R. §199.21(t)(2)(ix) (2006)
9 Ibid.
10 10 U.S.C. §1074g(a)(6) (2004)
11 Ibid.
12 Department of Defense Pharmacoeconomic Center, Cost Per 30 Day Equivalent Rx, May 1, 2007. See https://reportal.army.mil
13 Ibid.
14 Nancy Gilbride, Steven B. Miller, Express Scripts, Brief to the Task Force, April 18, 2007, Slide 8.
15 Ibid.
16 Testimony of RADM Thomas McCinnis, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity, Official Transcript of the Task Force on the Future of Military Health Care Meeting, February 6, 2007, Washington, D.C., p. 68.
17 Testimony of Nancy Gilbride, Vice President and General Manager, TRICARE Pharmacy Division, Express Scripts, Inc., Official Transcript of the Task Force on the Future of Military Health Care Meeting, April 18, 2007, Washington, D.C., p. 215.

Table 2 Unique User Trends—Number of Users

POINT OF SERVICE	FY02	FY03	FY04	FY05	FY06	FY07
MTF only	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Retail only	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Mail Order only	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MTF & Retail only	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MTF & Mail Order only	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Retail & Mail Order only	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
MTF, Mail Order & Retail	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Total Unique Users	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Source: DoD Pharmacy [illegible]

Pharmacy expenditures in Fiscal Year 2006 totaled $6.18 billion and are expected to reach $15 billion by Fiscal Year 2015.[18]

In Fiscal Year 2006, the TRICARE Pharmacy Program filled 115 million prescriptions through 536 dispensing pharmacies at 121 MTFs, 58,650 pharmacies in the TRICARE network, and 1 mail order pharmacy, Express Scripts, Inc.[19]

MTF Pharmacies

Prescriptions may be filled (up to a 90-day supply for most medications) at an MTF pharmacy at no cost to the beneficiary if the medication is in the MTF formulary. Across the MHS, the 536 pharmacies located at the 121 MTFs dispensed 51 percent of the prescriptions filled in Fiscal Year 2006, for 25 percent of the total MHS pharmacy bill (see Figure 1).[20] There are several reasons for the relatively low costs for drugs at the MTF pharmacy: 1) MTFs have the ability to strictly control the formulary, 2) MTF drug purchase prices are at federal pricing ceilings or lower (resulting from DoD's ability to leverage volume and negotiate with the prime vendor), and 3) the use of drug rebate programs. In addition, Tier 3 (nonformulary) as well as many other medications are not available at MTFs. In both other venues (retail and mail order pharmacies), all legal prescription medications are available regardless of cost or clinical efficiency. With no copayment, the MTF pharmacy also presents the best value to the beneficiary.

18 RADM Thomas McCinnis, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity, Capt. Patricia Buss, Chair, DoD Pharmacy and Therapeutics Committee, Overview of the DoD Pharmacy Program, Brief to the Task Force, February 6, 2007
19 Ibid
20 Ibid

DoD DRUG EXPENDITURES THROUGH FISCAL YEAR 2007

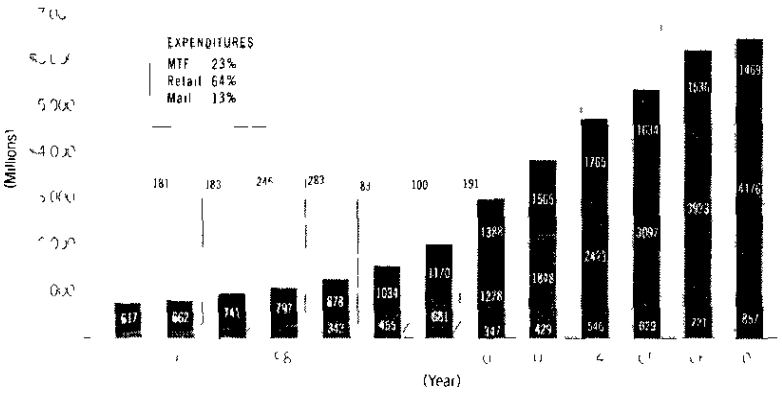


Figure 1

TRICARE Retail Pharmacy Program (TRRx)

TRRx is administered by Express Scripts, Inc. Beneficiaries in the continental United States and its territories may use the expanded, nationwide network of 58,650 retail pharmacies to fill prescriptions.[21] The retail portion of TRRx accounted for 35 percent of the workload in Fiscal Year 2006, amounting to 63 percent of the total MHS pharmacy bill (see Figure 2).[22] The mail order portion of TRRx accounted for 14 percent of the workload in Fiscal Year 2006, amounting to 12 percent of the total MHS pharmacy bill (see Figure 1).

Non-Network Pharmacies

A non-network pharmacy is a retail pharmacy that is not part of the TRICARE network. Filling prescriptions at non-network pharmacies is the most expensive option for the beneficiary. Beneficiaries may have to pay the total amount and then file a claim to receive partial reimbursement. Beneficiaries incur penalty fees if they are TRICARE Prime enrollees utilizing non-network pharmacies.

21 Ibid.
22 Ibid.

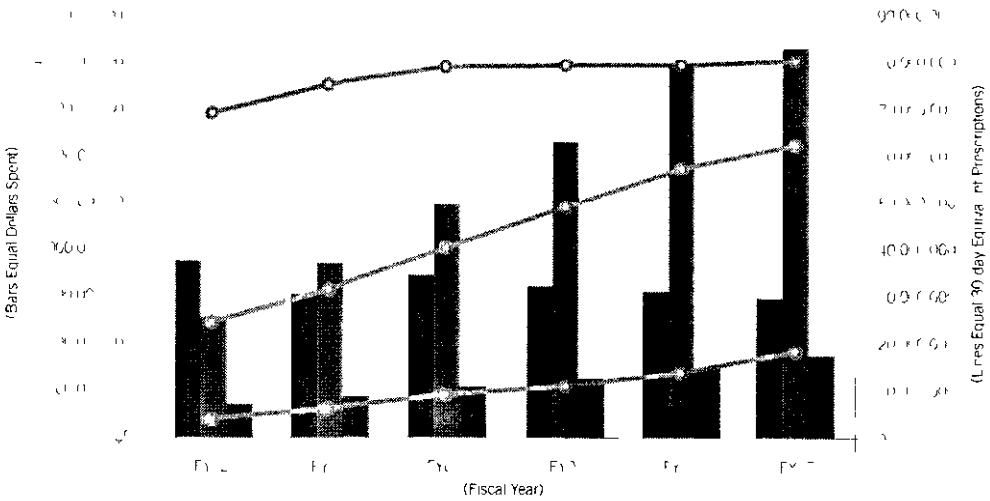
TRICARE Mail Order Pharmacy (TMOP)

TMOP also is administered by Express Scripts, Inc. To use TMOP, beneficiaries register by completing an online registration form.[23] Beneficiaries must then mail their health care provider's written prescription and the appropriate copayment to Express Scripts, Inc. New prescriptions may be faxed or phoned in by the provider. Within 10 to 14 days, the medications are sent directly to the beneficiary through the U.S. Postal Service. TMOP prescriptions accounted for 14 percent of prescriptions filled in Fiscal Year 2006, yet they accounted for 12 percent of the total MHS pharmacy bill.[24]

The number of TRICARE-covered individuals has been growing, with steady growth in the last two years. Since the advent of TFL, pharmacy costs have been growing dramatically, with the retail network being the biggest cost driver (see Figure 2). The costs of drugs have been increasing rapidly overall. Express Scripts, Inc., has reported that "certain drugs had a higher level of cost growth in 2006, including medications to treat diabetes, which experienced a 15.5 percent growth, the second year of double-digit increases. In addition, the trend for expensive, but critically important specialty drugs rose 2.9 percent."[25]

TOTAL DRUG SPEND AND PRESCRIPTION VOLUME

By Point of Service



Source: Patricia Horn, TRICARE Management Activity Office of Pharmaceutical Operations, Response to Task Force Request for Information, November 15, 2007.

Figure 2

23 See www.express-scripts.com/TRICARE.
24 RADM Thomas McCinnis, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity; Capt. Patricia Buss, Chair, DoD Pharmacy and Therapeutics Committee, Overview of the DoD Pharmacy Program, Brief to the Task Force, February 6, 2007.
25 Federal Health Update, April 27, 2007. See www.usminstitute.org/newsletter.html. Express Scripts Annual Drug Trends Report. Also see www.express-scripts.com/ourcompany/news-industryreports/drugtrendreport-2006/dtrFinal.pdf.

In 2001, Congress expanded the pharmacy benefit for 1.8 million military retirees age 65 and older and their elderly dependents. Prior to 2001, this population always could use the military prescription benefit at no cost only at MTF pharmacies. Under the new TSRx, retirees can use the TRICARE pharmacy benefit to obtain prescriptions through four sources: 1) MTF pharmacies, 2) retail pharmacies in the TRICARE network, 3) TMOP, and 4) non-network retail pharmacies.

In 2005, DoD asked the RAND Center for Military Health Care Policy to assess factors contributing to the rising costs of prescription medications for military retirees and their families.[26] By examining TRICARE pharmacy claims data, RAND found that the majority of TSRx prescriptions still were being dispensed from MTFs, however, the amount dropped from 100 percent to 60 percent in the two years following the expansion of the benefit. There was a corresponding increase in the use of retail pharmacies.

RAND also found that:

- because of higher prices to DoD, retail pharmacies account for the majority of pharmaceutical costs;
- retail pharmacy use is related to the distance to the nearest MTF and to the nonavailability of certain drugs at MTFs; and
- implementing a three-tier drug benefit in the private sector slowed the increase in pharmaceutical spending.

RAND recommended that "to save costs without adversely affecting beneficiaries' health, DoD should carefully consider the drugs that it places in the more costly third-tier." RAND also recommended that to achieve greater overall health care cost savings, "DoD must assess the possible advantage of lowering the copayment for third-tier medications obtained from TMOP, easing some of the prior authorization requirements at MTFs, and instituting other changes that would limit the incentive to use retail pharmacies."[27]

Mail Order Practices in the Private Sector

"Mail order pharmacy is the fastest growing segment of the retail pharmacy marketplace."[28] The average consumer is nearly 64 years old, and most are over 65 years old. This group tends to use multiple/maintenance medications for long-term chronic conditions.[29] The civilian sector encourages, as does DoD, the use of mail order refills and provides a number of options for patients for this process, including phone, mail, and online refill ordering. For phone and online refills, the original prescriptions must be faxed by the provider. Requiring mail order greatly increases its use: "a recent study found that, on average, voluntary plans achieve 14 percent mail order use rates while mandatory plans increase use rates to 27 percent."[30]

26 Geoffrey Joyce, Jesse D. Malkin, Jennifer Pace, *Pharmacy Use and Costs in Employer Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector*, Santa Monica, CA: RAND Corporation, MG-154-OSD, 2005.
27 Ibid.
28 Michael Johnstud, *Will a Mandatory Mail Order Pharmacy Benefit Save Payers Money? Investigating the Evidence*, 2006. See www.nacdsfoundation.org/user_assets/Document_PDF/Mail_Order_Pharmacy_Literature_Review_Manuscript_2.pdf.
29 Ibid.
30 Ibid.

Findings and Recommendations in the Interim Report

In developing its interim report, the Task Force heard convincing arguments that private sector plans have been able to reduce the growth in pharmacy costs while retaining clinical effectiveness by providing beneficiaries with greater incentives to utilize preferred drugs and fill maintenance prescriptions using mail order services. Generic drugs have the lowest copayment, followed by formulary drugs and nonformulary drugs. However, current DoD pharmacy copayment policies do not provide adequate incentives for patients to use the most cost-effective alternatives, such as the mail order pharmacy or an MTF. Employing financial incentives to encourage the use of the mail order pharmacy across all beneficiary groups should decrease retail pharmacy costs while preserving access to the local pharmacy. The Task Force recommended the following:

- Copayments for prescriptions filled outside an MTF should be changed in order to alter incentives. DoD should increase the differentials in copayments to increase the use of more cost effective practices. (The interim report noted that in its final report, the Task Force will make more specific recommendations about payment structure.)
- DoD should engage in an outreach program to publicize the value of using TMOP program and generic drugs, utilizing the best practices that are followed by private companies in order to achieve savings.

Final Findings and Recommendations

Since the submission of its interim report, the Task Force has concluded that the current DoD formulary tier structure and copayment policies do not create effective incentives to stimulate compliance with clinical best practices or the most cost-effective point of service for medications. The Task Force in this final report presents a series of new recommendations regarding tiering, the copayment structure, the inclusion of over-the-counter (OTC) medications, and the point of service for certain medications.

Tiering Structure for Pharmacy

The current tiering structure is as follows:

- Tier 1: Uniform Formulary Generic
- Tier 2: Uniform Formulary Brand
- Tier 3: Nonformulary

In the current structure, the MHS pharmacy program does not cover OTC medications, except insulin and diabetic supplies.

Under current law, TMA cannot add OTCs (except insulin) to Tier 1 (or any tier) of the Uniform Formulary. However, recent legislation directed the DoD to carry out a demonstration project on coverage of selected OTC medications under the pharmacy benefits program.[31] This legislation required that OTC drugs provided under this demonstration project be available through at least two of the following venues—MTFs, TRICARE retail network pharmacies, or TMOP.[32] TMA initiated the demonstration project in TMOP and started the retail program on September 10, 2007.[33]

31 National Defense Authorization Act for Fiscal Year 2007, §705 (P.L. 109-364), (120 Stat. 2083, 2280) (2006).
32 Ibid., 120 Stat. 2281, §705(b)(2).
33 Ibid., §705(b)(2), 120 Stat. 2281.

The demonstration project does not cover all OTC drugs. As an example, TMOP is currently providing Prilosec OTC as an alternative to prescription Proton Pump Inhibitors, such as Prevacid, Aciphex, and Nexium.[34] The DoD Pharmacy and Therapeutics Committee recommended that OTC loratidine (Claritin) be added to the Uniform Formulary for the purposes of the OTC program. TMA anticipates that MTFs will use this product to participate in the demonstration.[35] As required by the demonstration project legislation, an OTC drug will be available to a beneficiary through the demonstration project if a) the beneficiary has a prescription for a drug requiring a prescription, and b) the OTC drug is in the Uniform Formulary and the Pharmacy and Therapeutics Committee has determined the OTC drug to be therapeutically equivalent to the prescription drug.[36]

TMA expects the project to last until the implementation of the combined TRICARE mail and retail contract (TPharm), which will be approximately two years from the start date of the demonstration project. If the current demonstration project generates a high level of beneficiary satisfaction and demonstrates cost-effectiveness, the Secretary of Defense can make a recommendation to include the provision of OTC drugs under the pharmacy benefits program and recommend whether or not Congress should provide permanent authority to cover OTC drugs under the pharmacy benefits program.

In its testimony to the Task Force, the United Mine Workers explained how it structured its "Preferred Product Program," which has five therapeutic categories containing generic and brand drugs.[37] Its program is treatment centered and outcome focused rather than focused on individual drug cost.

In PhRMA's presentation to the Task Force, it cited the efforts of Pitney Bowes as an example of effective pharmacy benefit design in facilitating effective disease management. After determining that employees who failed to take their prescription medications for chronic conditions increased health care costs, Pitney Bowes restructured its prescription benefits to make medicines that treat chronic conditions such as asthma, diabetes, and hypertension available at the lowest level of copayment regardless of brand or generic status. This strategy promoted adherence in taking maintenance medications, and this generated cost avoidance in acute care and lowered overall pharmacy costs.[38]

Concerned about rising pharmacy costs, health plans, and self-funded plans, employers are analyzing a variety of alternatives for pharmacy benefit design, including the four-tier formulary.[39] A four-tier formulary can encourage the use of less-costly drugs and more appropriate drug utilization, generate manufacturer discounts, and result in the lowest net cost for drugs. When there are more tiers, it is easier to lower the out-of-pocket costs for drugs for important medications for certain chronic diseases, such as diabetes, and remove compliance barriers.[40] Additionally, certain medications demand central monitoring and procurement for improved clinical oversight/safety and cost-effectiveness.

34 Ibid.
35 Ibid.
36 National Defense Authorization Act for Fiscal Year 2007, §705(b)(1)(B) (P.L. 109-364), (120 Stat. 2083, 2280-2281) (2006).
37 UMWA Health and Retirement Funds, Outreach Programs, Generics, Mail Order and Other Healthcare Service, April 16, 2007, Slide 26.
38 PhRMA, Brief to the Task Force, April 25, 2007, Slide 26.
39 Mary Eblin, Health Plans Creative Model Help Four-Tier Formularies Gain Acceptance, March 1, 2005. See www.managedhealthcareexecutive.com/mhe/article/articleDetail.jsp?id=150899.
40 Ibid.

ODS Companies based in Portland, Oregon has modified the conventional three-tier program by creating a first tier with no copayment that includes selected OTC products, cost-effective brand products and generic drugs [41] The next three tiers are generics, preferred brands, and nonpreferred brands with consumer copayments of $15, $25, and $50, respectively, that originally occupied the three-tier structure [42] Claims data from January 1 2004, to October 31, 2004, indicate that generic utilization reached 60 percent in the four-tier program, compared with 55 percent in the three tier model [43] In addition, the four-tier model promotes the use of OTC drugs for treating allergies and ulcers ODS also tracked the average amount paid per prescription for drugs treating high blood pressure high cholesterol, depression, and ulcers, showing cost savings of 23 percent, 14 percent 22 percent and 20 percent, respectively [44]

A four-tier system could potentially provide a way to incorporate lessons learned from United Mine Workers and Pitney Bowes in the MHS

Copayment Structure

Federal law places a ceiling on nonformulary (Tier 3) pharmacy copayments

> The Secretary in the regulations prescribed under subsection (g) may establish cost sharing requirements (which may be established as a percentage or fixed dollar amount) under the pharmacy benefits program for generic, formulary, and nonformulary agents For nonformulary agents, cost sharing shall be consistent with common industry practice and not in excess of amounts generally comparable to 20 percent for beneficiaries covered by section 1079 of this title or 25 percent for beneficiaries covered by section 1086 of this title [45]

When on April 1, 2001, DoD established $22 as the nonformulary copayment, that amount represented approximately 20 percent of the aggregate average cost of all brand name medications [46] TMA established the uniform formulary and generic cost-shares so that the cost-sharing differential between tiers was consistent with common industry practice to the extent possible, given the statutory constraints [47]

The per prescription copayments may be adjusted periodically based on experience with the uniform formulary, changes in economic circumstances and other appropriate factors [48] Any such adjustment requires the recommendation of the Pharmacy and Therapeutics Committee and approval from the Assistant Secretary of Defense for Health Affairs However, any such adjusted amount has to maintain compliance with the requirements of federal maximum nonformulary cost-share limits [49] To significantly change the upper limit of the nonformulary cost-share, a statutory change would be required Currently, Congress has placed a moratorium on increasing pharmacy cost shares, which would continue under both the House and Senate versions of the National Defense Authorization Act for Fiscal Year 2008

41 Ibid
42 Ibid
43 Ibid
44 Ibid
45 10 U S C §1074g(a)(6) (2004)
46 Co pay Changes Will Simplify TRICARE Pharmacy Benefit February 16 2001 See www.tricare.mil News/2001 news2001_006 htm
47 RADM Thomas McCrum Chief Pharmaceutical Operations Directorate TRICARE Management Activity Response to Task Force RFI October 26 2007
48 32 C F R §199 21(i)(2)(x) (2006)
49 10 U S C §1074g(a)(6) (2004)

David Walker, Comptroller General of the United States, encouraged the Task Force to investigate whether "TRICARE cost-sharing requirements should be brought into parity with those of other public and private payers" and to explore "how cost-sharing requirements [can] be designed to encourage TRICARE beneficiaries to use options that are most cost-efficient for DOD, such as purchasing drugs through mail order rather then retail pharmacy."[50] According to the Pharmacoeconomic Center (PEC), its research indicates that industry practice for cost-shares for pharmacy are equal to or less than 25 percent.[51] According to the presentation of Express Scripts Inc., to the Task Force, the "general rule of thumb is mail equals twice retail with commercial economics." Thus, the mail order copayment is twice that of the retail copayment, however, the beneficiary gets a 90-day supply instead of a 30-day supply.

David McIntyre, in his TriWest presentation to the Task Force, stated that "DoD could and should modify pharmacy co-payments to promote home delivery of prescriptions in lieu of in-store purchases. Last year, Congress considered legislation that would make mail order pharmacy mandatory. I do not believe it is necessary to go that far ... develop a program that preserves individual choice but encourages and incentivizes use of mail order or home delivery of prescriptions."[53] United Mine Workers' 1992 Plan and Combined Benefit Fund have virtually no monetary incentives to use mail service and have very low usage, however, the 1993 plan uses financial incentives and has increased the participation rate in the mail service program to 43 percent.[54]

Recommendation 9

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 (see Table 3).

Action Items

- The tier structure should be as follows:
  - Tier 1: Preferred—preferred medications, to include selected OTCs, cost-effective brand products, generics.
  - Tier 2: Other formulary medications.
  - Tier 3: Nonformulary medications.
  - Tier 4: Special Category Medications—very expensive, specialty, and/or biotechnology drugs with a mandated point of service. The DoD PEC would specify the tier for establishing the copayment and point of service for the most cost-effective delivery for the special medication.

50 David M. Walker, DoD 21st Century Health Care Spending Challenges, April 18, 2007, Slide 27.
51 Wade Tiller, Dave Bretzke, DoD Task Force on the Future of Military Health Care Brief, April 11, 2007, Slide 47.
52 Nancy Gilbride, Steven Miller, A Discussion with the Department of Defense Task Force on the Future of Military Health Care, April 18, 2007, Slide 17.
53 David McIntyre, Testimony before the Task Force, March 28, 2007.
54 UMWA Health and Retirement Funds, Outreach Programs, Generics, Mail Order and other Healthcare Services, April 18, 2007, Slide 13.

Table 3 Proposed Pharmacy Copayment Structure

	DOD CURRENT		TASK FORCE RECOMMENDATION	
	Retail Network 30 Days	Mail 90 Days	Retail Network 30 Days	Mail 90 Days
Tier 1 Preferred	$[illegible] ($[illegible]/year)	$[illegible] ($[illegible]/year)	$15 ($180/year)	$[illegible] (~$[illegible]/year)
Tier 2 Other	$[illegible] ($108/year)	$[illegible] ($[illegible]/year)	$[illegible] ($300/year)	$15 (~$[illegible]/year)
Tier 3 Non Formulary Brand	$22 ($[illegible]/year)	$22 ($88/year)	$[illegible] ($[illegible]/year)	$[illegible] ($[illegible]/year)

Copayments for Tier 1 and 2 drugs only should be applied against the catastrophic cap in order to drive beneficiary behavior toward the most cost-effective medications. For example, the copayment for a Tier 2 drug using the retail point of service would result in yearly copayments totaling $300, which can be used against the catastrophic cap.

- Congress should
  - Grant authority to DoD to selectively include OTC medications in the formulary based on clinical effectiveness and cost-effectiveness as evaluated and recommended by the PFC.
  - Grant authority to DoD to mandate the point of service for certain carefully selected medications (Special Category Medications) based on prior established criteria that take into consideration high clinical risk, short supply, or extreme cost, as recommended by the PFC.
- 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. This pilot should test and evaluate alternative approaches, successfully implemented in the private sector, that would seek to reduce the total health care spend, increase mail order use, better integrate pharmacy programs and clinical care, and maintain or improve beneficiary satisfaction. The goal of such a pilot program would be to achieve better total financial and health outcomes in the MHS as a result of an integrated pharmacy service. The overall results in total costs and health outcomes in this one region should eventually be compared with those in the other regions to determine the best approach for the MHS in terms of total spend and outcomes.

Other Issues for Consideration

TMA's New Outreach Program for Effectiveness in Increasing Mail Order Usage

Given that only 7 percent of TRICARE beneficiary prescriptions are filled through TMOP, while 20 percent are filled by mail in the commercial sector,[55] PhRMA recommended to the Task Force that DoD should develop "educational campaigns promoting awareness of the mail order option and its substantial benefits".[56] PhRMA further recommended that "DoD should work with providers issuing prescriptions to TRICARE beneficiaries to educate them about the mail order option".[57]

In testimony, TMA representatives cited the Privacy Act as an obstacle to informing beneficiaries about their option to use TMOP. Congress enacted the Privacy Act of 1974[58] to safeguard individual privacy contained in federal records. The Act provides individuals with the right to access and amend records owned and held by federal agencies. The intent of Congress was to balance an individual's right to privacy with the government's need to maintain information about individuals. The act restricts the use of the data collected to those uses disclosed to individuals from whom the data was solicited. Using data to improve the quality and efficiency of care under the MHS is a disclosed usage,[59] which is permitted. The Defense Privacy Officer has consistently stated that the Privacy Act allows the use of personal information for educational mailings but not for marketing mailings—that is, frequent contacts with a beneficiary concerning the same subject would probably constitute marketing and as such would be prohibited.[60] Thus, although there is no blanket prohibition on the use of a mailed flyer to beneficiaries explaining the cost benefits of using a mail order system rather than the traditionally more expensive retail system, the flyer must be focused on education rather than on marketing.[61] Educational material is acceptable, but marketing material is not. Additionally, this interpretation limits the government's ability to contact beneficiaries as frequently as occurs in commercial pharmacy benefit plans.[62]

Historically, not enough information has been available to beneficiaries about TMOP, and this has been partially a result of inadequate education. However, on August 29, 2007, TMA launched its Member Choice Center (MCC) for TMOP. MCC provides assistance to TRICARE beneficiaries from customer service representatives in order to ease the TMOP registration process, to help build member profiles (which are required to use TMOP), and to contact the physician to obtain new prescriptions and forward them to TMOP for processing. The goal is to make the switch from retail to mail order virtually effortless for beneficiaries. The mail order pharmacy can save beneficiaries as much as 66 percent on medications for conditions such as high blood pressure, asthma, and diabetes.[63] The beneficiary may receive up to a 90-day supply of most medications for the same amount they would pay for a 30-day supply at a retail pharmacy. In addition, DoD pays 30 to 40 percent less for prescriptions filled through the mail order service, compared to retail pharmacies.[64] DoD's savings could be substantial—$24 million per year—with just a 1 percent shift of prescriptions from retail to mail order.[65] Since its opening, MCC has received 48,887 requests for conversions. Of those, MCC has converted 38,541, and 4,888 are in the conversion process.[66]

55 PhRMA, Brief to the Task Force, April 25, 2007, Slide 29
56 Ibid., Slide 30
57 Ibid.
58 See 5 U.S.C. §552a et seq. (2005)
59 TMA Response to Memo, SUBJECT: Request for Information on 13 and 14 Pharm Contract Activities, October 5, 2007, p. 11
60 Ibid.
61 Michael Rebeuser, DoD Office of the General Counsel, Response to Task Force RFI, June 19, 2007
62 TMA Response to Memo, p. 6
63 Tricare's Member Choice Center Simplifies Mail Order Prescriptions, September 5, 2007. See www.keesler.af.mil/news/story.asp?id=1230669 11
64 Ibid.
65 Ibid.
66 Capt. William Blanche, Deputy Chief, TMA Office of Pharmaceutical Operations, Response to Task Force RFI, November 2, 2007

The MCC Communication Plan includes the following educational strategies[67]

- utilize TMA's communications and customer support outreach mechanisms (e g , newsletters, bulletin, annual mailings, e-mail distribution, website),
- utilize the managed care support contractor s voluntary distribution of information through websites, selective mailings, and distribution of MCC communication material to TRICARE Service Centers
- publish advertisements in a variety of publications which will be paid for by Express Scripts, Inc , the mail order contractor, and
- target beneficiaries who are high retail users of high cost medications with two letters educating them on the value of using TMOP

Given that TMA recently fielded this new educational initiative its plan must be fully implemented and monitored for effectiveness (increased TMOP utilization) and revised as necessary

Innovative Approaches and Cost Benefit Analysis

The Task Force considered other existing models within the MHS for pharmacy service delivery, such as the Department of Veterans Affairs (VA) Consolidated Mail Outpatient Pharmacy (CMOP), the use of DoD refill centers or the use of a centralized high-dollar pharmacy Although these options appeared to have some positive features the Task Force did not believe that they have been adequately evaluated in terms of goals, costs savings, or requirements

VA CMOP In August 2000 a tri-service working group recommended processing refills in a centralized refill center The MTF Refill Mail Service (MRMS) initiative was designed to recapture prescription workload from the retail network and to offer a cost-effective, value added service to DoD beneficiaries by giving them an option to receive their refills through the mail at no expense, as an extension of MTF services The MRMS pilot program started in September 2002 and concluded in September 2003 The pilot sites included Darnall Army Community Hospital, Fort Hood, Texas, the 377th Medical Group Kirtland Air Force Base, New Mexico, and the Naval Medical Center, San Diego, California (NMC SD) Because the outcome of the pilot showed no discernable amount of recaptured retail workload, TMA discontinued funding for the overall program Nonetheless, NMC SD has continued the program for its convenience NMC SD currently mails 80 percent of prescription refill requests NMC SD also has seen other benefits[68]

- a July 2003 CMOP survey indicated a 94 percent patient satisfaction rating (very good to excellent),
- improved NMC SD access to care,
- decreased unnecessary travel to MTFs, with significantly increased availability of patient parking,
- a 33 percent reduction in new prescription wait time,
- 300 fewer patients waiting for pharmacy services, improving the environment of care,
- has become essential to the successful delivery of prescription services during limited base access that has resulted from increased security precautions since 2001

67 RADM Thomas McGinnis Chief Office of Pharmaceutical Operations TRICARE Management Activity Response to Task Force RFI October 26 2007
68 Center for Naval Analyses MTF Refill Mail Service Initiative Pilot Fiscal Year 2003 Report CRM D0009205 A2 December 2003

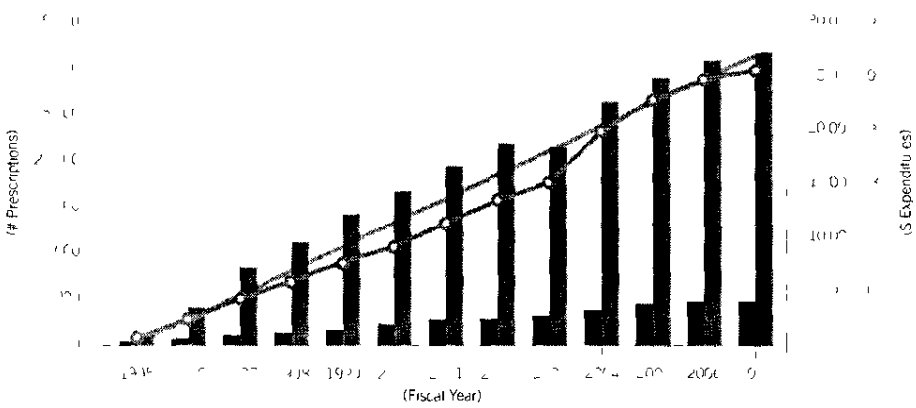
Although the program appears to improve service, DoD has not rigorously analyzed the full costs associated with it to assess return on investment. The decreased MTF workload savings were reallocated to improve other services at MTFs, but additional costs of outsourcing have not been sufficiently quantified. Furthermore, it is difficult to compare average costs with other points of service, given the current accounting structure. Finally, there has been no detailed analysis of the impact to TMOP when medications are also mailed to the patient's home but with a copayment.

There is a current proposal to expand this program to the National Capital Region.[69]

Wright Patterson "High" Dollar Drug Program.[70,71] In December 1994, the Air Force Surgeon General sponsored an initiative to centralize the purchase and provision of high-cost drugs for Air Force beneficiaries. The initiative was implemented at Wright-Patterson Medical Center (WPMC) in February 1995. The program targets high-dollar drugs required for a relatively small portion of the beneficiary population—items that are least likely to be available at smaller MTFs. Medications eligible for the program must have a minimum cost of $500 per individual order (i.e., one month's supply). MTFs are not required to use the program, but it is available as an alternative procurement option. Requests for support are patient specific and include diagnosis and dosing regimen. The MTF remains responsible for dispensing, counseling, and interacting with the patient. All requests are reviewed for appropriateness of therapy and all doses are recalculated and verified by program personnel. Items depart WPMC with continental United States delivery by noon the next day; overseas shipments average 48 to 60 hours in transit. The program currently operates with two technicians and one pharmacist. In 12 years, the program's budget has grown from $3 million to $27 million (see Figure 3).

AIR FORCE HIGH DOLLAR DRUG PROGRAM

Cumulative History



Source: Nancy Misel, Chief, Air Force High Dollar Drug Program, Response to Task Force RFI, October 26, 2007

Figure

69 Ronald A. Nosek, Head of Pharmacy, National Naval Medical Center, Bethesda, Maryland. Interview regarding CMOP implementation in the National Capitol Region, July 9, 2007.
70 Nancy Misel, Chief, Air Force High Dollar Drug Program, Talking Paper on AF High Dollar Drug Program, September 12, 2007.
71 Nancy Misel, Chief, Air Force High Dollar Drug Program, Response to Task Force RFI, October 26, 2007.

This program has supported 15 244 Active Duty members retirees, and dependents from all of the services and the National Oceanic and Atmospheric Administration, providing 219 drug entities (434 line items) to 92 facilities The average cost per prescription in Fiscal Year 1995 was $535, compared to $812 in Fiscal Year 2007 (see Figure 4) The current highest cost prescription is $22 065/month

AIR FORCE HIGH DOLLAR DRUG PROGRAM

Annual Average Cost Per Prescription

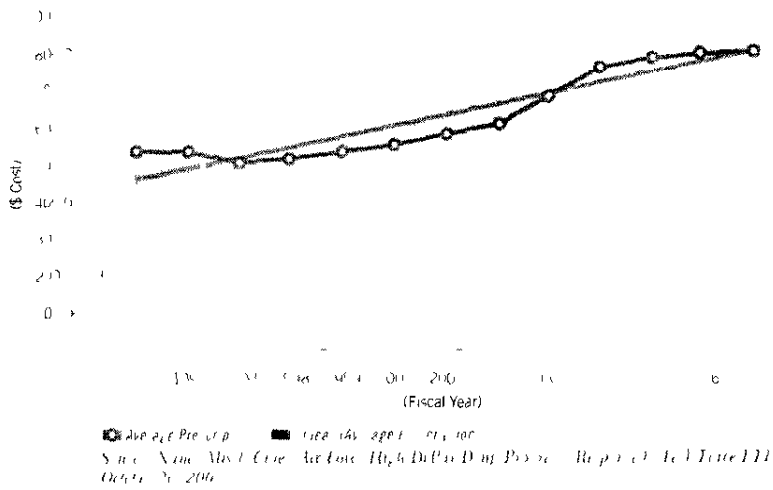


Figure 4

To illustrate the potential savings for the MHS, in Fiscal Year 2007, the program expended $4 4 million on Enbrel (5 784 prescriptions) and $1 9 million (2 451 prescriptions) on Humira Both are packaged as a 4-week supply, thus there would be 13 prescription fills in a 52-week year Current Federal Supply Schedule pricing on a four-week supply of Enbrel 50mg (at the recommended standard dose) is $720, and for Humira 40mg it is $695 The current network cost for Enbrel 50mg is $1 422, and for Humira, it is about the same [72]

Colorado Springs Refill Facility [73] The 2000 Pharmacy Reallocation Study identified the need to combine and reallocate DoD pharmacy resources recapture prescription workload, and improve patient care [74] The study focused on regionalizing the prescription refilling process The Tri-Service Pharmacy consultants reviewed the study's proposals, evaluated existing pharmacy automation equipment and systems, and identified potential combined refill processing center sites They selected the U S Air Force Academy to be the pilot location for processing refills for MTFs in the Pikes Peak Region This facility processes refill prescriptions for the MTFs in the Pikes Peak Region to include the U S Air Force Academy, Peterson Air Force Base Buckley Air Force Base, and Fort Carson Filled prescriptions are couriered back to

72 Nancy Mixel Chief Air Force High Dollar Drug Program Response to Task Force RFI October 24 2007
73 Lt Col Scott Sprenger Pharmacy Flight Commander USAF Academy Response to Task Force RFI April 19 2007
74 PUMA Systems Inc Evaluation of Pharmacy Resource Allocation Evaluating Best Business Practices and Commercial Technologies to Improve Delivery of Pharmaceutical Care in the Military Health System August 16 2000 p

the MTF Courier operation arrangements differ by participating locations. Fort Carson and Buckley Air Force Base contract with the local Prime Vendor courier service to deliver to each respective site. Peterson Air Force Base and the U.S. Air Force Academy courier their own refills back to the dispensing locations using government-owned vehicles. The refill center, which began operations in March 2004, operates 6 days/week, approximately 10 to 11 hours/day. Strengths of the program include the following:

- MTF space: Consolidating refills at the refill center allows each MTF to maximize staff and local site automation to focus on new prescriptions, which take the most time and energy to fill.
- Patient satisfaction: Local MTF dedication to processing new prescriptions reduces wait times because there is no need to share automation with refill operation running concurrently.
- Quality, accuracy, and patient safety: Utilizing the enterprise pharmacy software implements built in safety protocols (bar coding and digital imaging).
- Manpower: Air Force manning standards designate that there should be 22 positions to handle existing refill center workload, however, at this time only 12 people are needed to staff the refill center.

These initiatives illustrate innovative approaches to pharmacy management. DoD should continue to encourage novel approaches, but also should conduct cost benefit analyses before recommending widespread adoption in the MHS.

Legal Issues in Pharmacy Operations

Several participants within the MHS have raised state regulatory requirements as a historical and potential barrier to efficient pharmacy operations. As reflected in the Code of Federal Regulations: "any State or local law relating to health insurance, prepaid health plans, or health care delivery or financing methods is preempted and does not apply in connection with TRICARE pharmacy contracts. Any such law or regulation pursuant to such law is without any force or effect, and state and local governments have no legal authority to enforce them in relation to the TRICARE pharmacy contracts."[75] If these changes have not sufficiently addressed the legal barriers and difficulties persist, the legal constraints must be clearly defined and raised for resolution.

75 32 C.F.R. § 199.21(a)(2) (2006).

Retiree Cost-Sharing

The Task Force was charged to address

"Alternative health care initiatives to manage patient behavior and costs, including options and costs and benefits of a universal enrollment system for all TRICARE users."

"The beneficiary and Government cost-sharing structure required to sustain military health benefits over the long term."

The Task Force concluded that these issues are interrelated and addresses them together in this chapter. The Task Force grappled with the complex issue of cost-sharing with strict attention to maintaining both a generous health care benefit and a fair and reasonable cost sharing arrangement between beneficiaries and DoD. In its interim report, the Task Force stated that in its final report it would address cost-sharing, enrollment fees, copayment levels, and phase-in time periods. Where possible, the Task Force also sought to update cost sharing provisions in a manner that improves retiree health care. Recommendations about annual indexing of premiums, deductibles, cost sharing, and tiering were also deferred for this final report.

In order to address these complex issues properly, the Task Force gathered extensive information relating to the share of costs that should be borne by beneficiaries of the military health care system. The Task Force held hearings involving a variety of personnel, including Active Duty personnel, dependents, retirees, DoD leaders, military association representatives, and others. It examined data on cost sharing in public and private health care plans. It also enlisted the expertise of recognized experts in the field of military health care, as well as that of experts in DoD.

The Task Force affirms the conclusions in its interim report that there should be no changes in the health care benefits offered to Active Duty military personnel, which are available mostly without charge to the beneficiaries. These benefits are designed principally to maintain a ready military, and the maintenance of a high level of health readiness constitutes one of the Task Force's most important guiding principles. In addition, the Task Force recommends no significant changes in costs for care provided to Active Duty dependents.

The Task Force does recommend changes in the costs borne by military retirees. The Task Force believes that the cost-sharing relationships for the largest program for retirees (TRICARE Prime) should be gradually restored to levels consistent with those of 1996—when fees and other cost-sharing elements were being established. Comparable changes should be made in cost-sharing for other programs that serve retirees.

These changes will reverse a downward trend in the portion of the health care costs borne by retirees. According to DoD, since 1996, military health care premiums paid by individual military retirees under age 65 utilizing DoD's most popular plan (TRICARE Prime) have fallen from 11 to 4 percent, when measured as a percentage of total health care costs.[1] By comparison, premiums for employer-provided plans in the civilian sector decreased only slightly, from 28 percent in 1996 to 25 percent in 2006.[2] Federal civilian retirees pay out-of-pocket costs of about 25 percent of total costs in the Federal Employees Health Benefit Plan (FEHBP).[3]

Although this downward trend has increased DoD's health care costs, the Task Force does not believe that cost pressures should be the only driver of changes in retiree cost sharing. Rather, changes also should be made because they offer some advantage to retirees, DoD, and the American taxpayer. The Task Force's proposed changes should provide better health care to retirees, because some fees recommended by the Task Force will improve DoD's ability to communicate health information. Changes proposed by the Task Force should increase stability in the beneficiary population, thus helping DoD plan a cost-effective health care program. The changes also end the current downward trend in costs borne by retirees, a trend so out of step with overall trends in the U.S. health care system that they are unfair to U.S. taxpayers. Finally, these changes are consistent with the Task Force philosophy that benefits available to military retirees should be very generous but not free.

In this chapter, the Task Force describes its recommended cost-sharing changes for retirees. Specifically, the Task Force offers four broad categories that support the overall recommendation to update and revise retiree cost-sharing:

- Implement a phased-in increase in cost-sharing for under-65 retirees
- Create a modest enrollment fee for retirees age 65 and over
- Index selected retiree costs
- Improve coordination of insurance among under-65 retirees

Phased-In Increase in Beneficiary Cost-Sharing for Retirees Under 65

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.

In the Task Force's view, restoring the cost-sharing relationships that existed when TRICARE was established makes sense and seems fair. DoD and Congress reviewed these relationships at the time of TRICARE's creation and agreed that there should be some charges for using the system. In the ensuing years beneficiary costs have remained fixed in dollar terms, while health care costs have risen sharply in part because of improvements in benefits.[4]

In recommending these changes, the Task Force adhered fully to its guiding principle that military retirees, in recognition of their years of service to their country, should receive a generous health care benefit. Even after the adjustments recommended by the Task Force, the costs paid by under-65 military retirees for their health care benefit would be generous compared to the costs of almost all private health care plans and to those of plans that are available to federal civilian retirees.

1 *The Military Compensation System: Completing the Transition to an All Volunteer Force. Report of the Defense Advisory Committee on Military Compensation, April 2006, p. 79.*
2 *Ibid.*
3 *5 U.S.C. Chapter 89 (2007); 48 C.F.R. Chapter 16 (2005).*
4 *Allen Middleton, Acting Deputy Assistant Secretary of Defense for Health Affairs and Acting Chief Financial Officer, TRICARE Management Activity, "The Military Health System and the Defense Health Program: An Overview for the Task Force on the Future of Military Health Care," Brief to the Task Force, January 16, 2007, Slide 3.*

The Task Force believes that restoring the cost-sharing relationships that existed when TRICARE was formed is consistent with another of its guiding principles fairness to the U.S. taxpayer. Americans fortunate enough to have health benefits pay more for those benefits each year. Fully exempting military retirees from these pervasive trends jeopardizes long-term taxpayer support for the military health care system and possibly for the military compensation system in general.

Increases in cost sharing for retirees may also reduce the incentives for retirees to drop their private sector insurance and rely entirely on TRICARE. Reversing this trend will improve coordination of insurance among under-65 retirees, an issue addressed more fully in a later section of this chapter.

The Task Force does not believe that changes in cost-sharing for retirees should be made only for budgetary reasons. For this reason, and also because of time limits, the Task Force did not perform detailed behavioral and budgetary assessments of its recommendations. The Task Force recommendations would reduce DoD costs and free up resources that could be used for other military needs. However, the Task Force believes that military budget problems should be resolved primarily in other ways. Moreover, the Task Force notes that its recommendations will do no more than slow the rapid growth in future DoD health care costs by a small amount. Cost-sharing changes will at most comprise a small part of the solution to problems of DoD health care cost growth.

The remainder of this section describes the Task Force's recommended changes in four TRICARE categories: Prime Family, Prime Single, Standard Family, and Standard Single.

Prime Family

The Task Force recommends that the average enrollment fee paid for an under-65 retiree in TRICARE Prime Family should rise gradually from the current level of $460 per year to an average of $1,100 per year (or from about $40 a month now to about $90 a month). The actual enrollment fee for a family in a particular year would reflect tiering and indexing as discussed below.

This increase restores the 1996 relationship between the fee paid by beneficiaries and the costs borne by the government, based on a conservative metric. Between 2000 and 2005, Prime Family costs for civilian care (that is, excluding costs of Military Treatment Facility [MTF] care for Prime beneficiaries) grew by an average of about 7.5 percent per year, based on data supplied by DoD. The Task Force's proposed increase in the enrollment fee is consistent with this figure, as well as the assumption that DoD and Congress agree to make changes in the enrollment fee in 2008. (If changes begin after 2008, they should be indexed using the cost index discussed below.)

The Task Force purposely chose a conservative metric to use in restoring this former cost sharing relationship. The metric is based on growth in Prime civilian care costs but is also consistent with many other public and private sector metrics. It is, for example, consistent with growth in per capita Medicare costs from 2000 to 2005 (which increased by an average of 7.3 percent per year, excluding the effects of the new Part D benefits),[6] data from the extensive Medical Expenditure Panel Survey (MEPS) compiled by the Department of Health and Human Services (which suggest average growth in private plans of 7 percent per year from 1996 to 2004), and growth in premiums in the FEHBP (which grew by an average of 6.7 percent per year from 1994 to 2006).[7]

5 GAO, Military Health Care: TRICARE Cost Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated, GAO-07-647, Washington, D.C., May 2007, p. 2.
6 Clare McFarland, Deputy Director, Medicare and Medicaid Cost Estimates Group, Office of the Actuary, Centers for Medicare and Medicaid Services, Response to Task Force for Request for Information, August 30, 2007.
7 RAND Analysis prepared for Task Force from Kaiser/HRET 2006 Annual Employer Health Benefit Survey, Medical Expenditure Panel Survey, Insurance Component (Data compiled by Richard Keach and colleagues, U.S. Census Bureau), and Milliman Health Cost Index Report, October 2007. Data were available for various years.

The Task Force notes that it could have chosen a plausible metric that would have led to a significantly higher proposed enrollment fee. For example, based on DoD data, Prime costs, including costs of MTF care, grew by an average of 10 percent per year from 1996 to 2006, while Prime costs for civilian-only care grew by 8.2 percent per year for the same period.[8] The use of either of these two metrics—both plausible in this context—would have resulted in higher enrollment fees, ranging from $1,180 to $1,440 per year. However, the Task Force intentionally chose to be conservative in recommending change.

An average enrollment fee of $1,100 per year is generous compared with that of almost any other health care plan, ensuring consistency with one of the Task Force's guiding principles. Enrollment fees for a sample of large plans under FEHBP range from $1,820 to $4,620 per year.[9] MEPS and Kaiser data suggest that a fee of $1,100 would be more generous than those offered by approximately 75 to 80 percent of all organizations in the private sector that offer health care benefits.[10] It is also important to note that approximately 40 percent of private sector entities offer no health care benefits at all.[11, 12]

Tiering. The Task Force believes that, for equity reasons, military retirees who earn more military retired pay should pay a higher enrollment fee than those who earn less. While this "tiering" approach is not commonly used in the private sector for enrollment fees, the Task Force believes it makes sense in a military environment. In its Sustaining the Military Health Benefit proposal, senior DoD leaders reached the same conclusion.[13]

The Task Force recommends that enrollment and other fees vary depending on the level of retired pay. Specifically, the Task Force recommends that enrollment fees should vary for retirees earning military retired pay in three ranges: $0-$19,999, $20,000-$39,999, and $40,000 or higher. At the low end, the range would include primarily enlisted personnel. The high range would consist primarily of officer personnel, while the middle tier would include a mix of both.

The Task Force believes that those in higher ranges should pay a higher enrollment fee, but not a proportionally higher one. Specifically, the Task Force recommends "half proportional tiering." Under the half-proportional approach, a 100 percent difference in average retired pay would result in a 50 percent difference in the enrollment fee for Prime Family enrollees.

Detailed calculations are based on retired pay counts and retired pay levels as of the end of Fiscal Year 2006. The Task Force first calculated a weighted average retired pay in each of the three tiers (weighted by number of retirees). The weighted average retired pay was used in calculating enrollment fees based on the half-proportional approach.

8 Robert Opsut, Health Benefits and Financial Planning, Office of the Assistant Secretary of Defense, Health Affairs, Response to Task Force for Request for Information, August 16, 2007.
9 See www.checkbook.org/nc.cfm?g2.x07/search/return.cfm. Copyright 2007 (Online guide to health insurance plans for federal health employees 2007 – HMO tables, Fairfax, VA, site used).
10 RAND Analysis prepared for Task Force from Kaiser HRET 2006 Annual Employer Health Benefits Survey; Medical Expenditure Panel Survey (MEPS) Insurance Component (Data compiled by Richard Keach and colleagues, U.S. Census Bureau) and Milliman Health Cost Index Report, October 2007. Data were available for various years. Results were adjusted to estimated 2008 levels by increasing them by 6 percent a year.
11 Ibid.
12 The Kaiser Family Foundation and Health Research and Education Trust, Employer Health Benefits, 2007 Annual Survey, 2007, p. 24.
13 John Kokulis, Special Assistant to the Assistant Secretary of Defense, Health Affairs, and Former Deputy Assistant Secretary of Defense for Health Affairs, Office of the Secretary of Defense, Sustaining the Military Health Benefit, Brief to the Task Force, January 16, 2007.

DoD should propose and Congress should approve indexing the retired pay ranges each year that are the basis of enrollment fees, based on the percentage change in retired pay. Otherwise "tier creep" will occur—that is, more and more retirees will be pushed into the higher tiers.

The Task Force also considered basing tiering on pay grade at retirement, but rejected this approach. If enrollment fees are based on pay grade at retirement, and officer retirees pay a higher fee than those who are enlisted, a substantial number of relatively junior officer retirees will pay a higher enrollment fee than senior enlisted retirees, even though they receive roughly equal amounts of retired pay. The Task Force concluded that basing tiering on pay grade at retirement would be inherently inequitable.

Phase-In. The Task Force recommends that changes in enrollment fees should be phased in gradually to permit retirees time to plan. Specifically, the Task Force recommends a phase-in period of four years.

Unfortunately, military health care costs will not remain static during this four year phase-in period. Without adjustments for changes in per capita health care costs, the relationship between the enrollment fee and costs—which the Task Force seeks to restore to 1996 levels—will not be preserved. The Task Force therefore recommends that enrollment fees after year one of the phase-in period include an adjustment for the previous year's growth in per capita military health care costs. The adjustment should be such that, after the four years of phase-in, the fee would equal the level proposed by the Task Force as adjusted for all growth in per capita military medical costs. A section below describes the index to be used to make this adjustment.

Catastrophic Cap. The cap on total out-of-pocket costs is particularly important for those retirees who are most vulnerable because of substantial health care costs. The Task Force reviewed the cap in light of its other recommendations, including the tiered enrollment fee.

After reviewing the catastrophic cap issue, the Task Force recommends that the cap be set at $2,500. The enrollment fee—which currently counts toward meeting the cap—would not count toward meeting the cap under the Task Force recommendation, but copayments for Tier 1 and 2 drugs would count. (See Chapter 9.) The recommended reduction in the catastrophic cap roughly reflects the size of the current enrollment fee for Prime Family enrollees.

The proposed catastrophic cap would be generous by private sector standards. According to data gathered by the Kaiser Family Foundation, a cap of $2,500 would be more generous than the cap provided by 85 to 90 percent of the private sector companies that offer health care benefits.[14] In many of these private sector plans, the enrollment fee does not count toward meeting the cap.[15]

Compared with the current approach, the proposed cap also is more consistent with other Task Force recommendations. With tiering, the enrollment fee for retirees with higher retired pay would equal more than two-thirds of the current cap, but the fee for those with lower retired pay would equal only about one-third of the cap. Not counting the fee toward meeting the cap eliminates this inequity.

14 RAND Analysis prepared for Task Force from Kaiser HRET 2006 Annual Employer Health Benefits Survey, Medical Expenditure Panel Survey (MEPS) Insurance Component (Data compiled by Richard Keach and colleagues, U.S. Census Bureau) and Milliman Health Cost Index Report, October 2007.
15 Louis T. Mariano et al., National Defense Research Institute and Rand Health, Civilian Health Insurance Options of Military Retirees: Findings From a Pilot Study, 2007, p. 44.

The Task Force does not recommend annual indexing of the catastrophic cap. However, DoD should assess the level of the cap at least every five years in light of trends in the public and private sectors. After a review, Congress should grant DoD the authority to adjust the cap, so long as the adjustment does not exceed growth in the cost index discussed below.

Copayments. Retirees who use Prime Family currently pay modest copayments when using medical services. Like other features of Prime, this copayment has not been adjusted since the mid 1990s.[16] The Task Force recommends a one-time adjustment in the copayment levels using the same conservative approach adopted for the TRICARE Prime Enrollment Fee. This adjustment will more than double the copayments. The implementation of this adjustment should be delayed for two years in order to permit the required contractual changes and to permit retirees to plan for the higher copayment levels.

In order to promote preventive care services, the Task Force proposes that certain medical procedures be exempt from copayments. Specifically, DoD should establish a list of specified clinical preventive services for which there would be no required copayment.

The Task Force does not recommend annual indexing of the copayments, in order to avoid the confusion associated with frequent changes in relatively small fees. However, a periodic reassessment of these copayments should be conducted at least every five years. After a review, Congress should grant DoD the authority to make changes in the copayment levels, so long as those changes do not exceed the growth in the cost index recommended below.

Overall Results. Based on the Task Force recommendations, Table 1 shows the recommended levels for the Prime Family Enrollment Fee, assuming that Task Force recommendations are enacted in 2008. The table shows the fee, assuming no growth in per capita military health care costs. Actual fees after the first year will be higher, depending on the growth in per capita health care costs. Fees are shown at both the annual and monthly levels.

Table 1. Annual/Monthly Enrollment Fees for Prime Family Before Proposed Indexing[1]

YEAR	RETIRED PAY		
[illegible]	[illegible]	[illegible]	[illegible]
2009	[illegible]	[illegible]	[illegible]
2010	[illegible]	[illegible]	[illegible]
2011	[illegible]	[illegible]	[illegible]
2012	[illegible]	[illegible]	[illegible]

[illegible]

16 CAO, *Military Health Care: TRICARE Cost Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated*, CAO-07-647, Washington, DC: May 2007, Table 1, p. 10.

Prime Single

The Task Force recommends retaining the current relationship between the enrollment fees for Prime Family and Single—that is, the Single fee should be half the Family fee. Data from the Kaiser Family Foundation survey of private health care benefits suggest that single fees are relatively smaller in the private sector than family fees—typically about one quarter of the family fee.[17] But the Task Force favors honoring the longstanding one-half relationship.

All other aspects of the Prime Single program should be changed to match the Task Force recommendations for Prime Family. Tiering would use the same approach and the phase-in approach would be identical. The catastrophic cap would be set at the same level and follow the same rules as Prime Family, as would copayments.

Based on these recommendations, the enrollment fee for Prime Single would be half of the fee shown in Table 1 for Prime Family.

Standard Family

The Task Force recommends changes in Standard Family that are comparable to those for Prime Family. Specifically, the Task Force sought changes in Standard that would be similar in dollar value to those in Prime. Because Standard and Prime differ markedly in the structure of their cost sharing—Standard currently has no enrollment fee but a high deductible, while Prime has an enrollment fee but no deductible—the Task Force considered fees and deductibles together when making its recommendations.

Fees. The Task Force recommends a modest enrollment fee for Standard Family—specifically, $120 per year ($10 per month). Because of its small size, this fee should not be tiered but should be indexed using the method noted below. Those beneficiaries wishing to use pharmacy benefits only would be required to enroll and pay the enrollment fee.

An enrollment fee is new to Standard, which currently does not require enrollment or a fee.[18] The Task Force does not propose a new enrollment fee to save money. Rather, it would help improve health care for Standard Family participants, because through this mechanism DoD will know who they are and thus can better communicate health care information to them. The Task Force also believes that DoD should spend a portion of the added revenue generated by this new fee to increase the number of health care providers available to Standard users and hence improve access.

A modest fee for TRICARE Standard also imposes some personal accountability for health care costs on all those using DoD health care programs. The Task Force supports this notion of personal accountability. The new fee is consistent with the Task Force philosophy that health care for military retirees should be quite generous but not entirely free.

17 RAND Analysis prepared for Task Force from Kaiser HRET 2006 Annual Employer Health Benefits Survey, Medical Expenditure Panel Survey Insurance Component (Data compiled by Richard Keach and colleagues, U.S. Census Bureau) and Milliman Health Cost Index Report, October 2007.
18 TRICARE Fundamentals Course Participant Guide, March 2007, p. 8.

Deductibles The Task Force recommends increasing the deductible for Standard Family to an average of $600 per year before tiering. The deductible should be tiered using the same approach as for Prime Family. To promote the use of preventive care services, the Task Force recommends that DoD create a list of specified preventive care services—the same list as the one for Prime copayments—that would be paid under Standard Family, even if a family had not met its deductible.

For the sake of simplicity, the deductible would not be automatically indexed each year. However, at least once every five years, DoD should reassess the level of the deductible, taking into account not only trends in military health care costs, but also the relationship of costs and cost sharing in Prime and Standard. Congress should grant DoD the authority to modify the deductible after a review, so long as the change does not exceed growth in the cost index proposed below.

Overall Assessment. The new Standard Family Enrollment Fee, coupled with the higher deductible, together result in out-of-pocket cost increases that would be similar for those in Prime Family, assuming that Standard families pay the full deductible. A Standard deductible averaging $600 per year, coupled with the new enrollment fee of $120, translates into an increase in out-of-pocket costs of $420 per year for those who pay both. The increase in Prime Family out-of-pocket costs would be somewhat higher—$640 per year—but this difference would be offset by the higher copayments under Standard.

The proposed deductible, coupled with the new enrollment fee, is clearly generous by public and private standards. The deductible amount is relatively high compared to those in the private sector. However, the fee is very low. For federal civilians under FEHBP, the enrollment fee alone for preferred provider organization (PPO) plans like TRICARE Standard ranges from $2,000 to $3,500 for a sample of large plans.[19] The Kaiser Family Foundation data suggest that 80 percent of private companies that offer health benefits charge an enrollment fee of more than $1,500 for PPO plans.[20] A fee of $120 per year, even coupled with a deductible averaging $600 per year, clearly provides a generous benefit for military retirees using TRICARE Standard.

The Task Force understands that, for some military retirees, Standard is the only available option. These retirees can only choose a high deductible plan with a low fee, whereas other retirees can elect Prime, which offers no deductible but a higher fee.

Other aspects of the Standard Family plan would mirror those in Prime Family. The catastrophic cap would be set at the same level and adjusted in the same manner, and phase-in provisions would be identical to those for Prime Family.

Copays under Standard are expressed as a percentage of medical costs. The Task Force recommends no change in the current formula.

Table 2 shows the Task Force recommendations for fees for Standard Family, assuming that changes are enacted beginning in 2008. Fees are shown both at annual and monthly levels. Table 2 shows fees and deductibles assuming no growth in per capita military medical care costs. Actual fees and deductibles beyond the first year will be higher depending on the rate of growth in medical costs.

19 See www.checkbook.org/me/chg2/vs07/carchetarato.cfm. Copyright 2007 (Online guide to health insurance plans for federal health employees 2007 – PPO tables. Fairfax, VA: site updated)
20 RAND Analysis prepared for Task Force from Kaiser HRET 2006 Annual Employer Health Benefits Survey, Medical Expenditure Panel Survey (MEPS) Insurance Component (Data compiled by Richard Keach and colleagues), U.S. Census Bureau, and Milliman Health Cost Index Report, October 2007.

Table 2 Annual/Monthly Enrollment Fees for Standard Family Before Proposed Indexing[1]

YEAR	RETIRED PAY		
	[illegible]	[illegible]	[illegible] and above
2003	[illegible]	[illegible]	[illegible]
2004	[illegible]	[illegible]	[illegible]
2005	[illegible]	[illegible]	[illegible]
[illegible]	$120/$10	120/$10	120/$10

1 [illegible]
2 [illegible]
3 [illegible]

Table 3 shows the Task Force recommendations for deductibles for Standard Family. Deductibles are shown prior to any reassessments. Actual deductibles could be higher. In keeping with typical practices, deductibles are shown only in annual terms.

Table 3 Annual Deductibles for Standard Family Before Any Reassessment[1]

YEAR	RETIRED PAY		
	[illegible]	[illegible]	[illegible] and above
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	[illegible]

1 [illegible]
2 [illegible]
3 [illegible]

Standard Single

Standard Single would feature an enrollment fee and a deductible that equals half of those for Standard Family. In other ways, cost-sharing under Standard Single would mirror cost-sharing for Standard Family. Tiering would be the same, as would the catastrophic cap and the copay formula. Under these recommendations, the enrollment fee and deductibles for Standard Single are simply half of those shown in Tables 2 and 3.

Enrolling in Standard and Changing Plans

Along with the enrollment plan for the Standard program, the Task Force recommends new rules regarding changes between plans. The Task Force recommends that retirees be permitted to switch from Standard to Prime or vice versa only during a designated annual open season period. Retirees who are enrolled in a TRICARE program would also be able to leave the program only during this open season. Limits on the ability to switch among plans are necessary to prevent retirees from choosing a plan based on its generosity with regard to a particular episode of military health care.

Because retirees will be able to join Standard or Prime only during an annual open season, special rules are required for those first entering retirement. The Task Force recommends that those entering retirement be automatically enrolled in Standard (Single or Family, depending on their marital status) unless they explicitly choose another option. Enrollment would be effective on the date that retirees first receive retired pay. New retirees would, of course, be permitted to elect Prime Family or Single rather than being automatically enrolled in Standard. They may also opt out of TRICARE altogether, but only if they make that choice explicitly. Automatic enrollment will ensure that personnel entering retirement do not inadvertently neglect to enroll in a TRICARE program and then discover that they must wait until the next open season to enroll.

Enrollment Fee for Retirees Age 65 and Over

After reviewing the TRICARE for Life (TFL) Program for military retirees age 65 and over, the Task Force recommends the requirement of a modest enrollment fee of $120 per year ($10 per month) per person for TFL participation. Because of its small size, the fee would not be tiered but would be indexed. The fee should be phased in over four years using the same approach proposed above for under-65 retirees.

The Task Force recognizes that this proposal runs counter to congressional intent for TFL when it was established in 2001.[21] At that time, Congress required no enrollment fee or other fee. TFL beneficiaries are required to enroll in Medicare Part B and pay the fee for that plan.[22]

Nonetheless, the Task Force believes that a modest fee is appropriate, for several reasons. First, and foremost, the fee is consistent with the Task Force philosophy that health coverage for military retirees should be very generous, but not free. A modest fee for TFL participants also requires the assumption of personal accountability for health care that the Task Force believes is appropriate. Imposition of the fee would be consistent with the new fee recommended by the Task Force for under-65 retirees using TRICARE Standard and the higher fee recommended for under-65 retirees using TRICARE Prime.

This newer fee also might be used to provide an incentive for individuals to improve their health and health care. Specifically, the Task Force recommends that DoD be permitted to waive part or all of the enrollment fee if TFL participants take part in activities, specified by DoD, that are designed to improve medical care and health or reduce costs.

This modest fee would clearly be consistent with the Task Force's desire to provide a military health care benefit that is generous in terms of cost-sharing. The Task Force reviewed data available from selected states that have large numbers of military retirees (specifically, California, North Carolina, Texas, and Virginia). The data describe fees for Medigap plans, a good benchmark because TFL essentially acts as a Medigap plan. Medigap fees for the popular Plan C in those states ranged from a low of about $1,260 per year to a high of $2,631 per year in 2007.[23] Even those Medigap plans with the lowest fees still required fees ranging from about $290 to $800 per year.[24] Clearly, a fee of $120 per year per person would be very generous by private sector standards.

21 National Defense Authorization Act for Fiscal Year 2001, §712(a) (P.L. 106-398), 114 Stat. 1654A-176, 177.
22 Ibid.
23 See www.insurance.ca.gov, www.tdi.state.tx.us, or www.medicare.com, or www.scc.virginia.gov, with search for Medigap coverage comparison.
24 Ibid.

The Task Force recommends this new fee not so much to reduce costs as to foster personal accountability and to provide possible incentives to improve health care. The enrollment fee, which would amount to less than 5 percent of the costs under TFL, would bring in substantial sums. But it would not fundamentally alter DoD trends for military medical care costs.[25]

Indexing of Selected Retiree Cost-Shares

Indexing represents the single most important step that can be taken if DoD and Congress wish to reverse some of the trends in military health care cost-sharing of the past decade. If DoD proposes and Congress approves the one-time changes recommended by the Task Force, the cost sharing relationships in place when TRICARE was being created will be restored based on a conservative metric. Leaving fees and deductibles fixed in dollar terms while health care costs rise substantially and relentlessly would, however, quickly erode these relationships. This erosion seems unfair to the American taxpayers, who must routinely pay more over time for their own health care.

The Task Force strongly recommends that DoD propose and that Congress accept a method for indexing that is annual and automatic. The Task Force recommends that indexing be based on changes in per capita military health care costs.

Specifically, the Task Force recommends that the Secretary of Defense direct the creation of a cost-sharing index based on changes in per capita civilian care costs for retirees under age 65 enrolled in TRICARE Prime. The Task Force recommends using civilian-only rather than total Prime costs (including both civilian and the MTF costs for Prime beneficiaries) because the Task Force and DoD have greater confidence in the accuracy of the civilian care data and its auditability.

In developing the index, DoD may wish to consider some refinements. An index based on Prime civilian care costs would be affected by shifts in the proportion of per capita Prime costs in the MTFs and civilian care. DoD may wish to propose a mechanism that adjusts the index to offset any shifts. Also, the Task Force realizes that this index would be based on Prime costs but would be used to adjust costs under Standard as well. If data permit, DoD may wish to propose a separate index for Standard.

The Task Force recommends that once DoD has designed an index, the indexing method be reviewed by GAO. This review would help establish the legitimacy of the indexing approach.

Based on the index, DoD would automatically and annually adjust the enrollment fee for Prime, Standard, and TFL. The index also would also play a role, described above, in the periodic reassessment of the level of the deductible for Standard, the catastrophic cap for Prime and Standard, and the copays for Prime. The Task Force recommends that these reassessments be made at least every five years and that DoD be permitted to implement increases, so long as the increases do not exceed growth of the cost index defined in this section.[26]

25 The Task Force notes that one of its members disagreed with the imposition of an enrollment fee for beneficiaries in TFL for the following reasons: TFL beneficiaries already must pay the Medicare Part B fee; Congress, in setting up TFL in 2001, mandated that TFL be available without any additional fees; and the benefits of the new fee are not sufficient to warrant its imposition.

26 One member of the Task Force believed that the use of an index based on growth in Prime civilian care costs alone would not be entirely appropriate because such an index could pass on to retirees inefficiencies in retiree care costs incurred by DoD. That member favored indexing but preferred an approach that based the index partially on the medical portion of the Consumer Price Index (CPI-M) and partially on a productivity component, similar to the format used in setting hospital reimbursement under the Medicare program. The consensus of the Task Force recommended an index based on per capita civilian care cost in Prime because it captures changes in both the price and usage of health care.

Summary of Cost-Sharing Recommendations[27]

Recommendation 10

With regard to TRICARE Prime Family

- The average enrollment fee paid by an under-65 retiree should rise gradually from the current level of $460 per year to an average of $1,100 per year
- The enrollment and other fees should vary depending on the level of retired pay. Those in the higher ranges should pay a higher enrollment fee, but not a proportionally higher one. Specifically, the Task Force recommends "half-proportional tiering." DoD should propose and Congress should approve indexing the retired pay ranges each year based on the percent change in retired pay
- Changes in enrollment fees should be phased in over a period of four years to permit retirees time to plan. After year one of the phase-in period, enrollment fees should include an adjustment for the previous year's growth in per capita military health care costs. The adjustment should be such that, after the four years of phase-in, the fee would equal the level proposed by the Task Force, as adjusted for all growth in per capita military medical costs
- The catastrophic cap should be set at the level of $2,500. The enrollment fee—which currently counts toward meeting the cap—would not count toward meeting the cap under the Task Force recommendation, but copayments for Tier 1 and 2 drugs would count (see Chapter 9)
- The Task Force does not recommend annual indexing of the catastrophic cap. However, DoD should assess the level of the cap at least every five years in light of trends in the public and private sectors. After a review, Congress should grant DoD the authority to adjust the cap, so long as the adjustment does not exceed growth in the cost index
- There should be a one-time adjustment in the copayment levels, which should be increased in the same manner as the Prime Enrollment Fee, with changes delayed two years. The Task Force does not recommend annual indexing of copayments; however, there should be a periodic reassessment of these copayments at least every five years. Congress should grant DoD the authority to make changes in the copayment levels, so long as those changes do not exceed the growth in the cost index

With regard to TRICARE Prime Single

- Retain the current relationship between the enrollment fees for Prime Family and Single—that is, the Single fee should be half the Family fee
- All other aspects of the Prime Single program should be changed to match the Task Force recommendations for Prime Family. Tiering would use the same approach, and the phase-in approach would be identical. The catastrophic cap would be set at the same level and follow the same rules as Prime Family, as would copayments

27 *Also see Appendix J*

With regard to TRICARE Standard Family

The Task Force recommends changes in Standard Family that are comparable to those for Prime Family. Specifically, the Task Force seeks changes in Standard that would be similar in dollar value to those in Prime.

- A modest enrollment fee of $120 per year should be implemented. This fee should not be tiered, but should be indexed using the method noted below. Those beneficiaries wishing to use pharmacy benefits only would be required to enroll and pay the enrollment fee.
- The deductible should be increased to an average of $600 per year before tiering. The deductible should be tiered using the same approach as the one recommended for Prime Family.
- To promote the use of preventive care, DoD should create a list of preventive care procedures that would be paid under Standard Family and that would not be subject to the new deductible.
- The deductible should not be automatically indexed each year; however, at least once every five years, DoD should reassess the level of the deductible, taking into account not only trends in military health care costs but also the relationship of costs and cost-sharing in Prime and Standard. After a review, Congress should grant DoD the authority to modify the deductible, so long as the change does not exceed growth in the cost index proposed below.

With regard to TRICARE Standard Single

- A modest enrollment fee of $60 per year should be implemented.
- This fee should not be tiered, but should be indexed using the method noted below. Those beneficiaries wishing to use pharmacy benefits only would be required to enroll and pay the modest enrollment fee.
- Increase the deductible to an average of $300 per year before tiering. The deductible should be tiered using the same approach as the one recommended for Prime Family.
- To promote the use of preventive care, DoD should create a list of preventive care procedures that would be paid under Standard Single, even if a beneficiary had not met the new deductible.
- The deductible should not be automatically indexed each year, however, at least once every five years, DoD should reassess the level of the deductible, taking into account not only trends in military health care costs, but also the relationship of costs and cost sharing in Prime and Standard. Congress should grant DoD the authority to modify the deductible periodically, so long as the change does not exceed growth in the cost index proposed below.

With regard to TRICARE for Life

- Implement a modest enrollment fee of $120 per person per year. Because of its small size, the fee would not be tiered, but would be indexed. The fee should be phased in over four years using the same approach proposed above for under-65 retirees.
- DoD should be permitted to waive part or all of the enrollment fee for those retirees who take steps specified by DoD to improve their health or reduce costs.

With regard to indexing

- DoD should propose and Congress should accept a method for indexing that is annual and automatic. Indexing should be based on changes in per capita military health care costs. Indexing should be applied to enrollment fees.
- The Secretary of Defense should direct the creation of a cost sharing index based on changes in per capita civilian care costs under TRICARE Prime. Prime civilian care costs should be used as a basis for the index, rather than total Prime costs (including both civilian and the MTF costs for Prime beneficiaries).
- Once DoD has designed an index, the indexing method should be reviewed by GAO to establish the legitimacy of the indexing method.

Action Items

- DoD should implement, and Congress should accept, all the cost-sharing recommendations listed above.
- Congress would need to make specific changes in the law as follows:
  - modify existing law to change the enrollment fee with tiering based on retiree pay for Prime Family and Prime Single,
  - establish a fee for TRICARE Standard with tiered deductibles for Family and Single, and
  - adjust the catastrophic cap.
- In addition, Congress would have to authorize the Secretary of Defense, or his designee, to make changes to the enrollment fees and tiered salary ranges annually based on the newly developed DoD index, and make changes to copayments, deductibles, and the catastrophic cap as necessary at least every five years, making certain to stay within the DoD-approved index.
- DoD should examine the feasibility of establishing other TRICARE options so that all retirees can be assured of having comparable choices among TRICARE options such as Prime and Standard.

Coordinating TRICARE and Private Insurance

All military retirees under age 65 have access to TRICARE; some of these retirees are also employed and have access to their employers' health insurance. The Task Force believes that resolving issues related to the coordination of private insurance and TRICARE offers the potential to provide retirees with better health care while also helping to control growth in DoD medical costs. The Task Force also believes that any resolution must be strictly voluntary—that is, retirees should have the option of choosing the approach that is best for them.

The coordination issue comes in several flavors, depending on the coverage available to retirees, which, in turn, generally relates to retirees' employment status. One-fourth of retirees do not have access to private employer insurance.[28] For these individuals, TRICARE is clearly their main and only insurance, and there are no issues of coordination.

28 Louis T. Mariano et al., National Defense Research Institute and RAND Health, Civilian Health Insurance Options of Military Retirees: Findings from a Pilot Study, 2007, p. 57.

Some retirees have access to private insurance and use this insurance while also using TRICARE. A survey in 2006 suggested that about half of all under-65 retirees with private insurance also used TRICARE. For these retirees, Congress designed TRICARE to be a second payer, and most retirees use it this way. Nonetheless, there are coordination issues for this group. If TRICARE does not know that a retiree has private insurance, TRICARE pays first, even though it should not—thereby adding to DoD medical costs. Also, retirees may choose to use whichever insurance plan is most advantageous for a particular episode of medical care. This can result in less-than-optimal health care because of lack of coordination among providers under the two plans.

Still other retirees are eligible for medical insurance through their private employer but voluntarily choose to drop that coverage and use TRICARE. They take this step for an understandable reason: TRICARE's coverage or cost-sharing is more advantageous for them. The number of retirees in this group is substantial. Estimates from a 2006 survey of military retirees suggest that about 65 percent of retirees under the age of 65, and 58 percent of their dependents, are eligible for insurance from the retiree's employer.[29] But of those eligible, only about 40 percent elect private coverage for themselves, while 29 percent elect dependent coverage. This suggests that the majority (60 percent) of retirees who are eligible for private insurance through their employer are instead using TRICARE. For these individuals, DoD pays all medical costs, even though they are employed and have access to employer health benefits.

To lower their health costs, some employers provide a financial incentive to encourage their employees to use other sources of health insurance, if available. Recently, Congress prohibited employers from offering this kind of incentive directed at TRICARE. However, because TRICARE is generous in terms of its benefits and cost-sharing—an outcome that, by design, will continue even after the Task Force's recommendations are put in place—this congressional action is not likely to change retiree reliance on TRICARE.

The Task Force believes that steps should be taken to better coordinate health insurance for those under-65 retirees with access to both TRICARE and private employer insurance. For these individuals, the goal is to ensure that the retiree relies on only one insurance plan, and hence one set of providers, with TRICARE acting at most as a second payer for those relying on employer insurance. The Task Force has identified two general approaches to accomplish this.

- Some retirees would prefer to use their employer's private insurance—perhaps because they prefer the available providers or because those providers offer care that is more convenient. However, these retirees elect not to use employer insurance because the contribution they must pay for their private insurance is substantially higher than the contribution required by TRICARE. TRICARE would offer these retirees the option of using their employer's private insurance (with TRICARE acting at most as a second payer), with the government paying part or all of their contribution or even, perhaps, a portion of the employer's premiums.

29 *Ibid.*, p. 29.

- Other retirees would prefer to use TRICARE, perhaps because for them TRICARE offers convenience or makes available trusted health care providers. In this case, and to be symmetric with the first approach, employers would not have to pay the premium to cover their retiree employee themselves but would be required to pay part or all of the TRICARE enrollment fee and, perhaps, a portion of the government's TRICARE costs.

Consistent with its basic principle of applying a strictly voluntary approach, the Task Force recommends that retirees should be able to choose the approach they prefer. They could change their minds periodically, perhaps during an annual open season.

How would these approaches affect the coordination and quality of health care for retirees and DoD's medical costs? The Task Force did not have time to answer this important question. These complex issues require more study and a pilot program to test the results of any paper study.

If cost effective, a new policy would represent a win-win situation for military retirees, because they could choose the approach that serves them best. The new policy might also provide better health care coordination for retirees, while slowing the growth in DoD medical costs.

Recommendation 11

DoD should commission a study, and then possibly a pilot program, aimed at better coordinating insurance practices among those retirees who are eligible for private health care insurance as well as TRICARE.

Appropriate Mix of Military and Civilian Personnel for Readiness and High-Quality Care

The Task Force was charged to address

"The appropriate mix of military and civilian personnel to meet future readiness and high-quality health care service requirements."

DoD's efforts to examine medical force requirements have been intermittent. In the post Cold War era, personnel downsizing and constrained budgets focused attention on DoD's need to determine the appropriate size and mix of its medical force.[1] In 1991, Congress enacted Section 733 of the National Defense Authorization Act (NDAA) for Fiscal Years 1992 and 1993, which ordered DoD to reassess its medical personnel requirements based on a post Cold War scenario.[2] Section 733 required that DoD determine the size and composition of the military medical system needed to support U.S. forces during a war or other conflict and identify ways of improving the cost-effectiveness of medical care delivered during peacetime.[3]

The "733 Study"

In April 1994, DoD completed the congressionally mandated assessment known as the "733 Study."[4] Although the study included all types of medical personnel, it used physicians to illustrate key points.[5] It estimated that about 50 percent of the 12,600 Active Duty physicians projected for Fiscal Year 1999 were needed to treat casualties from 2 nearly simultaneous major regional conflicts.[6] In March 1995, GAO testified that the 733 Study results were credible and that its methodology was reasonable.[7] However, GAO noted that the study's results differed from the war plans prepared by the commanders in chief for the two anticipated conflicts, resulting mainly from different warfighting and casualty assumptions.[8]

Partly for these reasons, DoD was directed to update the study's physician manpower estimates to reflect changes in forces and planning from the original analysis.[9] The "733 Update Study" was approved by the Director of Program Analysis and Evaluation in 1999, but not issued by DoD.[10]

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1 GAO, *Wartime Medical Care: Personnel Requirements Still Not Resolved*, GAO/NSIAD-96-173, June 28, 1996, p. 2
2 National Defense Authorization Act for Fiscal Years 1992 and 1993, P.L. 102-190, § 733, 105 Stat. 1390 (1991)
3 Ibid., at §733(b)(1)
4 U.S. Department of Defense, Office of Program Analysis and Evaluation, *The Economics of Sizing the Military Medical Establishment: Executive Report of the Comprehensive Study of the Military Medical Care System*, April 1994
5 GAO, *Wartime Medical Care: Personnel Requirements Still Not Resolved*, GAO/NSIAD-96-173, June 28, 1996, p. 2
6 U.S. Department of Defense, Office of Program Analysis and Evaluation, *The Economics of Sizing the Military Medical Establishment: Executive Report of the Comprehensive Study of the Military Medical Care System*, April 1994, p. 45
7 GAO, *Wartime Medical Care: Aligning Sound Requirements with New Combat Care Approaches Is Key to Restructuring Force*, GAO/T-NSIAD-95-129, March 30, 1995
8 GAO, *Wartime Medical Care: Personnel Requirements Still Not Resolved*, GAO/NSIAD-96-173, June 28, 1996, p. 2
9 Gary Cecchine, David Johnson, John Boudreaulle, J. Michael Polich, Jerry Sollinger, *Army Medical Strategy: Issues for the Future*, Santa Monica, CA: RAND Corporation, IP-208, August 2001, p. 11-12
10 GAO, *Chemical and Biological Defense: DoD Needs to Clarify Expectations for Medical Readiness*, GAO-02-38, October 2001, p. 14

The 733 Update Study used the force structure from the 1997 Quadrennial Defense Review (QDR)[11] It provided for a larger physician component in the Military Health System (MHS) than did the original study, concluding that 72 percent of Active Duty physician strength was required to meet military missions and peacetime and training needs[12] DoD noted that "the numerical results of the analysis are dependent on the particular force structure and scenarios used in the analysis," and "the importance of the study lies in the analytical methods developed to evaluate medical requirements"[13] This implied that the 72 percent estimate could be highly sensitive to assumptions[14]

Recent Developments

The dawn of the 21st century continued to bring a changing security environment that caused DoD to move away from its two Major Theater War Force sizing constructs that were utilized during the 1990s In 2001, the Secretary of Defense issued a new QDR that detailed, among other things, the force structure elements of the defense program[15] The 2001 edition of the QDR introduced a new concept, commonly referred to as the "1/4/2/1 force planning construct" This formula called on DoD to shape its forces to defend the United States, deter aggression and coercion forward in four critical regions, swiftly defeat aggression in two overlapping major conflicts while preserving for the President the option to call for a decisive victory in one of those conflicts—including the possibility of regime change or occupation, and finally, conduct a limited number of smaller-scale contingency operations[16]

The events of September 11, 2001, and the resulting Global War on Terrorism (GWOT) drove a further refinement of DoD's force construct strategy The 2006 edition of the QDR continued to emphasize the transformational efforts articulated in the 2001 edition, as well as changes in the U S global defense posture and Base Realignment and Closure study, and, most importantly, the operational experiences of the preceding four years[17] The new force planning construct focused DoD on better defining its responsibilities for homeland defense within a broader national framework, including GWOT and asymmetric warfare activities, to include long-duration unconventional warfare, counterterrorism, counterinsurgency, and military support for stabilization and reconstruction efforts It also accounted for and drew a distinction between steady state force demands and surge activities over many years[18]

The MHS Transformation Effort and the Medical Readiness Review

The MHS transformation effort for the QDR process was designed to provide the Joint Force with best operational medicine and force health protection in the world and deliver high-quality health care to DoD's 9 2 million eligible beneficiaries[19] The MHS QDR process identified 18 initiatives across 4 focus areas—transform the force, transform the infrastructure, transform the business, sustain the benefit—to ensure successful transformation within the MHS[20] It was this process that utilized the

11 Quadrennial Defense Review Report Department of Defense May 1997
12 Cary Cerchine David Johnson John Bondanella J Michael Polich Jerry Sollinger Army Medical Strategy Issues for the Future Santa Monica CA RAND Corporation IP 208 August 2001 p 12
13 Ibid citing Robert R Soule Director Program Analysis and Evaluation Memorandum 733 Update—Final Report DoD May 10 1999
14 Ibid
15 10 U S C §118(a) (2006)
16 Quadrennial Defense Review Report Department of Defense September 30 2001 p 17
17 Ibid February 6 2006 p 2
18 Ibid p 3 4
19 Quadrennial Defense Review Roadmap for Medical Transformation Paper issued by the Military Health Service Office of Transformation Office of the Assistant Secretary of Defense for Health Affairs April 3 2006 p 1
20 Ibid p 2

Medical Readiness Review (MRR), DoD's latest attempt at examining its medical force requirements. The Under Secretary of Defense for Personnel and Readiness established the MRR in August 2004[21] and dictated that "the MRR will systematically review the Military Health System (MHS) and provide recommendations to the Deputy Secretary of Defense for transforming the MHS to meet the medical readiness requirements of the future."[22]

The MRR influenced the formation of the 2006 edition of the QDR, which made some important recommendations for the field of operational medicine. The report recommended that medical support be aligned with the growing movement toward joint capabilities. It also recommended improving the planning process and transparency of information. The policies, techniques, and tools that were developed during the MRR are now being integrated within the system for future use in rapidly determining optimal force structure in a constantly changing threat environment.[23]

The purpose of the MRR was to find a reliable and consistent means for DoD to identify, develop, and sustain critical military capabilities in support of resource management and the operational planning processes. The MRR also was created to provide a full spectrum assessment of the baseline capabilities required to support the Warfighter during peacetime and to assess the surge capabilities required for wartime.[24] The MRR was intended to evaluate the total assets available to provide support, the associated costs of those assets, and alternative strategies to supply those capabilities.[25]

Since that time, there has been a significant effort aimed at identifying the health services requirements needed to meet the military's transformation goals. The MRR evaluated the available capabilities and resources and factored in the likely number of wartime casualties to determine the optimal size of the Active Duty medical force.[26]

The review has generated revised estimates and subsequent recommendations of conventional wartime requirements, and the Deputy Secretary for Defense is currently in the process of reviewing the requirements associated with scenarios involving chemical, biological, radiological, nuclear, and high-yield explosives and homeland defense events.[27]

Military Versus Civilian Personnel—Initiative 6

The MHS QDR process identified other initiatives addressing medical force requirements. One of the 18 MHS QDR initiatives is QDR Initiative 6, Shaping the Future Joint Medical Force. The purpose of this initiative is to provide the required skill mix and number of medical personnel needed to meet projected wartime missions and deliver effective beneficiary health care.[28]

21 Ibid., p. 5
22 Deputy Secretary of Defense for Personnel and Readiness, Memorandum to Secretaries of Military Departments, Chairman of the Joint Chiefs of Staff, Undersecretary of Defense for Acquisition, Technology and Logistics, Undersecretary of Defense for Comptroller/Chief Financial Officer, Undersecretary of Defense for Personnel and Readiness, Assistant Secretary of Defense (Health Affairs), Commander, Joint Forces Command, and Director, Program Analysis and Evaluation, August 2, 2004, p. 2
23 See fhp.osd.mil/about.jsp?topic=6
24 Ibid.
25 Ibid.
26 Quadrennial Defense Review, Roadmap for Medical Transformation, Paper issued by the Military Health Service Office of Transformation, Office of the Assistant Secretary of Defense for Health Affairs, April 3, 2006, p. 5
27 Ibid.
28 Ibid., p. 11

Recruiting and retaining highly qualified health care professionals is becoming more challenging for all of the services which have been challenged for years by chronic shortages in certain critical health care specialties that are required for sustaining operational readiness. Current personnel accession tools, such as the Health Professions Scholarship Program which recruits and trains highly competent military medical students who can fill any entry level medical specialty billet, do not guarantee the required skill mix or total number of specialists to meet projected wartime missions. DoD medical training programs are relatively expensive and, as currently administered, cannot always responsively address these shortages and imbalances.[29] In addition, each service uses unique management tools and systems and regulatory policies for the management of its medical personnel.

The aims of Initiative 6 are to eliminate service competition for scarce health care human resources, improve the use of medical personnel in a cross-service, joint environment, meet service-specific requirements for Force Health Protection, make use of external medical resources in federal and civilian environments, and allocate available medical personnel resources in a cost-effective and equitable manner.[30]

Optimizing Graduate Medical Education—Initiative 7

Yet another one of the 18 MHS QDR initiatives is QDR Initiative 7, Integrate Graduate Medical Education (GME). The objective of this initiative is to optimize GME training capabilities without hindering the services' ability to meet applicable training requirements. GME is the primary means of retaining medical professionals on active duty because it provides opportunities for additional medical education, with a subsequent increase in active duty service obligations.[31]

Annually, each service validates the GME training requirements and then develops a school year plan approved by the service Surgeon General. The services then participate in a Joint Service GME Selection Board which determines selection for the service training programs. A mechanism for interservice placement of Joint Service GME Selection Board selectees also exists, and civilian-sponsored training and civilian educational delay is judiciously used as a mechanism to meet service training requirements.[32]

Certifying the Need for Reductions

Federal law also imposes limits on the services in determining the proper number of medical personnel. Title 10 prohibits the Secretary of Defense from making reductions in the number of medical personnel, unless the Secretary makes a certification for the particular fiscal year in which reductions are sought.[33] Certification is triggered if the Secretary wants to reduce the number of medical personnel to a number that is less than 95 percent of medical personnel from the previous fiscal year,[34] or less than 90 percent of medical personnel at the end of the third fiscal year preceding the previous fiscal year.[35] The Secretary carries out the certification by stating to Congress that the number of medical personnel being reduced is excess to the current and projected needs of DoD,[36] and that such a reduction is not to result in an increase in the cost of the health care services provided by DoD.[37]

29 Ibid.
30 Ibid.
31 Ibid., p. 12.
32 Ibid.
33 10 U.S.C. §129c (2005).
34 Ibid., at §129c(b)(1).
35 Ibid., at §129c(b)(2).
36 Ibid., at §129c(c)(1).
37 Ibid., at §129c(c)(2).

Determining the Appropriate Mix

DoD maintains internal guidance for determining the appropriate mix of military and civilian manpower and the private sector support necessary to accomplish peacetime and wartime missions.[38] When establishing the workforce mix of an activity, manpower authorities review both peacetime and wartime missions so that activities are designed to transition easily from peacetime to wartime operations.[39] When determining or revalidating the workforce mix of an activity, manpower authorities first verify functions and tasks to be performed, performance objectives, and other factors relevant to mission success.[40] Then, manpower authorities identify the type of work from the list of DoD functions[41] and use the risk-assessment guidance[42] to help identify risks. Manpower authorities then use the Manpower Mix Criteria[43] to distinguish between functions that are inherently governmental and those that are commercial. The Manpower Mix Criteria also is used to identify the inherently governmental and commercial functions that should be performed by military personnel and those that should be performed by DoD civilian personnel.[44]

Current Status

The services have begun to implement and certify military to civilian conversions of medical personnel billets. From Fiscal Year 2005 to Fiscal Year 2007, the Navy converted 2,676 military positions to civilian positions, created a hiring plan for 2,116 converted positions, and hired 1,349 civilians.[45] Since 2006, the Army has programmed 20 percent of its military medical structure for conversion to civilian personnel, with 1,588 positions slated for conversion in Fiscal Years 2006 and 2007.[46] As of August 2007, the Air Force has slated 1,216 military positions for conversion, with 750 of those positions already converted.[47]

Military to civilian conversions are affecting the services in ways not contemplated when the process began three years ago. The Army Medical Department leadership views uniformed Army medics as the cornerstone of the Army's health care system because of their extensive training combined with their operational theater experience. If medical military to civilian conversions continue unabated, the sustainability of the quality medical force will face continued risk.[48] The Army Medical Department has historically had the highest proportion of civilians in its medical work force. If Army Medical Department conversion continues as currently programmed, the proportion of military members will fall from 48 percent to 42 percent. The concern is that this reduction will result in reduced operational agility.[49]

38 DoD Instruction 1100.22, §1.1, Guidance for Determining Workforce Mix, September 7, 2006
39 Ibid., §6.1
40 Ibid., §6.1.1.1
41 See www.dod.mil/prhome/docs/pifunctions.doc
42 DoD Instruction 1100.22, §F3, Guidance for Determining Workforce Mix, September 7, 2006
43 Ibid., §F2
44 Ibid., §6.1.1.2
45 RDML Michael H. Mittelman, Determining the Appropriate Manpower Mix Within Navy Medicine, Presentation to the Task Force, October 3, 2007, Slide 8
46 Maurice Yaglom, Determining the Optimal Manpower Mix to Meet the Army's Health Care Mission, Presentation to the Task Force, October 3, 2007, Slide 14
47 Col. Dennis Beatty, Air Force Medical Service Personnel Requirements Program, Presentation to the Task Force, October 3, 2007, Slide 8
48 Testimony of Maurice Yaglom to the Task Force, Official Transcript, October 3, 2007, p. 98
49 Ibid., p. 101-102

The Navy and Air Force take a different tack to continued medical military to civilian conversions. The House of Representatives passed a version of the NDAA for Fiscal Year 2008 containing a provision prohibiting the service Secretaries from converting any military medical or dental positions to civilian positions beginning October 1, 2007.[50] The Navy and Air Force posit that the prohibition would result in a loss of savings accrued from military to civilian conversions.[51,52] Furthermore, additional legislation was introduced barring the conversion of medical military positions to contractors.[53]

In addition, military to civilian conversions have contributed to unfilled vacancies within the services. For example, the Army Medical Department has more than 6,000 civilian vacancies. Because of keen competition with civilian health care providers in the labor market, Military Treatment Facility commanders face significant hurdles in filling many of these vacancies to meet additional mission requirements and health care demands.[54]

Competition is not only restricted with civilian health care organizations, but also among the other services implementing medical military to civilian conversion programs.[55] Some military installations are located in remote locations where it is conducive to conduct military training and operations. However, these same remote areas do not possesses a sufficient labor market from which to hire qualified personnel or to draw people from other geographic areas.[56]

Strategists know that the fluid and uncertain nature of military operations means that what is planned for today may be irrelevant tomorrow. When considering the proper mix of military and civilian force structure requirements, it is important to be aware of evolving missions. For example, when Navy medicine was first directed to convert military billets in Fiscal Year 2005, the staffing model was based largely on a surgically intensive major theater conflict. Since then, there has been a much greater emphasis placed on nonkinetic missions to include the deployment of hospital ships in support of theater cooperation agreements and humanitarian assistance and disaster relief missions, all of which required different capability sets not captured in the traditional staffing models.[57]

Conclusions

Given the services' differing views and the uncertain state of legislative developments regarding further military to civilian conversions, the Task Force does not take any position on this matter. Final legislative direction and its effect on the services' ability to meet mission requirements, and the demands of peacetime health care, should be considered before further action is recommended.

50 National Defense Authorization Act for Fiscal Year 2008, H.R. 1585, 110th Cong., § 704(a) (2007)
51 Testimony of RDML Michael Mittelman to the Task Force, Official Transcript, October 3, 2007, p. 118
52 Testimony of Col. Dennis Beatty to the Task Force, Official Transcript, October 3, 2007, p. 130
53 Wounded Warrior Assistance Act of 2007, S. 1283, 110th Cong., § 301(b) (2007)
54 Ibid., p. 101
55 Testimony of RDML Michael Mittelman to the Task Force, Official Transcript, October 3, 2007, p. 121
56 Testimony of Col. Dennis Beatty to the Task Force, Official Transcript, October 3, 2007, p. 131
57 Ibid., p. 119

Command and Control Structure to Manage the Military Health System

The Task Force was charged to address

"The appropriate command and control structure within the Department of Defense and the Armed Forces to manage the military health system."

For many years DoD as a whole has been on a path to greater integration of the military branches and a greater emphasis on what is called "jointness." Joint regional commands came about to enhance warfighting success through the designation of a joint commander with responsibility and authority over all military units in a region.

In addition to ongoing debates about greater integration, some consolidation is already occurring through the ongoing Base Realignment and Closure (BRAC) process, which has forced elements of the Military Health System (MHS) enterprise together physically.

Proponents of a Unified Medical Command (UMC) cite potential benefits to enhance the ability of the MHS to be a global medical force provider. These benefits include a unified command under one authority, a single point of accountability, increased integration for all elements of the medical command and control, better integrated health care delivery, enhanced peacetime effectiveness and ability to quickly transition to war, a rapidly deployable and flexible medical capability, and more.

Those opposed to a joint/UMC say that the objectives are unclear and that the expansion of the TRICARE benefit is responsible for driving costs up at an alarming rate, a problem that having a joint/UMC will not solve. They provide many reasons why such expansion is not advisable, including that the direct care system has seen only modest growth in recent years, that having medics aligned with the parent service is the best arrangement, because medical capabilities will remain aligned with the service doctrine and culture, and that service Title X accountability for the health and welfare of forces will be maintained.

Recent Reviews

The National Defense Authorization Act (NDAA) for Fiscal Year 2000 tasked the Secretary of Defense with examining the merits and feasibility of establishing a joint medical command, a joint training curriculum, and a unified chain of command and budgeting authority. To fulfill the congressional request, RAND Corporation was hired to develop organizational structure alternatives that appear to have some merit and to outline the trade-offs inherent in choosing among the alternatives.

Both GAO and RAND have reported that the "military services' longstanding independence"[1] has been one of the key obstacles to the medical departments developing a joint approach to delivering health care, however, there are examples of jointness in military medicine that illustrate the benefits of synthesis and integration. As a critical supporting element, warfighting medics already operate within the joint

[1] GAO, *Defense Health Care: Tri-Service Strategy Needed to Justify Medical Resources for Readiness and Peacetime*, HEHS-00-10, Washington, D.C., November 1999, p. 2.

framework. In Iraq and Afghanistan, the military health care system has operated jointly with exceptional skill and outcomes.[2] These accomplishments have been achieved through shared medical research, enhanced service- and joint training programs, and greater synchronization of aeromedical evacuation. Also, mental health programs—such as pre- and postdeployment assessments and in-theater care—reflect common, joint products and tools, providing a shared baseline from which to better evaluate performance.

A driving force in the direction of a UMC was Program Budget Decision (PBD) 753, issued by the Secretary of Defense on December 23, 2004, which directed the Under Secretary of Defense for Personnel and Readiness (P&R) to "work with the Chairman of the Joint Chiefs of Staff to develop an implementation plan for a Joint Medical Command by the FY 2008 – FY 2013 Program/Budget Review."[3] A UMC working group was formed, which developed three courses of action: 1) a UMC, 2) a joint/UMC and joint/Unified Healthcare Command, and 3) a single service.

A subsequent working group was charged with developing recommendations for two specific commands: 1) a single joint/UMC responsible for all market areas, and 2) a joint/UMC responsible for operational deployed medicine.[4] The working group was unable to reach consensus on a course of action for the development of an implementation plan.

During a September 6, 2006, meeting of the Defense Business Board, it was unanimously recommended that the Secretary of Defense appoint a task force to oversee the establishment of a UMC by January 1, 2007. The board also recommended to realign the current activities of the TRICARE Management Activity (TMA) to function alongside a unified command and to streamline TMA's management functions to concentrate on policy and oversight of health plan management and then to "outsource the management activity once the agency has been re-aligned."[5] While concerns were raised during this meeting that the proposed recommendations may require changes to DoD Title 10 legislation, the board's review "determined a unified command was not only feasible within Title 10, but in fact the Department may not be fulfilling its obligations under public law requiring consolidation of shared services."[6] The proposal to establish the UMC as a Unified Combatant Command was ultimately rejected by the Secretary of Defense.

On November 27, 2006, Deputy Secretary of Defense Gordon England approved an action memorandum submitted by Dr. William Winkenwerder, Assistant Secretary of Defense for Health Affairs, to satisfy the intent of PBD 753. According to the memorandum, the recommended approach:[7]

- takes incremental and achievable steps that will yield efficiencies of operations,
- achieves true economies of scale by combining common functions,
- provides structural changes enabling MHS Quadrennial Defense Review (QDR) transformation initiatives,
- preserves service-unique culture for each of the service's medical components,
- supports the principles of unity of command and effort under joint operations,
- maintains Under Secretary of Defense (P&R) and Assistant Secretary of Defense for Health Affairs oversight of the Defense Health Program,
- facilitates consolidation of medical headquarters under the 2007 BRAC law,
- creates a joint environment for the development of future MHS leaders, and
- positions the MHS for further advances, if warranted, toward more unification.

2 S. Ward Casscells, *Unified Medical Command*, MOAA Military Officer, June 2007. See www.moaa.org/pubs_mom_070601_unified.htm
3 *PBD 753, December 23, 2004, p. 9*
4 *Defense Business Board, Report to the Secretary of Defense, Military Health System – Governance, Alignment and Configuration of Business Activities Task Group Report, Report FY06-5, September 2006, Appendix B, p. 6*
5 *Ibid., p. 4*
6 *Ibid., p. 3*
7 *Read Ahead for Deputy Secretary of Defense, Unified Medical Command – Way Ahead Decision, November 27, 2006*

The memorandum identified "shared support services and functions along with co-location of MHS headquarters" as a target area to improve service enhance efficiency and support mission effectiveness [8] It called for 'smaller operating headquarters, lower personnel and operating overhead, consolidation of shared and common service functions including business development, communications, finance and budget services, human capital management, information technology management, logistics and support services, facilities management, doctrine and standards development for mission support, and joint and combined medical requirements development [9]

By approving this memorandum, Deputy Secretary of Defense Gordon England directed the services and Office of the Secretary of Defense leadership to move forward to even greater integration of medical services Although he did not direct a 'joint medical command, he did set forth a clear course—that reorganization must enhance DoD operational capabilities and remove redundancy and unnecessary costs [10] Conservative estimates on the reorganization outlined project annual savings approaching $200 million per year [11] In the approval memorandum, the Deputy Secretary of Defense established a three-year timeline, beginning in Fiscal Year 2007, for establishing a transition team and beginning the phased implementation

The 2006 QDR provided strategies to improve the management, performance, and efficiency of the MHS [12] These strategies included the elimination of redundant command structures, the alignment of resource streams, and the provision of clear lines of authority and responsibility for local decisionmaking Pursuant to these strategies, the Deputy Secretary of Defense directed establishment of the Joint Task Force National Capital Region Medical [13] The Joint Task Force's mission is to deliver integrated health care in the National Capital Region, ensure readiness and disaster preparedness of the assigned forces, and execute the BRAC business plans to achieve a world-class medical center at the hub of the Nation's premier regional health care system serving our military and our Nation [14]

In response to all of these inputs, DoD has developed a governance plan that created joint oversight in four key areas 1) medical research, 2) medical education and training, 3) health care delivery in major military markets, and 4) shared support services [15] The creation of a "shared services activity" calls for "the consolidation of administrative or support functions from several departments or agencies into a single, stand alone organizational entity whose mission is to provide services as efficiently and effectively as possible "[16]

On June 8, 2007, the Assistant Secretary of Defense for Health Affairs submitted to the Deputy Secretary for Defense two courses of action for reorganizing the MHS

1) a Defense Health Agency model with subordinate activities for education and training, research and development, and major multiservice markets, and
2) an Executive Agency model,[17] which implements jointness in education, training, and research and development, but preserves service control of the multiservice markets

8 Action Memorandum for Deputy Secretary of Defense SUBJ Joint/Unified Medical Command Way Ahead November 27 2006 Tab B p 1 2
9 Ibid Tab B p 2
10 S Ward Cassells Unified Medical Command MOAA Military Officer June 2007 See www moaa org/pubs_mom_070601_unified htm
11 Action Memorandum for Deputy Secretary of Defense SUBJ Joint/Unified Medical Command Way Ahead November 27 2006 Tab B p 1
12 Quadrennial Defense Review Report Department of Defense February 6 2006 p 72 73
13 See www bethesda med navy mil/joint_task_force/ JTF_Establishment aspx
14 See www bethesda med navy mil/joint_task_force/
15 DSD Decision Memorandum Unified Medical Command – Way Ahead Decision November 27 2006
16 Shared Services Quick Look – for Way Ahead Meeting (PowerPoint presentation) February 28 2007 p 2
17 Executive Agent definition A DoD component assigned a function by the Secretary of Defense to provide defined levels of support for either operational or administrative missions that involve two or more organizations

The Assistant Secretary of Defense for Health Affairs recommended approval of the Defense Health Agency course of action [18] The phased implementation of the Defense Health Agency model, which includes the creation of a new Joint Military Health Services Directorate, is currently under review [19]

The Comptroller General was directed to review the studies undertaken by DoD, as well as those conducted by the Center for Naval Analyses Corporation and other organizations such as the Defense Business Board and provide an analysis of the various UMC structures under consideration by DoD and outside organizations [20] GAO released its report on this review in October 2007 and determined that DoD did not perform a comprehensive cost-benefit analysis of all potential options "[21] GAO stated, 'DoD has not demonstrated that its decision to move forward with the fourth option was based on a sound business case A sound business case should include detailed qualitative and quantitative analyses in support of selecting and implementing the new process in terms of benefits, costs, and risks "[22] GAO further stated that "the business case does not demonstrate how DoD determined the fourth option to be better than the other three in terms of its potential impact on medical readiness, quality of care beneficiaries' access to care, costs, implementation time, and risks because DoD does not provide evidence of any analysis it has performed of the fourth option or a sound business case justifying this choice' [23]

Consequently, GAO recommended that "DOD address the expected benefits, costs, and risks for implementing the fourth option and provide Congress the results of its assessment The Task Force is also recommending that DOD develop performance measures to monitor the progress of its chosen plan toward achieving the goals of the transformation [24]

Findings and Recommendations

There has been considerable debate by other groups about the costs and benefits of a unified or more integrated command and control structure for the MHS culminating with the most recent recommendation for a Defense Health Agency Given the relatively short period that has passed since this recommendation was made, the Task Force believes it is premature to make additional recommendations at this time, although the Task Force also believes that it is appropriate that the effects of these changes be monitored and assessed Furthermore, consistent with an October 2007 GAO report any additional options for change should be assessed in terms of the costs and benefits to be derived from each of the options under consideration

Recommendation 12

DoD should develop metrics by which to measure the success of any planned transformation of the command and control structure of the MHS, taking into consideration its costs and benefits

18 S Ward Casscells Memorandum for USD (P&R) Request for Coordination on Improving Military Health System Governance June 8 2007
19 GAO Defense Health Care DoD Needs to Address the Expected Benefits Costs and Risks for Its Newly Approved Medical Command Structure GAO 08 122 p 15
20 H R Rep No 109 452 at 343 (2006)
21 GAO Defense Health Care DoD Needs to Address the Expected Benefits Costs and Risks for Its Newly Approved Medical Command Structure GAO 08 122 p 4
22 Ibid p 5
23 Ibid
24 Ibid

Appendix A Task Force Biographies

General John D W Corley (Co-Chair)
Commander, Air Combat Command

Gen John D W Corley is Commander Air Combat Command, with headquarters at Langley Air Force Base, Virginia, and Air Component Commander for U S Joint Forces Command As the Commander, he is responsible for organizing, training, equipping, and maintaining combat ready forces for rapid deployment and employment while ensuring strategic air defense forces are ready to meet the challenges of peacetime air sovereignty and wartime defense Previously, General Corley was Vice Chief of Staff, Headquarters, U S Air Force, a role in which he presided over the Air Staff and served as a member of the Joint Chiefs of Staff Requirements Oversight Council His previous staff positions comprise a mix of operational and joint duties in the Tactical Air Command, Headquarters, U S Air Force, and the Joint Staff He received his B S in engineering from the U S Air Force Academy and earned his wings at Reese Air Force Base, Texas, in 1974 He earned an M B A and another master's degree in national security and strategic studies He also is a graduate of Harvard University's John F Kennedy School of Government's Program for Senior Executives in National and International Security General Corley has significant experience in intense combat most recently during Operation Enduring Freedom As Combined Air Operations Center Director, he directed the safe recovery of isolated personnel during the largest combat search-and-rescue mission in 50 years and was awarded the Bronze Star as a result His aviation career includes more than 3,000 flying hours with a wide range of combat experience He has commanded at the squadron, group and wing levels In addition to the Bronze Star, General Corley is a recipient of the Distinguished Service Medal, the Defense Superior Service Medal, the Legion of Merit, and the Defense Meritorious Service Medal, among other awards

Gail R Wilensky, Ph D (Co-Chair)
Senior Fellow, Project HOPE

Gail Wilensky is a Senior Fellow at Project HOPE, an international health education foundation, where she analyzes and develops policies relating to health reform and to ongoing changes in the health care environment She testifies frequently before congressional committees, acts as an advisor to members of Congress and other elected officials, and speaks nationally and internationally before professional, business, and consumer groups Dr Wilensky was a member of the President's Commission on the Care of Returning Wounded Warriors From 2001 to 2003, she co-chaired the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, which addressed health care for both veterans and military retirees From 1997 to 2001, she chaired the Medicare Payment Advisory Commission, which advises Congress on payment and other issues relating to Medicare, and from 1995 to 1997, she chaired the Physician Payment Review Commission She also served as Deputy Assistant for Policy Development to President George H W Bush, advising him on health and welfare issues Prior to assuming this position, she served as Administrator of the Health Care Financing Administration, overseeing the Medicare and Medicaid programs Dr Wilensky is an elected member of the Institute of Medicine (IOM) and serves as a trustee of the Combined Benefits Fund of the United Mine Workers of America and the National Opinion Research Center She is

a former chair of the board of directors of Academy Health, a former trustee of the American Heart Association, and a current or former director on the boards of numerous other organizations, including several corporate boards. Dr. Wilensky is the recipient of numerous honorary degrees and awards and has published more than 125 articles. She received a bachelor's degree in psychology and a Ph.D. in economics from the University of Michigan.

Major General Nancy Adams (Ret.)
Senior Partner, Martin, Blanck & Associates, Inc.

Nancy Adams joined Martin, Blanck & Associates in August 2005 after a distinguished career as both a military officer, retired in the rank of Major General, and a member of the Senior Executive Service in the federal government. Ms. Adams is one of Martin, Blank & Associates' leading experts on federal health acquisition policies and procedures. In addition, Ms. Adams has extensive clinical, administrative, and senior management experience with large, complex government health care systems, and has demonstrated expertise and competency as an organizational leader, effective communicator, and resource manager with results that produced performance improvements. From 1998 through 2002, Major General Adams served as commanding general of Tripler Army Medical Center in Hawaii, a 266-bed tertiary care medical center employing 3,000 personnel with a $245 million annual budget. She led the organization to a perfect 100 percent score on the survey by the Joint Commission on Accreditation of Healthcare Organizations. She also had responsibility for TRICARE Pacific, serving 527,960 beneficiaries in Hawaii and throughout the Pacific region. Prior to this command, she commanded William Beaumont Army Medical Center in El Paso, Texas, a 200-bed tertiary care medical center with 1,800 personnel serving 400,000 beneficiaries. Brigadier General Adams served as the Chief of the Army Nurse Corps and Assistant Surgeon General of the Army for Personnel and Commander for the Center for Health Promotion and Preventive Medicine from 1991 to 1995. Prior to these leadership positions, she served in a variety of clinical nursing and nursing administration positions in the Army Medical Department and DoD.

Shay Assad
Director, Defense Procurement and Acquisition Policy

Mr. Shay Assad assumed his position as Director of Defense Procurement and Acquisition Policy (DPAP) on April 3, 2006. As the Director of DPAP, he is responsible for all DoD acquisition and procurement policy matters. He serves as the principal advisor to the Under Secretary of Defense for Acquisition, Technology and Logistics, Deputy Under Secretary of Defense for Acquisition and Technology, and on the Defense Acquisition Board on acquisition/procurement strategies for all major weapon systems programs, major automated information systems programs, and services acquisitions. Mr. Assad is responsible for procurement/sourcing functional business process requirements in the department's business enterprise architecture and enterprise transition plan. In addition, Mr. Assad is DoD's advisor for competition, source selection, multiyear contracting, warranties, leasing, and all international contracting matters. Before assuming this position, Mr. Assad was the Assistant Deputy Commandant, Installations and Logistics (Contracts), at the Marine Corps Headquarters. Mr. Assad served two tours of duty aboard U.S. Navy destroyers and won recognition as Outstanding Junior Officer, Fifth Naval District. He then served as a Naval Procurement Officer at the Naval Sea Systems Command, where he was responsible for the negotiation and administration of the Aegis Weapons Systems engineering and production contracts. Between 1978 and 1994, Mr. Assad served in several increasingly responsible contract management positions for the Raytheon

Company's largest electronics and missile divisions. In 1994, he was promoted to Vice President, Director of Contracts, for Raytheon and subsequently was promoted to Senior Vice President, Contracts in 1997. In 1998, he was promoted to Executive Vice President, served as the Chief Operating Officer, and subsequently served as the Chairman and Chief Executive Officer of Raytheon's engineering and construction business. Mr. Assad graduated with distinction from the U.S. Naval Academy.

Carolyn M. Clancy, M.D.
Director, Agency for Healthcare Research and Quality

Carolyn M. Clancy, M.D., was appointed Director of the Agency for Healthcare Research and Quality (AHRQ) on February 5, 2003. Prior to this appointment, Dr. Clancy served as AHRQ's Acting Director (from March 2002) and as director of the Agency's Center for Outcomes and Effectiveness Research. Dr. Clancy holds an academic appointment at the George Washington University School of Medicine (Clinical Associate Professor, Department of Medicine) and serves as the Senior Associate Editor of Health Services Research. Dr. Clancy has served on multiple editorial boards—including those of the *Annals of Family Medicine*, the *American Journal of Medical Quality*, and *Medical Care Research and Review*—and has published widely in peer reviewed journals. She also has edited or contributed to seven books. She is a member of IOM and was elected a Master of the American College of Physicians in 2004. Dr. Clancy, a general internist and health services researcher, is a graduate of Boston College and the University of Massachusetts Medical School. Following her clinical training, Dr. Clancy was a Henry J. Kaiser Family Foundation Fellow at the University of Pennsylvania. She was also an assistant professor in the Department of Internal Medicine at the Medical College of Virginia in Richmond before joining the staff of AHRQ in 1990.

Robert S. Galvin, M.D.
Director of Global Healthcare, General Electric Company

Robert Galvin, M.D., is Director of Global Healthcare for General Electric (GE). He oversees the design and performance of GE's health programs, which total more than $3.0 billion annually, and is responsible for GE's medical services, encompassing more than 220 medical clinics in more than 20 countries. Dr. Galvin completed his undergraduate work at the University of Pennsylvania, where he graduated magna cum laude and was elected to Phi Beta Kappa. He also received his M.D. degree at the University of Pennsylvania and was elected to Alpha Omega Alpha. He received an M.B.A. in health care management from Boston University's School of Management in 1995. In his current role, Dr. Galvin has focused on issues of market-based health policy and financing, with a special interest in quality measurement and improvement. He has been a leader in pushing for public release of performance information and reform of the payment system. Dr. Galvin is a founder of both the Leapfrog Group and Bridges to Excellence. He was a member of the Strategic Framework Board of the National Quality Forum and currently sits on the board of the National Committee for Quality Assurance and the Centers for Disease Control and Prevention's Director's Advisory Group on Emergency Preparedness. He has served on several IOM committees and is currently a Commissioner on the Commonwealth Fund's program on a High Performance Health System. Dr. Galvin has received awards for his work from the National Health Care Purchasing Institute, the National Business Group on Health, and the National Coalition for Cancer Survivorship. He is a Fellow of the American College of Physicians, and his work has been published in the *New England Journal of Medicine* and *Health Affairs*. He is Professor Adjunct of Medicine and Health Policy at Yale where he leads a seminar in the private sector at the School of Medicine and the M.B.A. program at the School of Management.

The Honorable Robert F Hale
Executive Director, American Society of Military Comptrollers

Robert Hale currently is the Executive Director of the American Society of Military Comptrollers (ASMC) In that capacity, he runs an 18,000-member association that provides professional development opportunities to defense financial managers His responsibilities include oversight of a large annual conference, a professional certification program, a quarterly journal, and many other activities From 1994 to 2001, Mr Hale was appointed by the President and confirmed by the Senate as Assistant Secretary of the Air Force (Financial Management and Comptroller) He was responsible for the Air Force budget and all aspects of Air Force financial management Mr Hale also served for 12 years as head of the defense unit of the Congressional Budget Office His group provided defense analyses to Congress, and he frequently testified before congressional committees Before coming to ASMC, Mr Hale directed a program group at LMI Government Consulting, and early in his career he served on active duty as a Navy officer and worked for the Center for Naval Analyses Mr Hale holds a B S and an M S from Stanford University and an M B A from George Washington University He is a Fellow of the National Academy of Public Administration and currently serves on the Defense Business Board He is a Certified Defense Financial Manager

The Honorable Robert J Henke
Assistant Secretary for Management Department of Veterans Affairs

Robert J Henke was nominated by President George W Bush to serve as Assistant Secretary for Management in the Department of Veterans Affairs (VA) and was sworn into office on November 3, 2005 In this position, he is responsible for the Department's budget (in excess of $87 billion requested for Fiscal Year 2008), financial policy and operations, acquisition and materiel management, real property asset management, and business oversight He serves as VA's Chief Financial Officer, Chief Acquisitions Officer, and Senior Real Property Officer Prior to his appointment, Mr Henke served as the Principal Deputy under the Secretary of Defense (Comptroller) at DoD In that capacity, he was the principal advisor to the DoD Comptroller/Chief Financial Officer, and his duties involved a broad range of financial management responsibilities, including development, justification, and execution of DoD's budget, and the formulation of DoD-wide financial and accounting policy Mr Henke served as a professional staff member with the U S Senate Committee on Appropriations, Subcommittee on Defense from 1999 to 2004 and as a Presidential Management Intern with the Office of the Assistant Secretary of the Navy (Financial Management and Comptroller) from 1997 to 1999 From 1993 to 1996, he was with General Electric, where he completed GE's Financial Management Program A Reserve Navy officer, Mr Henke graduated from the University of Notre Dame with a B A in government and international relations, and earned a Master's of Public Administration from Syracuse University's Maxwell School of Citizenship and Public Affairs

Lawrence S Lewin
Executive Consultant, Washington D C

Larry Lewin founded the Lewin Group in 1970 and remained its president and CEO through three acquisitions until 1999 He has directed a wide range of projects in health policy and finance, academic medicine, public and private health insurance, technology and market assessment of medical devices and pharmaceutical products, strategic visioning and planning, and health systems management and governance He has conducted nearly 100 workshops and strategic planning conferences for a wide variety of health care executives and organizations He left the Lewin Group in December 1999 and currently as an executive consultant, is assisting senior health care executives, foundations, and organizations in strategic decisionmaking, program improvement, and executive coaching Recently, he has focused his attention on clinical and technology effectiveness, health promotion, and the challenge of managing collaborative organizations and programs in both the academic and clinical realms Mr Lewin serves on a number of corporate boards including those of CardioNet, H&Q Healthcare and Life Sciences Funds, and Medco Health Solutions He also serves on the Intermountain Healthcare Board of Trustees (since 1984) and has chaired its Information Systems Board Committee (since 1993) He was elected to the IOM/National Academies in 1984, served eight years as an elected member of the IOM Council, and in 2004 was awarded the IOM's Adam Yarmolinsky Medal for Distinguished Service He was a founding member of the Association for Health Services Research (now Academy Health) and is currently a member of the National Commission on Prevention Priorities Mr Lewin holds an A B from Princeton University's Woodrow Wilson School of Public and International Affairs and an M B A from the Harvard Business School, where he was a Baker Scholar Mr Lewin proudly served as an officer in the U S Marine Corps

Rear Admiral John M Mateczun, M D
Commander Joint Task Force National Capital Region

Rear Admiral John M Mateczun is Commander, Joint Task Force National Capital Region Admiral Mateczun began his career of service as an enlisted member of the U S Army and trained at the Explosive Ordnance Disposal School at Indian Head, Maryland He served two tours of duty in Vietnam and later received a Doctor of Medicine degree from the University of New Mexico He completed training in psychiatry at the Naval Regional Medical Center, Oakland, California, and also received a Master's of Public Health degree from the University of California, Berkeley Admiral Mateczun was assigned as Division Psychiatrist and Assistant Division Surgeon, 3d Marine Division Okinawa, Japan He was then assigned to the Naval Hospital, Bethesda, Maryland, as a staff physician, where he became the Intern Advisor and Transitional Intern Program Director He also has completed requirements for a law degree at Georgetown University Law Center He became Chairman of Psychiatry at Naval Hospital Portsmouth and then at the National Naval Medical Center, where he became the Acting Director of Medical Services during Operation Desert Shield During Operation Desert Storm, he was assigned to I Marine Expeditionary Force in Saudi Arabia as a consultant on the establishment and operation of Combat Stress Centers He was a medical crew member on the first flight that retrieved repatriating Prisoners of War in Amman, Jordan Returning to Bethesda, he was appointed Director of Medical Services and then was assigned as the Force Surgeon for Marine Forces Pacific He was the first Chief of Staff at TRICARE Region 1 and was then appointed Principal Director for Clinical Services under the Assistant Secretary of Defense for Health Affairs Subsequent to that tour he commanded the Naval Hospital, Charleston, South Carolina Selected for promotion to flag rank, he headed Navy medical operations and was then selected to be the Joint Staff Surgeon and Medical Advisor to the Chairman of the Joint Chiefs

of Staff He was the United States delegate to the NATO Committee of Chiefs of Medical Services He was present at the Pentagon on September 11, 2001, and subsequently served on the Joint Staff during Operations Noble Eagle Enduring Freedom, and Iraqi Freedom Admiral Mateczun was subsequently the Chief of Staff and Program Executive Officer at the Bureau of Medicine and Surgery He was selected for promotion to Rear Admiral and assumed command of the Naval Medical Center, San Diego, the military s largest Medical Center, employing 6,200 military personnel, civilians, and contractors with an operating budget of $380 million Under his leadership, Naval Medical Center, San Diego, deployed more than 1,000 personnel in support of Operations Iraqi Freedom, Enduring Freedom, and Unified Assistance Admiral Mateczun was subsequently the Deputy Surgeon General of the Navy and Vice Chief, Bureau of Medicine and Surgery He also served as Director of the Military Health System Office of Transformation Admiral Mateczun is board certified in adult psychiatry and forensic psychiatry His awards include the Navy Distinguished Service Medal, the Defense Superior Service Medal with Oak Leaf Cluster, the Legion of Merit with two Gold Stars, the Bronze Star, the Defense Meritorious Service Medal, the Meritorious Service Medal with Gold Star, the Navy/Marine Corps Commendation Medal, the Army Commendation Medal, and the Navy/Marine Corps Achievement Medal

General Richard B Myers (Ret)
Former Chairman, Joint Chiefs of Staff

Retired U S Air Force General Richard B Myers served as the 15th Chairman of the Joint Chiefs of Staff, the U S military's highest ranking officer, from 2001 to 2005 In this capacity, he served as the principal military advisor to the President, the Secretary of Defense, and the National Security Council He previously served as Vice Chairman of the Joint Chiefs of Staff, a role in which he served as the Chairman of the Joint Requirements Oversight Council, Vice Chairman of the Defense Acquisition Board and member of the National Security Council Deputies Committee and the Nuclear Weapons Council General Myers entered the Air Force in 1965 through the Reserve Officer Training Corps program His career includes operational command and leadership positions in a variety of Air Force and Joint assignments General Myers is a command pilot with more than 4 100 flying hours As the Vice Chairman from March 2000 to September 2001, General Myers served as the Chairman of the Joint Requirements Oversight Council, Vice Chairman of the Defense Acquisition Board, and as a member of the National Security Council Deputies Committee and the Nuclear Weapons Council In addition, he acted for the Chairman in all aspects of the planning, programming, and budgeting system including participation in the Defense Resources Board From 1998 to 2000, General Myers was Commander in Chief of the North American Aerospace Defense Command and U S Space Command, Commander, Air Force Space Command, and DoD manager, space transportation system contingency support at Peterson Air Force Base Colorado As commander, General Myers was responsible for defending America through space and intercontinental ballistic missile operations Prior to assuming that position, from 1997 to 1998, he was Commander of the Pacific Air Forces, Hickam Air Force Base, Hawaii, from 1996 to 1997, he was Assistant to the Chairman of the Joint Chiefs of Staff, and from 1993 to 1996, he was Commander of U S Forces Japan and the 5th Air Force at Yokota Air Base, Japan He is a graduate of Kansas State University and received a master's degree in business administration from Auburn University The General has attended the Air Command and Staff College at Maxwell Air Force Base, Alabama, the U S Army War College at Carlisle Barracks, Pennsylvania, and the Program for Senior Executives in National and International Security at Harvard's John F Kennedy School of Government

Lt Gen (Dr) James G Roudebush
Surgeon General of the Air Force, Headquarters U S Air Force

Lieutenant General (Dr) James G Roudebush is the Surgeon General of the Air Force, a role in which he serves as functional manager of the U S Air Force Medical Service He advises the Secretary of the Air Force and Air Force Chief of Staff, as well as the Assistant Secretary of Defense for Health Affairs, on matters pertaining to the medical aspects of the air expeditionary force and the health of Air Force staff General Roudebush has authority to commit resources worldwide for the Air Force Medical Service, to make decisions affecting the delivery of medical services, and to develop plans, programs, and procedures to support worldwide medical service missions He exercises direction, guidance, and technical management of more than 42,400 people assigned to 74 medical facilities worldwide Before his selection as the 19th Surgeon General, he served as the Deputy Surgeon General of the U S Air Force, and before becoming Deputy Surgeon General, he served as Command Surgeon for U S Central Command, Pacific Air Forces, U S Transportation Command and Headquarters Air Mobility Command He completed residency training in family practice at the Wright-Patterson Air Force Medical Center, Ohio, in 1978, and aerospace medicine at Brooks Air Force Base, Texas, in 1984 The General commanded a wing clinic and wing hospital before becoming Deputy Commander of the Air Force Materiel Command Human Systems Center General Roudebush entered the Air Force in 1975 after receiving a Bachelor of Medicine degree from the University of Nebraska at Lincoln, and a Doctor of Medicine degree from the University of Nebraska College of Medicine

Rear Admiral David J Smith
Joint Staff Surgeon

Rear Admiral David J Smith serves as the Joint Staff Surgeon at the Pentagon In this capacity, he advises the Chairman of the Joint Chiefs of Staff, the members of the Joint Staff, and Combatant Commanders, and coordinates all issues related to operational medicine, force health protection, and readiness among the Combatant Commands the Office of the Secretary of Defense, and the services He is the U S delegate to the NATO Council of Medical Directors and is involved in other international medical relationships As a lieutenant, he completed his rotating medicine internship at Naval Regional Medical Center, Oakland, California, in 1982 and subsequently transferred to the Naval Undersea Medical Institute in Groton Connecticut, where he completed the Undersea Medical Officer training program Rear Admiral Smith completed his occupational medicine training at the University of Cincinnati Medical School, with a Master of Science in environmental health, and he served as Chief Resident As an Undersea Medical Officer, Rear Admiral Smith has served in a variety of medical officer positions, including aboard the U S S Grayback, at the Naval Diving and Salvage Training Center, at the Naval Medical Research Institute, and at the Royal Navy Institute of Naval Medicine He served as Head of the Safety and Health Department at the Armed Forces Radiobiology Research Institute and as the occupational health consultant for the Defense Nuclear Agency In November 1995, Rear Admiral Smith reported to the National Naval Medical Center to serve as the Deputy Director, Occupational and Community Health and was appointed as Director in July 1996, where he oversaw the provision of primary and occupational health care by 24 medical clinics in a six-state region In June 1999, Rear Admiral Smith became the Executive Officer and then the Commanding Officer at the Naval Hospital in Rota, Spain During his tenure, the command received numerous awards and hosted the Expeditionary Medical Facility, supporting casualty flow from Operation Iraqi Freedom and Operation Enduring Freedom In July 2003, Rear Admiral Smith was appointed the Chief of Staff of TRICARE Management Activity, Office of the Assistant Secretary of Defense

(Health Affairs), and in this role he helped lead the migration to the new TRICARE contracts, the expansion of the Reserve Health Benefit, and the approval and implementation of the new regional governance. In February 2005, Rear Admiral Smith assumed the duties of the Assistant Deputy Chief, Health Care Operations, at the Bureau of Medicine and Surgery (BUMED). He became the Chief of BUMED, Operations (M3), in June 2005, and in this role he has been responsible for guidance and policy for all peacetime and deployed medical operations. Rear Admiral Smith received a B.S. from the University of Illinois in 1977 and completed his Doctor of Medicine from Northwestern University Medical School in 1981. He is a certified physician executive and a Fellow of the American College of Occupational and Environmental Medicine. He is board certified in Occupational Medicine, with a Certificate of Added Qualification in Undersea Medicine.

Major General Robert W. Smith III (Ret.)
U.S. Army Reserve

Major General Robert W. Smith III, U.S. Army Reserve (Ret.) served as President of the Reserve Officers Association from July 2005 to July 2006 and continues to serve on the association's Executive Committee as the Immediate Past President. General Smith retired from the Army after 34 years of active and reserve commissioned service. He is a former air defense and infantry officer who commanded from detachment to division level and served in many key staff positions at numerous levels of the Army. A Vietnam War combat veteran, General Smith has been decorated with the Distinguished Service Medal, the Legion of Merit, the Bronze Star with Oak Leaf Cluster, and the Meritorious Service Medal with two Oak Leaf Clusters, and other awards. General Smith also is a retired Ford Motor Company finance executive with 32 years of service. During his career with Ford, General Smith held a number of financial and managerial positions, including Manager for Sarbanes-Oxley compliance testing and eight years as the Global Controller, Service Engineering Office. General Smith has served as CEO of Two Star Strategic Services, a business and professional consulting firm in West Bloomfield, Michigan, as General Partner with Smith and Jones Enterprises, and as a member of the board of directors of Volunteers of America, State of Michigan. He was also the Vice Chair of the Pentagon Federal Credit Union Foundation Board, Arlington, Virginia, a group that helps returning wounded soldiers and all soldiers with financial management. He has been featured on the cover of Fortune magazine and profiled in the *Wall Street Journal*. General Smith's other memberships include the Association of the U.S. Army, Sigma Pi Phi Fraternity, Kappa Alpha Psi Fraternity, National Black MBA Association, and the Sovereign Military Order of the Temple of Jerusalem. He earned a master's degree in business administration from the University of Pittsburgh Katz Business School and currently serves on its Board of Visitors. He also is the recipient of an honorary Doctor of Humane Letters from Florida A&M University.

Expert Consultant to the Task Force

Major General (Dr.) Joseph E. Kelley (Ret.)
Former Joint Staff Surgeon

Retired U.S. Air Force Major General Joseph E. Kelley served as the Joint Staff Surgeon at the Pentagon from 2005 to 2007. He was the chief medical adviser to the Chairman of the Joint Chiefs of Staff, and provided advice to the Chairman, the Joint Staff, and Combatant Commanders. He coordinated all issues related to operational medicine, force health protection, and readiness among the Combatant Command Surgeons, the Office of the Secretary of Defense, and the services. He also served as the appointed U.S. delegate to the NATO Council of Medical Directors. General Kelley has held academic appointments as clinical professor and assistant dean and is certified by the American Board of Surgery and is a distinguished graduate of the Aerospace Medicine Primary Course. General Kelley graduated second in his class from the U.S. Air Force Academy. While at the Academy, he received the Surgeon General's award as the outstanding graduate in life sciences. He received his M.D. from Rush University Medical School and performed his residency in general surgery at David Grant Medical Center, Travis Air Force Base (AFB), California. At Nellis AFB, Nevada, he served as a general surgeon and later as Chief of General Surgery. At Misawa Air Base, Japan, General Kelley served as Chief of Hospital Services, Chief of Surgery, and interim Chief of Aerospace Medicine. He was reassigned as Commander of the 90th Strategic Hospital, Francis E. Warren AFB, Wyoming, and after his service there was selected as the Strategic Air Command's Outstanding Medical Leader. As Commander of the 857th Strategic Hospital, Minot AFB, North Dakota, General Kelley is the only individual to win the Strategic Air Command's Medical Leadership Award for a second time. He commanded the Ehrling Berquist Hospital at Offutt AFB, Nebraska, served as Chief of Medical Resources in the Office of the Surgeon General, and was Command Surgeon for Pacific Air Forces. As Commander of Wright-Patterson Medical Center, Wright Patterson AFB, Ohio, and Lead Agent, Department of Defense Health Region 5, he led a unit that received Defense Department awards for patient's satisfaction and access, as well as a Commander Installation Excellence Unit Award. Prior to assuming his current position, he was Assistant Surgeon General for Healthcare Operations, Office of the Surgeon General. General Kelly is certified by the American Board of Surgery.

Appendix B Authorizing Language and Charge to the Task Force

NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR OF 2007
109th Congress, Public Law 109-364

SEC 711 DEPARTMENT OF DEFENSE TASK FORCE ON THE FUTURE OF MILITARY HEALTH CARE

(a) REQUIREMENT TO ESTABLISH—The Secretary of Defense shall establish within the Department of Defense a task force to examine matters relating to the future of military health care

(b) COMPOSITION—

(1) MEMBERS—The task force shall consist of not more than 14 members appointed by the Secretary of Defense from among individuals described in paragraph (2) who have demonstrated expertise in the area of health care programs and costs

(2) RANGE OF MEMBERS —The individuals appointed to the task force shall include—

(A) at least one member of each of the Medical Departments of the Army, Navy, and Air Force,

(B) a number of persons from outside the Department of Defense equal to the total number of personnel from within the Department of Defense (whether members of the Armed Forces or civilian personnel) who are appointed to the task force

(C) persons who have experience in—

(i) health care actuarial forecasting,

(ii) health care program and budget development,

(iii) health care information technology,

(iv) health care performance measurement,

(v) health care quality improvement including evidence-based medicine, and

(vi) women's health,

(D) the senior medical advisor to the Chairman of the Joint Chiefs of Staff,

(E) the Director of Defense Procurement and Acquisition Policy in the Office of the Under Secretary of Defense for Acquisition, Technology, and Logistics,

(F) at least one member from the Defense Business Board,

(G) at least one representative from an organization that advocates on behalf of active duty and retired members of the Armed Forces who has experience in health care, and

(H) at least one member from the Institute of Medicine

(3) INDIVIDUALS APPOINTED OUTSIDE THE DEPARTMENT OF DEFENSE—

(A) Individuals appointed to the task force from outside the Department of Defense may include officers or employees of other departments or agencies of the Federal Government, officers or employees of State and local governments, or individuals from the private sector

(B) Individuals appointed to the task force from outside the Department of Defense shall include—

(i) an officer or employee of the Department of Veterans Affairs, and

(ii) an officer or employee of the Department of Health and Human Services

(4) DEADLINE FOR APPOINTMENT—All appointments of individuals to the task force shall be made not later than 90 days after the date of the enactment of this Act

(5) CO-CHAIRS OF TASK FORCE —There shall be two cochairs of the task force One of the co-chairs shall be designated by the Secretary of Defense at the time of appointment from among the Department of Defense personnel appointed to the task force The other co-chair shall be selected from among the members appointed from outside the Department of Defense by members so appointed

(c) ASSESSMENT AND RECOMMENDATIONS ON THE FUTURE OF MILITARY HEALTH CARE —

(1) IN GENERAL—Not later than 12 months after the date on which all members of the task force have been appointed the task force shall submit to the Secretary a report containing Reports containing an assessment of, and recommendations for, sustaining the military health care services being provided to members of the Armed Forces, retirees, and their families

(2) UTILIZATION OF OTHER EFFORTS—In preparing the report, the task force shall take into consideration the findings and recommendations included in the Healthcare for Military Retirees Task Group of the Defense Business Board, previous Government Accountability Office reports, studies and reviews by the Assistant Secretary of Defense for Health Affairs, and any other studies or research conducted by organizations regarding program and organizational improvements to the military health care system

(3) ELEMENTS—The assessment and recommendations (including recommendations for legislative or administrative action) shall include measures to address the following

(A) Wellness initiatives and disease management programs of the Department of Defense, including health risk tracking and the use of rewards for wellness

(B) Education programs focused on prevention awareness and patient-initiated health care

(C) The ability to account for the true and accurate cost of health care in the military health system

(D) Alternative health care initiatives to manage patient behavior and costs, including options and costs and benefits of a universal enrollment system for all TRICARE users

(E) The appropriate command and control structure within the Department of Defense and the Armed Forces to manage the military health system

(F) The adequacy of the military health care procurement system, including methods to streamline existing procurement activities

(G) The appropriate mix of military and civilian personnel to meet future readiness and high-quality health care service requirements

(H) The beneficiary and Government cost sharing structure required to sustain military health benefits over the long term

(I) Programs focused on managing the health care needs of Medicare-eligible military beneficiaries

(J) Efficient and cost effective contracts for health care support and staffing services, including performance-based requirements for health care provider reimbursement

(d) ADMINISTRATIVE MATTERS—

(1) COMPENSATION—Each member of the task force who is a member of the Armed Forces or a civilian officer or employee of the United States shall serve without compensation (other than compensation to which entitled as a member of the Armed Forces or an officer or employee of the United States, as the case may be) Other members of the task force shall be treated for purposes of section 3161 of title 5, United States Code, as having been appointed under subsection (b) of such section

(2) OVERSIGHT—The Under Secretary of Defense for Personnel and Readiness shall oversee the activities of the task force

(3) ADMINISTRATIVE SUPPORT—The Washington Headquarters Services of the Department of Defense shall provide the task force with personnel, facilities, and other administrative support as necessary for the performance of the duties of the task force

(4) ACCESS TO FACILITIES—The Under Secretary of Defense for Personnel and Readiness shall in coordination with the Secretaries of the military departments, ensure appropriate access by the task force to military installations and facilities for purposes of the discharge of the duties of the task force

(e) REPORTS—

(1) INTERIM REPORT—Not later than May 31 2007, the task force shall submit to the Secretary of Defense and the Committees on Armed Services of the Senate and the House of Representatives an interim report on the activities of the task force At a minimum, the report shall include interim findings and recommendations regarding subsection (c)(3)(H), particularly with regard to cost sharing under the pharmacy benefits program

(2) FINAL REPORT—

(A) The task force shall submit to the Secretary of Defense a final report on its activities under this section The report shall include—

(i) a description of the activities of the task force,

(ii) the assessment and recommendations required by subsection (c), and

(iii) such other matters relating to the activities of the task force that the task force considers appropriate

(B) Not later than 90 days after receipt of the report under subparagraph (A), the Secretary shall transmit the report to the Committees on Armed Services of the Senate and the House of Representatives The Secretary may include in the transmittal such comments on the report as the Secretary considers appropriate

(f) TERMINATION—The task force shall terminate 90 days after the date on which the final report of the task force is transmitted to Congress under subsection (e)(2)

Appendix C Preliminary Findings and Recommendations from the Task Force's Interim Report

DoD analysts project that DoD health care costs will rise from $38 billion in 2006 to $64 billion in 2015, which translates to an increasing proportion of the DoD Total obligation Authority from 8 percent to 12 percent The increase in DoD's health care obligations places significant challenges before the defense health system

In order to achieve even a modest reduction in the rate of growth, while preserving the generous benefit due to and earned by our Uniformed Service members and their families, DoD must pursue both the implementation of best business and management practices and the adjustment of financial incentives and cost shares

Based on its deliberations thus far, the Task Force offers the following preliminary findings and recommendations relative to DoD health care costs in general and to cost-sharing and the pharmacy program in particular These recommendations are designed to achieve greater efficiencies and cost savings while continuing to ensure quality health care and maintain readiness to provide health care services during war

Recommendations are offered in the following areas improving business and management practices, altering incentives in the pharmacy benefit, cost-sharing and realignment of fee structures, and ensuring that when applicable, TRICARE is the second payer

Improving Business and Management Practices

The Task Force has begun to examine best practices in the public and private health care sectors that produce efficiencies, including improved financial controls and procurement practices and heightened awareness and greater use of mail order pharmacy services These efficiencies will increase the cost-effectiveness of the military health care system

In undertaking changes in practice or policy, pilot studies and/or demonstration projects should be used to assess the feasibility and cost-effectiveness of new ideas These studies and projects can be accomplished more quickly than systemic changes that probably will require statutory changes

1 Review the DoD Pharmacy Contract Process

Findings

Current practices in the DoD pharmacy procurement process appear to pose obstacles to negotiating both best price and best use Additionally, some have interpreted legal provisions governing beneficiary contact as prohibiting multiple targeted programs to increase home delivery that have been used successfully in the private sector The last iteration of TRICARE Contracts (T-Nex) promoted a contract environment that focused on outcomes and best business practices The Task Force heard from several current TRICARE contractors who spoke of their inability to implement their best business practices because of government regulations and/or strict interpretation of requirements

Recommendation

1 1 DoD should review its pharmacy acquisition strategies to determine if changes can be made to effect greater reductions in the cost of drugs and to foster improvements in effective utilization In doing so, DoD should consider pursuing policy, regulatory, and/or statutory changes that would allow for alternative commercial best practices to be implemented when in the best interests of the government

2 Conduct Eligibility Audits

Findings

Audits of typical civilian health care plans have found that a substantial portion of payments are made for patients who are not eligible for care While the percentage of erroneous payments may be small, the savings can be large, given the amount of expenditures The Task Force did not see any evidence of extensive eligibility audits conducted by DoD or analyses of the accuracy of the Defense Enrollment Eligibility Reporting System (DEERS) personnel system in determining eligibility

Recommendations

2 1 An independent audit of TRICARE is necessary to determine the adequacy of control measures that ensure that only those who are eligible are receiving care

2 2 An audit of DEERS accuracy is needed beyond simply verifying ID cards at the point of service for care

Altering Incentives in the Pharmacy Benefit

The Task Force was briefed on best practices in the public and private sectors to control prescription drug costs, including the provision of incentives to increase generic prescription use and the use of mail order pharmacy services The Task Force developed the following recommendations to lower future spending over what otherwise would have occurred

3 Promote Mail Order and the Use of Generics

Findings

Pharmacy services, including prescriptions filled at Military Treatment Facilities (MTFs) and outside of them, cost the DoD health care system $6 18 billion in 2006 and costs are expected to reach $15 billion by 2015, based on current trends The Task Force heard convincing arguments that private sector plans have been able to reduce the growth in pharmacy costs while retaining clinical effectiveness by providing beneficiaries with greater incentives to utilize preferred drugs and fill maintenance prescriptions using mail order services Generic drugs have the lowest copayment, followed by formulary drugs and nonformulary drugs However, current DoD pharmacy copayment policies do not provide adequate incentives for patients to use the most cost-effective alternatives, such as the mail order pharmacy or an MTF Employing financial incentives to encourage the use of the mail order pharmacy across all beneficiary groups should decrease retail pharmacy costs while preserving access to the local pharmacy

Recommendations

3.1 Copayments for prescriptions filled outside an MTF should be changed in order to alter incentives. DoD should increase the differentials in copayments to increase the use of more cost-effective practices. In its final report, the Task Force will make more specific recommendations about payment structure.

3.2 DoD should engage in an outreach program to publicize the value of using the TRICARE Mail Order Pharmacy (TMOP) program and generic drugs, utilizing the best practices followed by private companies in order to achieve savings.

Cost-Sharing and Realignment of Fee Structures

In recognition of the years of demanding service that military retirees have provided to the Nation, the Task Force believes that military retirees should receive health care benefits that are generous compared with U.S. public and private plans. Congress also has recognized this contribution. Much of the increase in the cost of DoD health care is attributed to explicit benefit expansion. Between 2000 and 2007, benefit expansion accounted for 64 percent of the increase in cost—57 percent for over-65 care and 7 percent for under-65 care.[1] However, when benefits have been expanded, it is not clear whether such expansions were implemented with an assessment of the impact that they would have on future costs or whether they were based on projections of the need for cost-sharing.

The Task Force believes that cost-sharing policies must be set in such a way that they are fair to America's taxpayers by ensuring the judicious use of scarce federal resources. The cost-sharing structure between the beneficiary and the government for health care services provided by the Military Health System (MHS) has remained unchanged, despite rapidly rising costs. Beneficiaries under the MHS incur far lower out-of-pocket costs than do their counterparts in the civilian sector for comparable care.

4. Increase the Share of Costs Borne by Beneficiaries

Findings

According to DoD, since 1996, military health care premiums paid by individual military retirees under age 65 utilizing DoD's most popular plan (TRICARE Prime) have fallen from 11 to 4 percent when measured as a percentage of total health care costs.[2] By comparison, premiums for employer-provided plans in the civilian sector decreased slightly, from 28 percent in 1996 to 25 percent in 2006.[3] Federal civilian retirees pay out-of-pocket costs of about 25 percent of total costs in the Federal Employees Health Benefit Plan (FEHBP).[4]

Trends in out-of-pockets costs (which include premiums/enrollment fees, deductibles, and copayments) suggest the same pattern. Total out-of-pocket costs have risen much more slowly for military retirees than for civilian retirees. Specifically, for military retirees under 65 who are enrolled in TRICARE Prime, out-of-pocket costs rose 2.6 percent from 2003 to 2005, while out-of-pocket costs in civilian HMOs have risen 21.2 percent for the same period (TRICARE 2003: $727, 2005: $746—HMO 2003: $3,036, 2005: $3,681).[5]

1 John Kokulis, Special Assistant to the Assistant Secretary of Defense, Health Affairs, and Former Deputy Assistant Secretary of Defense, Health Affairs, Office of the Secretary of Defense, Sustaining the Military Health Benefit, Brief to the Task Force, January 6, 2007.
2 The Military Compensation System: Completing the Transition to an All-Volunteer Force, Report of the Defense Advisory Committee on Military Compensation, April 2006, p. 79.
3 Ibid.
4 FEHBP law, P.L. 105-33, approved August 5, 1997.
5 Evaluation of the TRICARE Program, The Health Program Analysis and Evaluation Directorate, TRICARE Management Activity in the Office of the Assistant Secretary of Defense (Health Affairs), March 2006, p. 89.

A revised cost-sharing system would shift some costs, but more importantly, it could provide incentives for beneficiaries to change their behavior in ways that would slow the rate of cost growth. For example, revisions in cost-sharing may cause fewer retirees to drop private coverage in favor of TRICARE, and such revisions may foster more individual responsibility for wellness and preventive care.

Recommendations

4.1 The portion of costs borne by beneficiaries should be increased to a level below that of the current FEHBP or that of generous private-sector plans and should be set at or below the level in effect in 1996. In its final report, the Task Force will recommend specific cost-sharing proposals and an accompanying set of enrollment fees and copayment levels.

4.2 Increases in cost-sharing should be phased in over three to five years to avoid precipitous changes. If Congress believes that increases in cost-sharing are too large relative to the amounts of retired pay, it should consider a one-time increase in military retired pay to offset part or all of the increase.

5. Index Premiums and Deductibles

Findings

The Task Force notes that increases in medical inflation have, for some years, outpaced growth in overall inflation as measured by the Consumer Price Index. Even if Congress phases in an adjustment in cost-sharing for military retirees, as recommended above, the share gradually will fall unless actions are taken to index the costs borne by retirees.

Recommendations

5.1 There should be an annual indexing of the premiums and deductibles paid by under-65 military retirees. In its final report, the Task Force will recommend a specific approach to indexing. In addition, periodic adjustment should be made to the catastrophic cap. These adjustments should avoid either frequent changes or increases that over time are excessively large.

5.2 Recommendation 5.1 will cause out-of-pocket costs for individual military retirees to rise more rapidly than their retired pay (which is increased annually based on the Consumer Price Index). All Americans face out-of-pocket health care costs that are rising faster than overall inflation. If Congress believes that retirees should not bear all of these added costs, it should periodically legislate special increases in retired pay to make up for some or all of the increases in the portion of retiree health care costs borne by individuals.

5.3 DoD should increase premiums and cost-sharing for under-65 military retirees so that the cost differential between TRICARE and private plans is smaller than it is currently. Premiums and deductibles should be indexed for increases on an annual basis according to an appropriate and widely acceptable index. The Task Force has not yet had time to consider options for increasing or maintaining the use of private coverage. In its final report, it will explore a variety of potential strategies, for example:

- providing a stipend to employers to encourage a higher rate of use by employees who are eligible for TRICARE,
- providing a stipend to a health savings account to those who choose not to participate in TRICARE, and

- offering some form of supplemental coverage to under-65 retirees who retain their private health insurance and do not use TRICARE. This "TRIGAP" insurance would increase the incentive for retirees to maintain their private health care insurance. The coverage would be analogous to Medigap insurance and would be financed by DoD.

6. Tier the Payment Structure

Findings

All military retirees, under age 65 or not otherwise Medicare-eligible, regardless of rank or retired compensation, pay the same individual or family enrollment fees. DoD has recommended that enrollment fees and deductibles vary in size based on an individual's pay grade at retirement, with higher-grade retirees paying larger amounts.

Recommendation

6.1 Enrollment fees, deductibles, and copayments should be tailored to different circumstances, such as retired pay grade. However, further study is needed before proposing specific recommendations for variances in the beneficiary share of costs. In its final report, the Task Force will provide more specific recommendations.

Ensuring That TRICARE Is a Second Payer

7. Audit Compliance with TRICARE Law and Policy

Findings

Although, under law, TRICARE is intended to be a second-payer system, insufficient data are available to conclude that it in fact is the second payer in all cases. In addition, the National Defense Authorization Act of Fiscal Year 2001 expanded TRICARE benefits for eligible beneficiaries who are 65 and older and enrolled in Medicare Part B. Under TRICARE for Life, TRICARE becomes the second payer to Medicare for medical care that is a benefit under both Medicare and TRICARE.

The relatively small portion of TRICARE costs borne by individual retirees encourages retirees with access to private sector plans to drop their private coverage and rely on TRICARE as their primary plan. DoD estimates that approximately 72 percent of retirees under age 65 are working and have access to private sector health insurance.[6] "Among those with access to an employer health plan, 35 percent paid to enroll in TRICARE Prime and 62 percent sought care through some TRICARE option."[7] Thus, nearly two-thirds seek care through some type of TRICARE benefit.

Recommendation

7.1 DoD should commission an independent audit to determine the level of compliance with law and policy regarding TRICARE as second payer.

6 *The Military Compensation System: Completing the Transition to an All Volunteer Force. Report of the Defense Advisory Committee on Military Compensation, April 2006, p. 78.*
7 *Ibid.*

Issues for Future Consideration

In the course of its deliberations, the Task Force identified several other issues relevant to cost sharing and potential improved efficiencies in the MHS, including

- recent proposals to reorganize military health care and increase the sharing of common services across DoD,
- strategies for modifying the pharmacy acquisition process to achieve greater savings and improved utilization, and
- the effects of the transition of the Guard and Reserve from a strategic force to an operational force—specifically the effects of mobilizations and demobilizations on beneficiaries as they access the healthcare system and on DoD healthcare costs

In addition to refining its analyses of the issues presented in this report, the Task Force will further explore these topics as well as assess and make recommendations pertaining to the elements listed in its charge.

Appendix D Meetings and Presentations

January 16, 2007
Arlington, Virginia

Allen Middleton, Acting Deputy Assistant Secretary of Defense for Health Affairs and Acting Chief Financial Officer, TRICARE Management Activity Overview of Military Health Care System and Defense Health Program

John T Kokulis Special Assistant to the Assistant Secretary of Defense for Health Affairs Sustaining the Benefit

Dr William Winkenwerder, Assistant Secretary of Defense for Health Affairs Comments

Dr David Chu, Under Secretary of Defense for Personnel and Readiness Comments

February 6, 2007
Washington, D C

Major General Robert Smith, U S Army Reserve (Ret), Task Force Member Presentation *Back Brief on Meeting with Advocacy Groups*

Jean Storck, Chief, Health Plan Operations, TRICARE Management Activity, Office of the Assistant Secretary of Defense for Health Affairs Presentation *TRICARE Contracts Overview*

Rear Admiral Thomas J McGinnis, U S Public Health Service, Chief, Pharmaceutical Operations Directorate, TRICARE Management Activity Office of the Assistant Secretary of Defense for Health Affairs Presentation *Overview of the DoD Pharmacy Program*

Captain Patricia Buss, Medical Corps, U S Navy, Chair, DoD Pharmacy and Therapeutics Committee Presentation *Overview of the DoD Pharmacy Program*

February 20, 2007
Washington, D C

Lieutenant General Kevin C Kiley, Surgeon General, U S Army and Commanding General, Army Medical Command Presentation *Army Surgeon General Brief*

Vice Admiral Donald Arthur, Surgeon General, U S Navy and Chief, Navy Bureau of Medicine and Surgery Presentation *Navy Medicine*

Major General C Bruce Green Deputy Surgeon General, U S Air Force Presentation *Air Force Medical Service 2007*

Major General Joseph Kelley Joint Staff Surgeon, the Joint Staff Presentation *Joint Staff Surgeon Briefing*

March 7, 2007
Washington, D C

Joseph L Barnes National Executive Secretary, Fleet Reserve Association and Co-Chairman, the Military Coalition Submitted written statement for the record

Colonel Steven Strobridge, United States Air Force (Ret) Director, Government Relations, Military Officers Association of America (MOAA), and Co Chairman, the Military Coalition Submitted written statement for the record

Joyce Raezer, Chief Operating Officer, National Military Family Association, presented on behalf of the National Military Family Association Submitted written statement for the record

Deirdre Parke Hollomon, Legislative Director, the Retired Enlisted Association, presented on behalf of the Retired Enlisted Association Submitted written statement for the record

Rick Jones, Legislative Director, National Association for Uniformed Services, presented on behalf of the National Association for the Uniformed Services Submitted written statement for the record

Captain Michael Smith, U S Navy Reserve (Ret), National President, Reserve Officers Association of the United States, presented on behalf of the Reserve Officers Association Submitted written statement for the record

Michael H Wysong, Director, National Security and Foreign Affairs, Veterans of Foreign Wars of the United States Written Statement for the record

D Michael Duggan, Deputy Director, National Security Commission, the American Legion Written Statement for the record

The Naval Reserve Association Written Statement for the record

Mary Ann Wagner, Registered Pharmacist, Senior Vice President Policy and Pharmacy Regulatory Affairs National Association of Chain Drug Stores (NACDS) Presentation *National Association of Chain Drug Stores*

Julie Khani, Vice President, Federal Health Programs, NACDS Presentation *National Association of Chain Drug Stores*

Debbie Garza, Registered Pharmacist, Director, Government and Community Relations, Walgreen Company Presentation *National Association of Chain Drug Stores*

Jeannie Rivet, Executive Vice President, UnitedHealth Group Presentation *Trends and Value-Driven Health Care*

March 28, 2007
Washington, D C

Steve D Tough, President, Health Net Federal Services Presentation *Health Net*

David J Baker, President and Chief Executive Officer, Humana Military Healthcare Services (HMHS) Presentation *Humana*

David J McIntyre, Jr , President and Chief Executive Officer, TriWest Healthcare Alliance Presentation *TriWest*

April 9, 2007
San Antonio, Texas

Town Hall Meeting—Open to Public, Sam Houston Club, Fort Sam Houston

April 10, 2007
San Antonio, Texas

Spouse Panel

Diane Rohrbough, U S Air Force (spouse was in the Medical Service Corps)
Elizabeth Radke, U S Navy Veteran (spouse is Active Duty Marine)
Kathy Shaffer, U S Air Force (spouse of retired Brigadier General)
Elizabeth Medley, U S Air Force, (spouse of U S Air Force physician)

Enlisted Panel

Sergeant Emily Little, U S Army
Sergeant First Class Santos Alonzo, U S Army
Senior Master Sergeant Douglas Onwiler, U S Air Force
Staff Sergeant Marilyn Clayton, U S Air Force
Master at Arms 1st Class Linda Coakely, U S Navy
Sergeant Chad Rozanski, U S Army

Guard and Reserve Panel

Lieutenant Colonel Grant Olbrich, U S Marine Corps
Sergeant First Class Santos Lopez, U S Army
Hospital Corpsman 2nd Class Gary Ard, U S Navy
Aviation Machinist's Mate 2nd Class Eric Mickett, U S Navy
Master Sergeant David Smith, 149 FW (ANG) U S Air Force
Major Mark Goldstein, U S Air Force Reserve

Officer Panel

Captain Jerome Smith, U S Army, Signal Corps
First Lieutenant Sean Thomas, U S Army
Lieutenant Suzanne J Wood, U S Navy
Captain Regina O Samuel, U S Air Force
Major Robb J Passinault, U S Air Force
Lieutenant Commander Joseph P Lawrence, U S Navy, DoD Pharmacoeconomic Center

Retired Panel

Major General Herbert Emmuel, U S Air Force (Ret), former Executive Vice President of USAA (United Services Automobile Association)

Colonel Homer Lear, U S Air Force (Ret), Texas Silver Haired Legislature

Major General Thomas P Ball Jr , M D , U S Air Force (Ret) Currently, Chief of Urology and Director of Residency Program University of Texas Health Science Center

Brigadier General Patrick O Adams U S Air Force (Ret) Currently, Vice President, Human Capital Solutions

Major General Harold Timboe, M D , U S Army (Ret) Currently, Associate Vice President for Research, University of Texas Health Science Center

April 18, 2007
Washington, D C

David M Walker, Comptroller General of the United States, Government Accountability Office (GAO) Presentation *DoD's 21st Century Health Care Spending Challenges*

Kenneth O Klepper, President and Chief Operating Officer, Medco Health Solutions, Inc Presentation *Medco*

Jeffrey L May, Senior Vice President, Drug Distribution and Control, Medco Health Solutions, Inc Presentation *Medco*

Lorraine Lewis, Executive Director, United Mine Workers of America, Health and Retirement Funds Presentation *Outreach Programs Generics, Mail Order and other Healthcare Services*

Dr Joel Kavet, Director, Managed Care Program Development and Research, United Mine Workers of America Health and Retirement Funds Presentation *Outreach Programs Generics, Mail Order and other Healthcare Services*

William Chisholm, Director of Operations United Mine Workers of America Health and Retirement Funds Presentation *Outreach Programs Generics, Mail Order and other Healthcare Services*

Joan Hunter Veal, Senior Manager, Pharmacy Programs, United Mine Workers of America Health and Retirement Funds Presentation *Outreach Programs Generics, Mail Order and other Healthcare Services*

Dr Peter B Collins, Medical Director, United Mine Workers of America Health and Retirement Funds Presentation *Outreach Programs Generics, Mail Order and other Healthcare Services*

Nancy Gilbride, Vice President and General Manager TRICARE Pharmacy Division, Express Scripts Presentation *Express Scripts*

Dr Steven B Miller, Chief Medical Officer, Express Scripts, Inc and CuraScript Presentation *Express Scripts*

April 25, 2007
Washington D C

Christopher Singer Executive Vice President and Chief Operating Officer PhRMA (Pharmaceutical Research and Manufacturers of America) Presentation *PhRMA*

Richard Smith, Senior Vice President Policy Research and Strategic Planning, PhRMA Presentation *PhRMA*

Ann Leopold Kaplan, Assistant General Counsel PhRMA Presentation *PhRMA*

Edward L Allen, Vice President, Coalition for Government Procurement Presentation *The Coalition for Government Procurement*

Donna Yesner, Esq , Partner, McKenna, Long, and Aldridge, LLC Presentation *The Coalition for Government Procurement*

May 22, 2007
Washington, D C

Marshall K Bolyard Executive Director of the US Family Health Plan for CHRISTUS Health Presentation *US Family Health Plan*

Linda Dunbar PhD, Vice President of Care Management, Johns Hopkins HealthCare, LLC Presentation *US Family Health Plan*

Robert E Stone, Executive Vice President and Chief Strategy Officer of Healthways Presentation *Healthway—Task Force on the Future of Military Health Care*

James Pope, MD, Executive Vice President and Chief Operating Officer of Healthways Presentation *Healthways—Task Force on the Future of Military Health Care*

Dexter Shurney, MD, Senior Vice President and Chief Medical Officer of Healthways Presentation *Healthways—Task Force on the Future of Military Health Care*

Aslam (Ozzie) Kahn, MD, Senior National Medical Officer of CIGNA HealthCare Presentation *DoD Presentation*

Jean Rush, President of CIGNA Government Services, a subsidiary of CIGNA HealthCare Presentation *DoD Presentation*

Ellen C Bonner, Vice President and Senior Counsel of CIGNA Government Services Presentation *DoD Presentation*

July 11, 2007
Washington, D C

Colonel Paul R Cordts Medical Corps U S Army, Director Health Policy and Services, Office of the Surgeon General, U S Army Presentation *Army Medical Department Changes to Improve Healthcare Outcomes*

Jack W Smith, MD, MMM, Acting Deputy Assistant Secretary of Defense for Health Affairs Clinical and Program Policy Chief Medical Officer, TRICARE Management Activity Presentation *Military Health System Disease Management and Campaign for Healthy Lifestyles*

Lieutenant Colonel William G Meyer, Medical Corps, U S Air Force, Deputy Chief, Preventive Medicine Operational Prevention Division, Air Force Medical Support Agency, Office of the Air Force Surgeon General Presentation *Air Force Wellness and Disease Management Initiatives*

Captain Neal A Naito, Medical Corps, U S Navy, Director of Public Health, Bureau of Medicine and Surgery Presentation *Navy Wellness and Disease Management Programs and Initiatives*

July 25, 2007
Washington, D C

Jerin Storck, Chief Health Plan Operations, TRICARE Management Activity, Office of the Assistant Secretary of Defense for Health Affairs Presentation *Future of Military Health Care Hearing TRICARE Management Activity*

Michael W O'Bar Director, Benefits Division, TRICARE Management Activity Presentation *Quadrennial Defense Review Roadmap for Medical Transformation Initiatives*

William (Bill) H Howell Principal Assistant, Acquisition, U S Army Medical Research & Material Command, U S Army Presentation *Brief to the Task Force on the Future of Military Health Care*

Colonel Earle Smith II, U S Army, Commander and Principal Assistant for Contracting, Health Care Acquisition Activity, U S Army Medical Command Presentation *U S Army Medical Command Health Care Acquisition Activity – Briefing for the Task Force on the Future of Military Health Care*

Eugene J Smith, Attorney-Advisor Office of the Staff Judge Advocate U S Army Medical Command Presentation *Brief to the Task Force on the Future of Military Health Care*

Andrew C Muenzfeld, Director, Healthcare Services Support, Naval Medical Logistics Command, U S Navy Presentation *Brief to the Task Force on the Future of Military Health Care*

Terry L Horst, Director of Acquisition Management, Head of Tri-Service DoD Drug Testing Program, Naval Medical Logistics Command, U S Navy Presentation *Briefing for the Task Force on the Future of Military Health Care*

Lieutenant Colonel Joseph B Murrow, Medical Service Corps, U S Air Force, Director, U S Air Force Medical Service Commodity Council Presentation *Air Force Medical Service Commodity Council*

September 5, 2007
Washington, D C

Susan D Hosek, Senior Economist, Co-Director of the Center for Military Health Policy Research, the RAND Corporation Presentation *Reorganizing the Military Health System Should There Be a Joint Command?*

Eric W Christensen, PhD, Senior Project Director Center for Naval Analyses Presentation *Cost Implications of a Unified Medical Command*

Stephen L Jones, DHA Principal Deputy Assistant Secretary of Defense for Health Affairs Presentation *Status Update for the Task Force on the Future of Military Health Care*

Michael P Dinneen, MD, PhD, Director, Office of Strategy Management for the Military Health System Presentation *Status Update for the Task Force on the Future of Military Health Care*

Major General Melissa A Rank, Nurse Corps, U S Air Force, Assistant Air Force Surgeon General, Medical Force Development, and Assistant Air Force Surgeon General, Nursing Services, Office of the Surgeon General, U S Air Force Presentation *Medical Education and Training Campus*

Colonel Donald A Gagliano, Medical Corps, U S Army, Chairman, Executive Integrated Process Team Presentation *Medical Education and Training Campus*

Colonel Suzanne Cuda, Medical Corps, U S Army, Co-Director, San Antonio Medical BRAC Integration Office Presentation *National Capital Region BRAC and Integration*

Colonel Charles (Chuck) Hardin, Medical Corps, U S Air Force, Co-Director, San Antonio Medical BRAC Integration Office Presentation *National Capital Region BRAC and Integration*

Captain Dave S Wade, Medical Corps, U S Navy, Chief of Staff, National Capital Area Multi-Service Market Office Presentation *National Capital Region BRAC and Integration*

September 19, 2007
Norfolk, Virginia

Guard and Reserve Panel

Lieutenant William (Will) Brooks, U S Navy Reserve

Second Lieutenant Seth Benge, Army National Guard, Pennsylvania

Sergeant Major John Davis, U S Air Force Reserve

Technical Sergeant Mike Harris, U S Air Force Reserve

Staff Sergeant Richard Davidson, Army National Guard, Virginia

Specialist Amanda Kendrick, Army National Guard, Virginia

Spouse Panel

Faith Baker, U S Air Force Spouse

Barbara Chronister, U S Air Force Spouse

Jessie Hight, U S Air Force Spouse

Jennifer Mancini, U S Navy Spouse

Dauphne McFarland, U S Navy Spouse

Lisa Schuler, U S Air Force Spouse

Linda Slater, U S Air Force Spouse

Network Providers Panel

Dr Joseph Hollis, Sole Practitioner, Portsmouth Gastroenterology

Dr Donald Lewis, Children's Health Systems

Dr Harold Markham, Patient First

Dr David Norris, General Booth Pediatrics

Dr David Pariser Pariser Dermatology

Dr Lynn Utech, Atlantic Dermatology

Under 65 Retirees Panel

Lieutenant Colonel Bernard Robinson, U S Army (Ret)
Senior Chief Petty Officer Ray Santee, U S Navy (Ret)
Chief Petty Officer Cindy Hefty U S Navy (Ret)
Sergeant First Class Jaz Thompson, U S Army (Ret)

Lunch Panel 1

Major George Goodwin, U S Air Force
Lieutenant Dan High, U S Navy
Captain Stacy Hill, U S Army
Staff Sergeant Francesca Curry, U S Army
Staff Sergeant Kristin Hofman, U S Air Force
Hospital Corpsman Second Class Kevin Gordon, U S Navy

Lunch Panel 2

Captain Joel Roos, U S Navy
Major Keith Anderson, U S Army
Lieutenant Commander Bryan Mack, U S Navy
Captain Charles Hayes, U S Army
Hospital Corpsman Second Class Joli Barden, U S Navy
Staff Sergeant Raul Flores, U S Air Force

Lunch Panel 3

Lieutenant Steven Strockon, U S Navy
Master Sergeant Cindy Gappert, U S Air Force
Staff Sergeant Clinton Carter, U S Air Force
Staff Sergeant Dequan Jones, U S Army
Hospital Corpsman Second Class Manuel Olivares, U S Navy
Hospital Corpsman James Boyd U S Navy

Lunch Panel 4

Major Aaron Kondor, U S Air Force
Captain John Davis, U S Air Force
Technical Sergeant Eric McCoy, U S Air Force
Sergeant Alicia Johnson, U S Army
Specialist Nicole Gilbert, U S Army

October 3, 2007
Washington D C

Town Hall Meeting

Frank A Camm, Jr, PhD, Senior Economist, RAND National Defense Research Institute Presentation *Thinking Strategically About Military-to-Civilian Conversions*

Jerry E Pannullo, Director, Economic and Manpower Analysis Division, Program Analysis & Evaluation Directorate, Office of the Secretary of Defense Presentation *Military Readiness Review Process*

Richard A Robbins, Head Requirements and Programming & Budgeting Division Office of the Undersecretary of Defense (Personnel & Readiness) Presentation *Military Readiness Review Process*

Maurice Yaglom, Chief, Manpower Programming Division, Office of the Surgeon General, Headquarters, Department of the Army Presentation *Determining the Optimal Manpower Mix to Meet the Army's Health Care Mission*

Rear Admiral Michael H Mittelman, Medical Service Corps, U S Navy Director, Medical Service Corps, Director, Medical Resources, Plans and Policy Division, Office of the Chief of Naval Operations Presentation *Determining the Appropriate Manpower Mix within Navy Medicine*

Colonel Dennis I Beatty, Medical Service Corps, U S Air Force Chief, Medical Programming Division, Office of the Air Force Surgeon General Presentation *Air Force Medical Service Personnel Requirements Program*

Richard J Migliori, MD, Executive Vice President, Business Initiatives and Clinical Affairs Commercial Services Group, UnitedHealth Group Presentation *Healthcare Transformation for An Older America—Creating Continuity in a Fragmented Healthcare Environment*

Steve Lillie, Deputy Chief, TRICARE Operations, TRICARE Management Activity Presentation *TRICARE for Life*

Robert (Bob) J Moss Jr, Deputy Director, Management Control and Financial Studies Division, Office of the Chief Financial Officer, TRICARE Management Activity Presentation *TRICARE for Life*

Appendix E Recommendations of Previous Review Groups

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING	PAGE
Defense Business Board	Report FY04-4	Report to Secretary of Defense: Health Care for Military Retirees	Dec 04	Managing Pharmacy costs: driving greater level toward generics and disease management driven formularies are key to savings	A–8
Defense Business Board	Report FY04-1	Report to Secretary of Defense: Healthcare for Military Retirees	Dec 04	Index existing client participation, industry deductibles, copayments and premiums	A-11, B-11
Defense Business Board	Report FY04-4	Report to Secretary of Defense: Healthcare for Military Retiree	Dec 04	Enhance dialogue between VA and the Military Health System (MHS) to achieve scale economies/market power for the Pharmacy benefits	A–13
Defense Business Board	Report FY04-4	Report to Secretary of Defense: Healthcare for Military Retiree	Dec 04	Managing Pharmacy costs: IT systems based on physician for delivery of care plan incentives are designed to drive patients towards OTC, mail, lower cost and disease management driven formularies	B–7
Defense Business Board	Report FY04-4	Report to Secretary of Defense: Healthcare for Military Retirees	Dec 04	Provide individuals with easy to use/understand comprehensive health information to optimize medical visits and encourage use of generic pharmaceuticals toward decreasing provider and fulfillment costs	B–11
GAO	GAO-04-[illegible]	Mail Order Pharmacy: DoD's Use of VA's Mail Pharmacy Could Produce Savings and Other Benefits	June 04	DoD could achieve savings if it used VA's centralized Mail Outpatient Pharmacy (CMOP) program to dispense refill prescriptions by taking advantage of VA's generally lower drug prices	3
RAND	RB9084	Pharmacy Benefits for Military Retirees: Controlling Costs Without Compromising Health	2005	The majority of pharmaceutical costs are incurred in retail drugs obtained at retail pharmacies because the cost of those drugs is DoD is higher than the cost of the same drugs dispensed from a Military Treatment Facility (MTF) or mail order pharmacy. Thus, DoD cost could decrease if retiree shifted from retail pharmacies to military pharmacies or the TRICARE Mail Order Pharmacy (TMOP) program	2
RAND	RB9084	Pharmacy Benefits for Military Retirees: Controlling Costs Without Compromising Health	2005	Analysis of health insurance data from large private employers shows that implementing a three-tier drug benefit in the military health system could reduce the rate of increase in spending on pharmaceuticals	2
RAND	RB9084	Pharmacy Benefits for Military Retirees: Controlling Costs Without Compromising Health	2005	To achieve the significant cost savings suggested in this study, DoD should not adversely affect the health status of beneficiaries. DoD should carefully consider the drugs and drug classes that it places in the more costly third tier	2

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING	PAGE
GAO	GAO-02-969T	VA AND DoD HEALTH CARE: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges	July 22, 2002	We identified four factors that have contributed to VA and DoD's success in reducing pharmacy costs: • Formularies that include cost-effective drugs • Different types of purchasing arrangements that secure lower prices • Mail order dispensing for refill prescriptions • Joint purchasing of prescription drugs to leverage purchasing power	9
GAO	GAO-02-969T	VA AND DoD HEALTH CARE: Factors Contributing to Reduced Pharmacy Costs and Continuing Challenges	July 22, 2002	A third DoD facility contributing challenge pharmacy cost reduction efforts is the unabated use of these facilities to increase joint purchasing of brand name drugs which account for most pharmacy costs. To do so, the two departments need to address how differences in their respective patient populations, national formularies, and practice patterns among prescribers, some of whom are private physicians, can be managed to facilitate joint purchasing. Effectively coming to grips with these challenges is critical to both VA and DoD to maintain a control of their overall health care budgets.	10
GAO	GAO-06-904T	INFORMATION TECHNOLOGY: VA and DoD Face Challenges in Completing Key Efforts	June 22, 2006	VA and DoD are implementing three near-term demonstration projects and, they are making progress toward their long-term effort to share electronic patient health data. The two demonstration projects that have been implemented include elements that provided significant benefits to both departments because they enable lower costs and improved service to both, in part by saving time and avoiding error. • Bidirectional Health Information Exchange, implemented at 10 sites, allows the two-way exchange of health information, sharing documents in text format and including patient pharmacy data, allergy and food allergy information, particulars on applicable administrative forms, and laboratory results.	xvii-xix
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	To achieve savings without adverse health consequences, the orders in a particular class should be equally substitutable and thus distinguishable primarily on the basis of price.	xviii-xix
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer-Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	The role of administrative restrictions and other financial incentives, such as those that the Department of Defense (DoD) will also implement, is a major source of savings.	xviii-xix

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING	PAGE
RAND	MG-151-OSD	Pharmacy Use and Costs in Employer Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	The transition to the new program raises another important issue. The principal concern here regards the potential for adverse health effects when patients switch from an effective medication to a medication they have not used in the past. To achieve the significant cost savings suggested in this study, and to avoid adversely impacting health, the DoD Pharmacy & Therapeutics Committee should carefully consider the drugs and drug classes that it places in the nonpreferred third tier. The most heavily scrutinized drugs should be those in the costliest therapeutic classes, which account for a disproportionate share of expenditures.	xvii–xix
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	Recent growth in pharmacy spending has been largely due to the increased number of prescription drugs dispensed, rather than to price increases. In this trend, continuous changes in benefit structures are likely to play a lesser role in reducing the level of drug spend relative than in slowing the growth in expenditures.	xvii–xix
RAND	MG-154-OSD	Pharmacy Use and Costs in Employer Provided Health Plans: Insights for TRICARE Benefit Design from the Private Sector	2005	TRICARE Management Activity (TMA) policy takers must also consider the critical question of whether lower pharmaceutical use results in higher patient costs, slowing recovery, affected clinical outcomes, and overall increased spending. Several previous studies, supported by control, suggest that the effects of prescribing drug cost containment policies are mostly benign. One study found that adding third-tier co-pay drugs reduced the probability of prescription use, but another study found no effect. Another study found that adding third-tier co-pay drugs reduced the probability of prescription use, but another study found no effect. Another study found that adding third-tier co-pay drugs reduced the probability of prescription use, but another study found no effect.	xviii–xix
RAND	MG-257-OSD	Determinants of Dispensing Location in the TRICARE Senior Pharmacy Program	2005	1) Although the majority of TRICARE Senior Pharmacy (TSRx) program prescriptions in FY02 were dispensed from MTF pharmacies, the majority of associated ingredient costs were attributable to drugs dispensed from retail pharmacies. 2) Estimated ingredient cost savings could be reduced if dispensing shifted from retail pharmacies to dispensing locations where federal pricing is the basis of DoD's ingredient cost. 3) Geographic proximity to MTFs was strongly associated with TSRx use and utilization patterns. 4) Within two major therapeutic classes, antihypertensives and gastrointestinals, the availability of a drug at an MTF was associated with increased use of the MTF and reduced use of retail pharmacies to fill other prescriptions.	xiv–xv
PUMA Systems, Inc		Evaluation of Pharmacy Resource Allocation Evaluating Best Business Practices and Commercial Technologies to Improve Delivery of Pharmaceutical Care in the Military Health System	Aug 16 2000	The recommendations are in order of importance: 1) Consolidate MTF Refills a Regional Refill Centers. 2) Implement the Pharmaceutical Care Practice Model at Each MTF. 3) Develop DoD Guidelines and Criteria for Procurement of Automated Systems. 4) Study the Feasibility of a Joint Pharmacy Staffing Model. 5) Develop a New Approach to Adequately Fund DoD Pharmacy Operations. 6) Explore Pharmacy Outsourcing and Contracting Opportunities.	v–vii

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING	PAGE
GAO	GAO 08 122	Defense Health Care DoD Needs to Address the Expected Benefits Costs and Risks for Its Newly Approved Medical Command Structure	Oct 07	We recommend that DoD address the expected benefits, costs, and risks for implementing the four-option and provide Congress the results of its assessment	5
GAO	GAO 08 172R	DOD Pharmacy Benefits Program Reduced Pharmacy Costs Resulting from the Uniform Formulary and Manufacturer Rebates	Oct 07	DOD summary data show that through its uniform formulary DOD avoided about $447 million in drug costs in fiscal year 2006 and estimates that it would avoid about $900 million in drug costs in fiscal year 2007. As of fiscal year 2007 DOD has collected about $28 million in voluntary manufacturer rebates on drugs dispensed at retail pharmacies since the program began in 2006. DOD expects to collect at least $120 million in fiscal year 2008 through voluntary rebates	Summary
GAO	GAO 07 12 51	DOD and VA Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers	Sep 07	The A[illegible] has taken steps to streamline its disability evaluation process and reduce bottlenecks and developed and conducted the first certification training for evaluation board liaisons who help service members navigate the system. To address more systemic concerns, the Senior Oversight Committee is planning to pilot a joint disability evaluation system. To achieve savings without adverse health consequences, the drugs in a particular class should be easily substitutable and thus distinguishable primarily on the basis of price	Highlights
GAO	GAO 0[illegible]647	Military Health Care TRICARE Cost Sharing Proposals Would Help Offset Increasing Health Care Spending, but Projected Savings Are Likely Overestimated	May 07	GAO estimates that DOD's proposed fee and deductible increases would achieve a[illegible] $2.3 billion in savings over 5 years, not DoD expected $9.8 billion	Highlights
Task Force on Mental Health a subgroup of the Defense Health Board		An Achievable Vision Report of the Task Force on Mental Health	Jun 07	Building a culture of support for psychological health, ensuring a full continuum of excellent care for service members and their families, providing sufficient resources and allocating them according to requirements, and Empowering leadership	FS 4
Independent Review Group		Rebuilding the Trust Report on Rehabilitative Care and Administrative Processes at Walter Reed Army Medical Center and National Naval Medical Center	Apr 07	Overhauling the Physical Disability Evaluation System, make Walter Reed National Military Medical Center into a premier military healthcare facility, research TBI, PTSD, amputations and burns, seamless transition from inpatient to outpatient, family support for servicemembers, recovery, systemic issues	79
President's Commission on Care for America's Returning Wounded Warriors		Serve, Support, Simplify	Jul 07	Immediately create comprehensive recovery plans to provide the right care and support at the right time in the right place, completely restructure the disability and compensation systems, aggressively prevent and treat Post Traumatic Stress Disorder and Traumatic Brain Injury, significantly strengthen support for families, rapidly unifer patient information between DoD and VA, strongly support Walter Reed by returning and returning first rate professionals through 2011	5-11

Appendix F DoD Guidance/Oversight of Wellness Initiatives

As part of its charge, the Task Force was asked to assess "wellness initiatives and disease management programs of the Department of Defense, including health risk tracking and the use of rewards for wellness." In addition, it was asked to review "education programs focused on prevention awareness and patient-initiated health care."

Background

DoD Instruction 6025.20

DoD Instruction 6025.20 (January 5, 2006) implements policy for establishing medical management programs within the Direct Care System according to the following directives and standards:

1) DoD Directive 1010.10, Health Promotion and Disease/Injury Prevention (August 22, 2003),
2) DoD Directive 6000.14, Patient Bill of Rights and Responsibilities in the Military Health System (MHS) (July 30, 1998),
3) DoD Directive 6025.13, Medical Quality Assurance in the Military Health System (May 4, 2004), and
4) Standards of the Joint Commission, current edition.

Instruction Number 6025.20 defines terms associated with medical management, provides guidance for the implementation of policies, assigns responsibility, and specifies content for component activities within Medical Treatment Facilities (MTFs). Appropriate medical management programs include disease management, case management, and utilization management, and all components associated with them. Program implementation and success at the MTF level are predicates for success in improving and sustaining the quality of care delivered and in achieving Tri-Service Business Plan objectives, which include meeting the following goals:

1) improved access to care,
2) increased provider productivity,
3) better-managed referrals,
4) more accurate labor reporting,
5) improved documented value of care (coding),
6) implementation of evidence-based health care,
7) better management of pharmacy expenses, and
8) readiness planning.[1]

The TRICARE Management Activity (TMA) defines the components of its Medical Management as follows:

1 DoD TRICARE Management Activity, Medical Management Guide, January 2006, Section V, 19

Disease management is defined as An organized effort to achieve desired health outcomes in populations with prevalent, often chronic diseases, for which care practices may be subject to considerable variation These programs use interventions that are evidence-based to direct the patient's plan of care Programs also equip the patient with information and a self-care plan to self-manage wellness and prevent complications that may result from poor control of the disease process [2]

Case management is defined as A collaborative process under the population health continuum which assesses, plans, implements, coordinates, monitors, and evaluates options and services to meet an individual's health to promote quality, cost-effective outcomes [3]

Utilization management is defined as An organization-wide, interdisciplinary approach to balancing cost, quality, and risk concerns in the provision of patient care [4,5]

The Disease Management Association of America (DMAA) defines disease management as "a system of coordinated health care interventions and communications for populations with conditions in which patient self-care efforts are significant" [6] The components of disease management include

- population identification processes,
- use of evidenced-based practice guidelines,
- collaborative practice models to include physician and support-service providers,
- patient self-management education (may include primary prevention, behavior modification programs, and compliance/surveillance),
- process and outcomes measurement, evaluation, and management, and
- routine reporting/feedback loop (may include communication with patient, physician, health plan, and ancillary providers, and practice profiling)

According to the DMAA, full-service disease management programs must include all six of these components, programs with fewer components are known as disease management support services [7]

To be effective, medical management is intended to be an integrated managed care model that promotes the three core areas as the approach to patient care Medical management promotes the use of evidence-based, outcome-oriented medicine that incorporates sound clinical practice guidelines into the care process, in addition, it allows for interdependency between the direct care and purchased care systems [8]

2 Department of Defense Instruction 6025 20 Military Management Programs in the Direct Care System and Remote Areas January 5 2006
3 Ibid
4 Ibid
5 Utilization management is an expansion of traditional utilization review activities to encompass the management of all available health care resources including referral management
6 Disease Management Association of America DMAA Definition of Disease Management See www dmaa org/dm_definition asp
7 Ibid
8 Ibid

The implementation of a well managed medical management program allows for accountability at every level of the Military Health System (MHS) facility regional, Major Commands, and ultimately DoD Guidance for the implementation and execution of DoD Instruction 6025 20 is outlined in the January 2006 Tri-Service and TMA experts *Medical Management Guide*—DoD's reference for establishing health care delivery programs The *Guide* specifically addresses utilization management, case management, and disease management as the approaches to managing patient care

Assistant Secretary of Defense for Health Affairs Memorandum

A January 4, 2006, Assistant Secretary of Defense for Health Affairs memorandum outlines broad implementation guidance for DoD s Medical Management Guide The memorandum describes DoD Instruction 6025 20 as the policy on "what to do,' and the *Medical Management Guide* as the "how to do it "[9] According to the memorandum, the *Guide* provides a strategic overview for those in leadership positions and practitioners at the facility, clinic, or bedside level The memorandum encourages "widespread use and dissemination" of the *Guide* The services are responsible for implementation and individualized policies, however, the intended use of the *Guide* is to ensure standardization in the implementation and execution of programs associated with medical management

Department of Defense Directive 1010 10

DoD Directive 1010 10 (August 22, 2003, and recertified November 24, 2003) sets policy and responsibilities for programs in health promotion, disease and injury prevention, and population health within DoD It establishes the requirement to implement these programs and to improve population health to improve and sustain military readiness, health, fitness, and quality of life for military personnel, DoD personnel, and other beneficiaries [10] This directive outlines DoD's policy of supporting the Department of Health and Human Services' Healthy People Goals and Objectives across DoD by placing emphasis on Healthy People's leading health indicators physical activity, overweight and obesity, tobacco use substance abuse, responsible sexual behavior, mental health, injury and violence, environmental quality, immunization, and access to care [11]

Responsibility

The Assistant Secretary of Defense for Health Affairs, under the Secretary of Defense for Personnel and Readiness, Secretaries of Military Departments, and the TMA Director, ensures that TRICARE Area Offices and TRICARE Regional Offices guarantee the availability of personnel to serve as medical management liaisons with TMA, Single and Multiservice Market Managers, MTFs, and managed care support contractors through the communication and dissemination of policies and the coordination of medical management education and training activities within local and regional areas [12]

9 Assistant Secretary of Defense Health Affairs Memorandum Medical Management Guide January 5 2006
10 Department of Defense Directive 1010 10 Health Promotion and Disease/Injury Prevention August 22 2003
11 Ibid
12 Department of Defense Instruction 6025 20 Military Management Programs in the Direct Care System and Remote Areas January 5 2006

In the course of its deliberations, the Task Force received briefings and background materials regarding these topics on the following services, agencies, and civilian plans

- TMA
- U S Army Medical Department
- U S Air Force
- U S Navy
- Healthways, Inc
- Uniformed Services Family Health Plan (USFHS) Alliance
- Johns Hopkins Health Care
- CIGNA Healthcare

DoD Programs

TMA

TMA, in conjunction with the Army, through its U S Army Center for Health Promotion and Preventive Medicine (CHPPM) and all subordinate commands within the U S Army Medical Command, the Navy, through its Navy Environmental Health Center and subordinate commands within the Naval Medical Department, and the Air Force through its U S Air Force Population Health Support Division and medical elements, disseminates guidance in support of DoD Instruction 6025 20 through the *Medical Management Guide* The services are responsible for policy implementation in relation to patient care management

Within the mission of the MHS—"To enhance DoD and our Nation's security by providing health support for the full range of military operations and sustaining the health of all those entrusted to our care" —TMA works within a population health and medical management model to promote care coordination that yields the desired wellness outcomes TMA employs a multifaceted approach to care management—disease management and a campaign for healthy lifestyles

Disease Management To TMA, disease management is advocating self-management to minimize complications in a patient population with the same chronic disease or condition [13] Appropriately implemented disease management programs utilize evidence-based medicine/empirical data in the form of clinical practice guidelines and allow for coordinated approaches through communication to ensure continuity and decrease variation in care patterns TMA has implemented programs targeting congestive heart failure (CHF), asthma, and diabetes [14] These programs target direct and purchased care TRICARE Prime enrollees, while TRICARE standard beneficiaries are included in a demonstration project TMA's Office of the Chief Medical Officer identifies (through the use of administrative data) eligible patients, based on the following factors

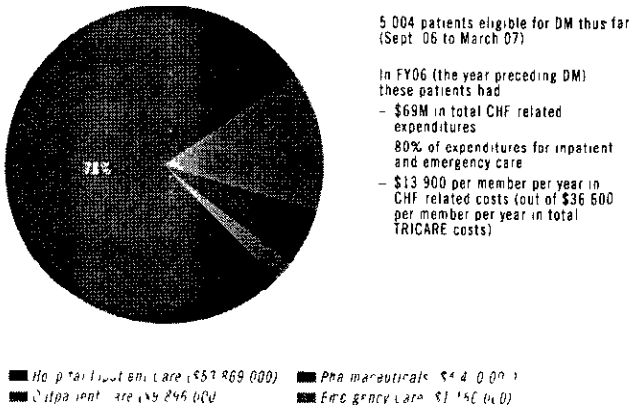
- history of outpatient visits,
- history of emergency department visits,
- history of hospitalizations, and
- history of medication usage (asthma and diabetes)

13 DoD TRICARE Management Activity Medical Management Guide January 2006 p 3
14 Jack Smith MD MMM TRICARE Management Activity Military Health System Disease Management and Campaign for Healthy Lifestyles Brief to the Task Force July 11 2007 Slide 7

Once identified, patients are assigned to one of four levels on a monthly basis, with levels three and four reserved for intervention

Although a comprehensive report on this effort will not be available until December 2007, ongoing evaluation includes critical performance measures, such as clinical outcomes, utilization, and financial outcomes Figures 1 and 2[15] display baseline Fiscal Year 2006 medical costs for CHF and asthma, respectively An effective disease management program will decrease pharmaceutical, emergency care, hospital inpatient, and outpatient costs

FISCAL YEAR 2006 (BASELINE) CHF MEDICAL COSTS FOR DM ELIGIBLE (LEVELS 3 & 4) PATIENTS

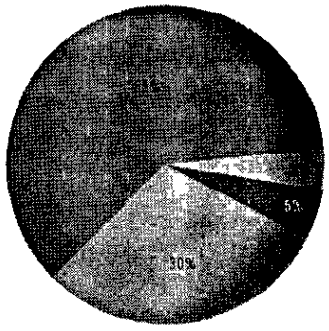


Source Jack Smith MD MMM TRICARE Management Activity Military Health System Disease Management and Campaign for Healthy Lifestyles Brief to the Task Force July 11 2007

Figure 1

15 Ibid Slides 11 and 12

FISCAL YEAR 2006 (BASELINE) ASTHMA MEDICAL COSTS FOR DM ELIGIBLE (LEVELS 3 & 4) PATIENTS



25 897 patients eligible for DM thus far (Sept 06 to March 07)

In FY06 (the year preceding DM) these patients had
- $65M in total asthma related expenditures
- 10% of expenditures for inpatient and emergency care
- $2 500 per member per year in asthma related costs (out of total per member per year in total TRICARE costs)

Hospital Inpatient Care ($[illegible]) — Pharmaceuticals ($[illegible])
Outpatient Care ($[illegible]) — Emergency Care ($[illegible])

Source Jack Smith MD MMM TRICARE Management Activity Military Health System Disease Management and Campaign for Healthy Lifestyles Brief to the Task Force July 11 2007

Figure 2

Campaign for Healthy Lifestyles TMA has awarded contracts for health promotion demonstration and pilot projects to reverse negative health trends in Active Duty and military family populations, to make the MHS a more proactive health care system through education and awareness of lifestyle choices, and to foster partnerships with commands, communities, and other agencies in support of healthy lifestyle choices The focus of the campaign is on three areas identified as negative health behavior and as the leading causes of death in 2002 1) smoking, 2) alcohol consumption and abuse, and 3) obesity [16]

- Tobacco Cessation A 2002 DoD survey of Health Related Behaviors among Military Personnel revealed a tobacco use rate of 33 8 percent, an increase in prevalence for the first time in two decades Use was attributed primarily to younger enlisted service members Findings from multiple levels of research are that 1) the availability of lower priced tobacco products in commissaries is viewed as supportive of tobacco use, 2) tobacco use is perceived as being consistent with the image of success in the military, and 3) "smoke pits" are viewed as social settings and opportunities to interact without consideration of rank [17] The medical care cost incurred by DoD in 2004 as a result of tobacco use is estimated to be $1 6 billion [18] The overarching goal of the military is aligned with the Healthy People 2010 tobacco use goal to "reduce illness, disability, and death related to tobacco use and exposure to second hand smoke"

16 Jack Smith MD MMM TRICARE Management Activity Military Health System Disease Management and Campaign for Healthy Lifestyles Brief to the Task Force July 11 2007 Slide 21
17 Samuel Olaiya TRICARE Management Activity Information Paper on Department of Defense Tobacco Use Counter Marketing Campaign January 5 2007
18 Jack Smith MD MMM TRICARE Management Activity Military Health System Disease Management and Campaign for Healthy Lifestyles Brief to the Task Force July 11 2007 Slide 13

The Tobacco Free Me and Quit Tobacco, Make Everyone Proud tobacco use cessation demonstration projects are two initiatives that have been implemented through TMA Tobacco Free Me became operational in May 2006 and continues to recruit participants in order to reach its demonstration target population of 400 The Quit Tobacco, Make Everyone Proud program, piloted in February 2007, targets 725,000 18 to 24 year olds Post-implementation data are required for refinement of the program if necessary or required

- Alcohol Abuse Prevention Annual medical costs to DoD for active duty care related to alcohol consumption are estimated to be $364 million Alcohol consumption contributes to 20 to 25 percent of motor vehicle accident fatalities, results in approximately 700 marital separations annually, and totals 1,764 full-time equivalents lost to productivity annually for DoD[19] TMA's alcohol abuse prevention targets the Active Duty population and/or 18- to 24-year-old enlisted personnel—it does not target the entire population of beneficiaries
- Obesity Obesity and weight gain negatively affect readiness by predisposing individuals to musculoskeletal injury, increasing daytime somnolence, increasing military fitness test failures, contributing to poor wound healing, and leading to increased rates of depression and suicide[20] TMA's Obesity Integrated Project Team was chartered in 2004 to develop a multidisciplinary strategy to decrease the incidence/prevalence of overweight and obesity within DoD by promoting a program of regular exercise and healthy eating in the military community

  The Healthy Eating and Active Living in TRICARE Households program is a demonstration project for an interactive weight loss program with multiple options, such as self-paced activities and lifestyle coaches accessible via the Internet or by telephone The project is confined to TRICARE Prime Non-Active Duty beneficiaries with body mass indices >25 and <31 who are 18 to 64 years old and who reside in Illinois, Indiana, Michigan, or Ohio The program's objective is to determine whether a combination of approaches—including distance learning, weight loss medication, and health coaching is cost-effective This project ends September 30, 2008

  TMA data additionally reference findings on tobacco cessation and obesity through the MHS Balanced Score Card Metrics Panel

- Preventive Services, Nonsmoking Rates The August 2007 MHS Balanced Score Card Metrics Panel reports nonsmoking rates of 72 percent 78 percent, and 78 percent for Active Duty, Prime enrollees, and all eligibles, respectively None of these met the Healthy People 2010 goal of 88 percent The rates of those counseled to quit smoking were 58 percent, 67 percent, and 66 percent, respectively, for the same category of beneficiary, below the Consumer Assessment of Healthcare Providers and Systems benchmark of 70 percent
- Preventive Services, Nonobese Population The MHS nonobese population rates for the same beneficiary populations were 87 percent, 78 percent, and 78 percent, respectively The only population achieving and surpassing the Healthy People 2010 goal of 85 percent is the Active Duty population[21]

19 Ibid Slide 30
20 Ibid Slide 42
21 Office of the Assistant Secretary of Defense Health Affairs Military Health System Balanced Score Card Metrics Panel August 2007

Summary of DoD Wellness Programs

The services, in accordance with the medical management activities outlined by TMA, have implemented service-specific wellness and disease prevention programs. At this time, service presentations and research do not provide adequate information to determine whether targets are being met in the areas of smoking cessation and weight management.

TMA sponsors wellness initiatives and pilots that support program implementation or change. TMA, however, does not reimburse beneficiaries for some interventions received outside of the MTF; one example is smoking-cessation interventions. TMA will reevaluate this issue after assessing the results of ongoing smoking-cessation demonstration projects.

Despite renewed interventions and emphasis on preventing suicides, suicide rates in the Army have increased, while data indicate that the Air Force has an extremely successful suicide prevention program. The services would benefit from continued monitoring of these programs at the MHS level.

The Air Force's Health and Wellness Center is a model for the MHS and supports wellness initiatives with appropriate qualified staff, physical space, and command emphasis. This model delivers and reinforces wellness initiatives and facilitates comprehensive program evaluation, documentation of outputs, and cost analysis to determine return on investment.

Appendix G Additional Information on Procurement and Contracting

Contracting for Direct Care Medical Services

The Air Force, Army, and Navy each has a separate organizational structure that supports contracting for direct care medical services. The National Defense Authorization Act (NDAA) for Fiscal Year 2001 required the Secretary of each military department to establish at least one center of excellence in contracting for services. Both the Army and Navy have centralized acquisition activities, while the Air Force uses medical service commodity councils that centralize acquisition strategy development while maintaining decentralized ordering. Key elements of the organizational structures are described below.

Army: Health Care Acquisition Activity

The Army has the largest organizational structure dedicated to health care procurement. In the U.S. Army Medical Command (MEDCOM), all requirements for direct care medical services generally flow from the Military Treatment Facilities (MTFs) through its six Regional Contracting Offices to the Army's Center for Health Care Contracting (CHCC). CHCC is colocated with the Health Care Acquisition Activity's (HCAA's) headquarters at Fort Sam Houston, Texas, and is the hub for MEDCOM-wide contract support. It also is dedicated to providing contractual instruments designed to facilitate the support that Regional Contracting Offices provide to their respective regions. The Army aligns its regional organizational structure to serve the needs of customers within that Regional Medical Command.

HCAA[1] primarily contracts for health care services in support of the Army Medical Department (AMEDD). HCAA awards and administers contracts for a variety of services, including nursing services, transcription services, reference laboratory services, imaging maintenance services, and services provided by physician, dentists, pharmacists, a variety of medical-specific technicians, and ancillary personnel. HCAA also contracts for other health care-related services in support of the Army health care mission, and it serves as a secondary contracting source to AMEDD for medical equipment and supplies.

Navy: Naval Medical Logistics Command

In 1987, the Bureau of Medicine and Surgery (BUMED) consolidated operations at the Naval Medical Logistics Command (NAVMEDLOGCOM) for most health care services contracting above the simplified acquisition threshold.[2] NAVMEDLOGCOM specializes in the acquisition of health care services, supplies, and equipment. Its contracting authority comes from the Naval Supply Systems Command and its program management from BUMED. Most health care services contracts include a base year and four option periods for a total of five years. NAVMEDLOGCOM uses two methods to procure health care services: Individual Set Asides (ISAs) and Request for Proposals (RFPs).

1 See hcaa.medcom.amedd.army.mil/default.htm

2 The simplified acquisition threshold is $100,000, except for acquisitions of supplies or services that, as determined by the head of the agency, are to be used to support a contingency operation or to facilitate defense against or recovery from nuclear, biological, chemical, or radiological attack (41 U.S.C. 428a); the term means: 1) $250,000 for any contract to be awarded and performed, or purchase to be made, inside the United States; and 2) $1 million for any contract to be awarded and performed, or purchase to be made, outside the United States.

The Navy provides technical support for direct care medical services acquisitions through the NAVMEDLOGCOM Healthcare Services Support Directorate The Acquisition Management Directorate has procurement authority and conducts acquisitions for personal services contracts [3] Fleet Industrial Supply Center Norfolk Detachment Philadelphia has procurement authority and conducts acquisitions for nonpersonal services contracts

Air Force Medical Service Commodity Council

The Secretary of the Air Force for Acquisition revised the Air Force Federal Acquisition Regulation Supplement to enable the establishment and function of enterprise-wide commodity councils in acquisition The Air Force identifies groups of items (commodities) purchased by many activities throughout the Air Force that can be better provided (e g , faster, better quality, less expensive) if a single activity establishes and implements a common strategy and contract vehicle for them Once established, decentralized ordering at the established prices is possible

In 2005, the Air Force Surgeon General established the Air Force Medical Service (AFMS) Commodity Council as a strategic sourcing team partnered with the Deputy Assistant Secretary for Contracting to look at strategic purchasing of health care services A commodity council is a strategic purchasing unit that uses a programmatic approach to acquisitions, has an approved buying strategy for goods and services, uses spiral development—needs/funding/contracting, implements a centralized strategy to save lead time/resources, and employs a cross-functional, integrated sourcing team AFMS was one of the first groups to establish a commodity council and now serves as a model for five new Air Force commodity councils [4] The team develops centralized acquisition strategies to meet direct care medical requirements The Commodity Council maintains overall program control of the strategies, modifies them as needed, and reports results to key stakeholders

Given the Air Force model the medical community develops the requirements through the AFMS Commodity Council, and the Air Force executes the strategies developed by the medical community, which includes the leveraging of local base contracting resources by MTFs

The AFMS Commodity Council's mission [5] is to support the AFMS and the Warfighter in enterprise-wide medical acquisition programs in order to improve customer support, reduce the purchase cost of services, reduce variation in services contracts by increasing standardization, accelerate delivery responsiveness, and provide lifecycle management support The Council's initial strategy spirals have been in the areas of professional services and clinical support services, in the future, it will examine facilities maintenance support

Previous Assessments and Recommendations for Medical Acquisitions

In 2002, DoD spent about $875 million to acquire medical services through direct care medical services contracts, excluding information technology contracts [6] The DoD Office of the Inspector General (DoD IG) conducted an audit to evaluate the efficiency and effectiveness of DoD contracting practices and procedures for acquiring non-TRICARE medical services and to evaluate the management control

3 In Part 37 104 personal services contracts the Federal Acquisition Regulation notes that a personal services contract is characterized by the employer employee relationship it creates between the government and the contractor s personnel
4 Joe Murrow Director AFMS Commodity Council Response to Task Force RFI July 19 2007
5 Joe Murrow Air Force Medical Service Commodity Council (PowerPoint presentation) July 25 2007 Slide 5
6 Department of Defense Office of the Inspector General Acquisition Direct Care Medical Services Contracts D 2004 04 p 1

program applicable to the audit objective The audit included 125 contracts valued at approximately $73 million During the audit the DoD IG identified examples where the approach used by the MHS involved the following [7]

- overlapping contracting efforts,
- inconsistent application and award of nonpersonal services contracts,
- liberal interpretation of forward funding guidance,
- different methods of awarding minimum guaranteed work under multiple award task order contracts,
- inappropriate use of individual set-aside contracts, and
- inadequate oversight of competition achieved

The DoD IG issued its report on June 24, 2004, concluding that "by developing an acquisition strategy for non-TRICARE medical services and better coordinating contracting efforts, the Military Health System could

- reduce duplication and fragmentation among DoD contracting organizations that acquire medical services,
- reduce exposure to risk from nonpersonal services contracts administered as personal services contracts,
- increase competition in contracting, and
- avoid a potential FICA [Federal Insurance Contributions Act] liability, which may be incurred by the use of ISA contracts "[8]

Based on a recommendation from the DoD IG, the Assistant Secretary of Defense for Health Affairs (HA) chartered the Army Surgeon General to lead a DoD-Wide Strategy Council to "develop a coordinated strategy for acquiring direct care medical services that includes the implementation of the centers of excellence concept "[9] Based on a thorough review of organizational structures, business processes, and spending data for each of the three services, the Strategy Council issued its final report in June 2005 presenting the results of its analysis and a set of recommendations for addressing the DoD IG's recommendations The report contained three key recommendations

1) Establish a DoD organization with tri-service support responsibilities and flexible contracting authority
2) Establish strategic sourcing councils for key labor categories
3) Standardize acquisition process and related capabilities [10]

See Table 1 for more specifics on the Strategy Council's findings and recommendations, as well as the findings and recommendations of other review groups

Quadrennial Defense Review Initiative 15 (Contracting for Health Care Services)

The Quadrennial Defense Review (QDR) was designed to continue progress toward the goal of MHS transformation To this end, the QDR process identified 18 initiatives across 4 focus areas 1) transform the force, 2) transform the infrastructure, 3) transform the business, and 4) sustain the benefit

QDR Initiative 15 addresses contracting for health care services The MHS Office of Transformation ensures that this and the other initiatives are developed and implemented in an integrated and effective manner with the services and the Joint Staff

7 Ibid p 4
8 Ibid p 14
9 DoD Wide Strategy Council for Acquiring Direct Care Medical Services Final Report June 2005 p 1
10 DoD Wide Strategy Council for Acquiring Direct Care Medical Services Final Report June 2005 p 12

Quadrennial Defense Review Initiative 16 (Contracting for Professional Services)

The impetus for QDR Initiative 16 came from a 2004 DoD IG report, which called for a joint and strategic enterprise approach to medical services acquisition and for strengthening the acquisition guidance and oversight process [11]

The Defense Wide Strategy Council published its final report in response to this initiative in June 2005 and recommended that the following be accomplished

- formalize tri-service support responsibilities while leveraging existing acquisition capabilities,
- establish strategic sourcing councils for key labor categories, and
- standardize acquisition process and related capabilities

These recommendations have served as a starting point for the TMA (TRICARE Management Activity) Health Care Contracting Work Group as it embarks on developing a coordinated tri service process for acquiring contract medical services personnel in accordance with QDR Initiative 16 Before the Work Group charter expires in June 2008, the group plans to complete the following tasks in accordance with the initiative [12]

- establish a Strategic Sourcing Council,
- standardize the professional services acquisition process,
- establish Multiple Award Task Order and ID/IQ contracts, and
- develop a common, automated databank for the services' professional services acquisition/contracting activities

Initiatives Planned or Started

Logistics and support services is one of the categories of shared support services and functions identified for consolidation in the Winkenwerder "Unified Medical Command—Way Ahead Memo" [13] The logistics personnel identified for consolidation in the Center for Naval Analyses study "Cost Implications of a Unified Medical Command" will come from the following organizations

- HCAA, Army Materiel Command, and MEDCOM,
- NAVMEDLOGCOM and Navy Fleet Hospital Support Office, and
- Air Force Materiel Command and Air Force Medical Support Agency [14]

Although the services already have consolidated most of their medical logistics personnel at Fort Detrick, Maryland, they still maintain separate command structures, thus, a source of potential savings comes from the unification of command structure Much of the potential savings to the MHS that could be realized in such a consolidation of logistics and acquisition comes from "the ability to pool purchases and purchasing power to get volume discounts" and this cost-saving strategy appears to be exhausted at the service level [15]

11 DoD IG Report Direct Care Medical Services Contracts June 2004
12 Michael O Bar Quadrennial Defense Review Roadmap for Medical Transformation Initiatives 15 and 16 Overview for the DOD Task Force on the Future of Military Health Care (PowerPoint presentation) July 25 2007 Slide 28
13 Action Memo for Deputy Secretary of Defense SUBJ Joint/Unified Medical Command Way Ahead November 27 2006 Tab B p 2
14 Eric W Christensen DeAnn J Farr James F Crofer Elizabeth Schaefer Cost Implications of a Unified Medical Command Alexandria VA CNA Corporation May 2006 p 79
15 Ibid

Strategic Sourcing and Commodity Councils

Strategic sourcing is a structured, analytical, and collaborative process for critically analyzing an organization's spending and using this information to make business decisions about acquiring commodities and services more effectively and efficiently. This approach to acquisition through commodity councils has been gaining favor within the federal government. On May 20, 2005, the Office of Management and Budget (OMB) directed federal agencies to establish and meet specific strategic sourcing goals.[16]

As part of this directive, the U.S. Army Medical Research Acquisition Activity is implementing a strategic sourcing initiative for its acquisition of medical research laboratory supplies, equipment, and services. This initiative was driven by the opportunity to significantly reduce costs in these areas based on current expenditures ($1.9 billion in Fiscal Year 2007)[17] and projected increased demand ($2 to $3 billion additional in Fiscal Year 2007) from other agencies (DoD, the Department of Homeland Security, and the Department of Agriculture) for these commodities. The target goal for cost saving from this initiative is 15 percent.[18]

Furthermore, the DoD Wide Strategy Council recommended in its June 2005 report the establishment of Strategic Sourcing Councils for three key labor categories: nurses, radiologists, and dentists.[19]

Alternative Contracting Vehicles

OMB's Acquisition Advisory Panel, established in accordance with the Services Acquisition Reform Act of 2003, "received evidence from witnesses and through reports by inspectors general and the GAO concerning improper use of task and delivery order contracts, multiple award IDIQ [Indefinite Delivery/Indefinite Quantity] contracts, and other government-wide contracts. Nonetheless, the panel strongly believes that when properly used these contract vehicles serve an important function and that the government derives considerable benefits from using them."[20] Over the years, the MHS has been working to establish several of these vehicles to maintain and encourage improved contractor performance, increase procurement flexibility, and reduce time to delivery. These include TMA Indefinite Delivery/Indefinite Quantity (ID/IQ) vehicles,[21] HCAAs Innovative Medical Acquisition Program in 2001 and the follow-on contract for Army Direct Care Medical Services, and Navy[22] services for direct medical health care with regionalized multiple award task order contracts.

16 OMB Memo, Implementing Strategic Sourcing, May 20, 2005
17 Office of the Under Secretary of Defense for Acquisition, Technology, and Logistics (OUSD(AT&L)), Office of Management and Budget Implementation of Strategic Sourcing Initiatives, Fiscal Year 06 Update, United States Department of Defense (DoD), March 2007, p. 54
18 Ibid., p. 56
19 DoD Wide Strategy Council for Acquiring Direct Care Medical Services Final Report, June 2005, p. 2
20 Report of the Acquisition Advisory Panel to the Office of Federal Procurement Policy and the United States Congress, December 2006, p. 1-59
21 Jean Storck, TRICARE Contracts Overview, Brief to the Task Force (PowerPoint presentation), February 6, 2007, Slide 17
22 Terry Horst, Andy Muenzfeld, Brief to the Task Force (PowerPoint presentation), July 2, 2007, Slide 14

Table 1 Recommendations of Previous Review Groups

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING
GAO	GAO 0[illegible]8/2[illegible]	VA AND DEFENSE HEALTH CARE Potential Exists for Savings through Joint Purchasing of Medical and Surgical Supplie	June 26 [illegible]	Considerable potential savings exist for procuring surgical and medical supplies if VA and DoD were to [illegible] contract. However, more work needs to be done to take advantage of these opportunities, including acquiring accurate, reliable, and comprehensive procurement information and establishing successful acquisition systems for each department. The success of joint VA and DoD procurement initiatives depends on improving their acquisition systems and sustaining their commitment to joint procurement.
GAO	GAO 05 [illegible]/[illegible]	DEFENSE HEALTH CARE Implementation Issues for New TRICARE Contracts and Regional Structure	July 2005	Throughout implementation of the new contracts and governance structure, we encountered issues related to program management and as a result, we identified costs and operations, although these problems have had little impact on health care delivery. Problems encountered in the implementation include a cost of approximately $250 from the unavailability of the Enterprise Wide Referral and Authorization System (EWRAS), which was intended to provide automated referrals and authorizations for specialty care. Cost and other problems with TRICARE Management Activity (TMA) offices have also resulted from confusion about the TRICARE regional offices (TRO) role in contract oversight, which could compromise TRO oversight of regional health care delivery.
GAO	GAO 05 [illegible]/[illegible]3	DEFENSE HEALTH CARE Implementation Issues for New TRICARE Contracts and Regional Structure	July 2005	We recommend that the Secretary of Defense direct the Assistant Secretary of Defense for Health Affairs (ASD(HA)) to develop a comprehensive cost for the development and maintenance of EWRAS as well as the process to be put in place to develop a solution, and that the ASD(HA) clarify the TROs' contract oversight role and responsibilities as they relate to other TMA offices and to establish procedures for how TROs are to collaborate with the military services, Military Treatment Facilities (MTFs).
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	Analysis by DoD Wide Strategy Council of the Army, Navy, and Air Force direct care medical services shows that all three services acquire similar labor segments, use many of the same suppliers, and have MTFs that operate in many similar local markets. To coordinate acquisition and contracting activities, the three services should evaluate strategies for buying similar services and goods, share information about common markets, and negotiate jointly with common suppliers.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	The Air Force is the only service without a dedicated direct care medical services acquisition staff reporting to the Surgeon General. Instead, it relies on the contracting activities of its contracting agencies (the Navy, Army, MEDCOM, VA). Without this staff, the Air Force is unable to perform the adequate contracting technical support required for medical services contracting. This results in lengthy acquisition times, limited use, and understanding of Personal Services Contracting, suboptimal contracting strategies, requirement generation and execution, and low prioritization placed on medical services.

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	The Naval Medical Logistics Command has developed unique organizational capabilities including medical services technical expertise, data management, analysis, and dedicated contracting support to support its customers during the acquisition process for medical services. Such a program is greatly appreciated by customers, has faster turnaround times, and results in a more consistent set of requirements prior to reaching the Contracting Office. It would be valuable to have centralized technical expertise across all three services.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	All three services have critical organizational capabilities including strategic sourcing, market/industry analysis, training, and information sharing tools, but to varying degrees. Each organization's capability supports effective planning, coordination, and knowledge management of the internal and external environment. These varying degrees of capabilities result in incomplete statement of Work/Performance Work Statements (SOWs/PWS), unrealistic expectations, and inconsistent levels of service to customers. It also limits the services' ability to collaborate and share best practices.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	The three services lack the authority to establish Personal Services Schedules and instead rely on VA and General Services Administration, which do not meet the specific needs of DoD. This limits the ability and flexibility of DoD to use a full range of contract types/vehicles/solutions to meet customer needs and adds to already long procurement cycle time.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	DoD has not standardized the medical services spend data elements. This makes it very challenging to aggregate data across the three services and complicates the planning and coordination processes.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	The three services vary greatly in pre- and post-contracting processes. This results in a lack of coordination and customer support, unclear requirements of customers, varying degrees of quality of SOWs/PWS, increased development of procurement package lead time, and limited opportunities to improve contractor performance. The areas with most potential to improve are needs identification, SOW/PWS development, and performance measurements.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	The three services have neither standardized tools and templates for developing procurement packages (RFx (RFP, RFQ, and RFI) and contract development) nor a standard mechanism for sharing templates or best practice information. This leads to varying degrees of quality of SOWs/PWS, increased developing procurement package lead times, and confusion among industry suppliers and increased costs.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	Acquiring activities across the MTFs do not have a similar basic understanding of the acquisition and contracting process. This increases the process time and decreases the quality of procurements.

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	The three services have neither a standardized credentialing process for medical services contractors nor a mechanism for sharing credentialing documents. This results in significant costs and delays, since contractors often have to repeat the credentialing process from one MTF to another.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	Contracting is not involved in the medical service requirements as they arise, and therefore plays a reactive role. It poses a risk of large Procurement Administrative Lead Times.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Services	June 2005	Solicitations and SOWs/PWS developed across MTFs and the three services have many common elements. For this reason, standardized tools and templates should be created, thus reducing costs and improving quality of services received by DoD.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Service	June 2005	The three services lack the adequate Contracting Officer's Representative/Quality Assurance Personnel (COR/QAP) assets required to appropriately manage contracts and customer relationships. This causes healthcare not to be delivered as intended and the government not to receive full value. In proved contract oversight, better pay performance information and better contractor performance would result from more dedicated COR/QAP.
Censeo Consulting		DoD Wide Strategy Council for Acquiring Direct Care Medical Service	June 2005	Based on the findings, the Strategy Council recommends three primary actions: 1) Establish a DoD organization with Tri-Service support responsibilities and flexible contracting authority; 2) Establish strategic sourcing councils for key labor categories; and 3) Standardize acquisition process and related capabilities.
DoD IG	D-2004-094	Acquisition: Direct Care Medical Services Contracts	June 24, 2004	By developing an acquisition strategy for non-TRICARE medical services and better coordinating contracting efforts, the Military Health System could reduce duplication and fragmentation among DoD contracting organizations that acquire medical services, reduce exposure to risk from non-personal services contracts administered as personal services contracts, increase competition in contracting, and avoid a potential Federal Insurance Contributions Act (FICA) liability, which may be incurred by the use of Individual Set Aside (ISA) contracts.
DoD IG	D-2004-094	Acquisition: Direct Care Medical Services Contracts	June 24, 2004	DoD IG recommends: 1) The USD for Personnel and Readiness (USD(PR)) review potential solutions to barriers of DoD and VA sharing caused by incompatible statutory authority to award personal services contracts.

REVIEW GROUP	REPORT NUMBER	REPORT NAME	DATE	RECOMMENDATION/FINDING
DoD IG	D-2004-094	Acquisition: Direct Care Medical Services Contracts	June 24, 2004	DoD IG recommends: 1) The USD(PR) request that the USD for Acquisitions, Technology, and Logistics (USD(ATL)) establish a pilot program for acquiring direct care medical services.
DoD IG	D-2004-094	Acquisition: Direct Care Medical Services Contracts	June 24, 2004	DoD IG recommends: 3) The ASD (Health Affairs) (ASD(HA)) request a legal review concerning FICA tax for ISA contracts.
DoD IG	D-2004-094	Acquisition: Direct Care Medical Services Contracts	June 24, 2004	DoD IG recommends: 4) If the legal review requested in recommendation 3) determines that ISA contracts are subject to FICA tax, that the USD (Comptroller) (USD(C))/Chief Financial Officer: a. Develop a process for future payments of FICA tax for ISA contracts. b. Direct fund holders who did not pay the required FICA tax to determine the existence of a liability and to make the necessary accounting entries for Government financial statements.
DoD IG	D-2004-094	Acquisition: Direct Care Medical Services Contracts	June 24, 2004	DoD IG recommends: 5) The ASD(HA), in conjunction with the Military Department Surgeons General (MDSG): a. Develop a coordinated strategy for acquiring direct care medical services that includes the implementation of the centers of excellence concept. b. Develop implementing guidance for acquiring direct care medical services. At a minimum, issue guidance on: (1) The use of personal versus non-personal services contracts. (2) The appropriate use of forward funding. (3) The fulfillment of minimum guarantees for multiple award task order contracts, and (4) The use of ISA contracts.
DoD IG	D-2004-094	Acquisition: Direct Care Medical Services Contracts	June 24, 2004	DoD IG recommends: 6) The MDSG develop an oversight process for the acquisition of direct care medical services to include, at a minimum, monitoring: a. The type and character of contracts used. b. The use of the forward funding statute. c. The award of minimum guarantees for multiple award task order contracts, and d. The extent of contract completion.

Appendix H The Reserve Component

Expansion of the Health Care Benefit for the Reserve Component

The National Defense Authorization Acts (NDAAs) for Fiscal Years 2004, 2005, 2006, and 2007 (see Table) have increased the health care benefits available to mobilized reservists and their dependents which generally include spouses and dependent children These acts expanded the number of reservists and their dependents who are eligible for TRICARE and the duration of their eligibility

Expansion of the Health Care Benefit for the Reserve Component

LAW	PROVISIONS
NDAA FY 2004	• Allowed nonactivated members of the Selected Reserve and the Individual Ready Reserve and their family members to enroll in TRICARE if the member was eligible for unemployment compensation or was ineligible for health care coverage from his or her civilian employer • Allowed reservists who had pending active duty orders to use TRICARE for up to 90 days before their active duty service began • Extended the length of time that service members, including demobilized reservists, could use TRICARE after they had been released from active duty to 180 days Transition Assistance Management Program (TAMP) • These provisions were set to expire on December 31 2004
NDAA FY 2005	• Indefinitely extended the temporary provision passed in 2003 that allowed reservists with pending active duty orders to use the military health care system up to 90 days before their active duty service began • Indefinitely extended the temporary provision that extended the length of time that service members could use TRICARE after they had been released from active duty service to 180 days TAMP • Provided TRICARE Standard coverage through a new program that DoD named TRICARE Reserve Select (TRS) made available to reservists who had been activated for a period of more than 30 days in support of a contingency operation on or after September 11 2001 and who agreed to continue serving in the Selected Reserves after release from active duty – Under this provision reservists are eligible to purchase TRICARE coverage for themselves and their family members for up to 1 year for each 90 days of active duty served or the number of full years for which they agreed to continue service whichever is less Reservists pay a monthly premium of 28 percent of the total amount determined by the Secretary of Defense on an appropriate actuarial basis as being reasonable for coverage

LAW	PROVISIONS
NDAA FY 2006	• Extended eligibility for TRICARE Standard to all Selected Reserve component personnel
	Those reservists who met TRS requirements established in the NDAA for Fiscal Year 2005 continue to pay the 28 percent premium
	– Those who are eligible for unemployment compensation, are self-employed, or are ineligible for insurance through an employer-sponsored plan pay 50 percent
	– Those who do not qualify for the two lower premium levels, such as those who are eligible for employer-based insurance but prefer to enroll in TRICARE, pay 85 percent
NDAA FY 2007	• Restructured the TRS program by eliminating the three-tiered premium structure
	– Members of the Selected Reserve will be eligible to purchase TRICARE coverage for themselves and their dependents at the 28 percent premium rate regardless of whether they have served on active duty in support of a contingency operation
	– Eligibility will not depend on the length of a service agreement entered into following a period of active duty; instead, reservists will be eligible for TRS for the duration of their service in the Selected Reserve
	– DoD is required to implement these changes by October 1, 2007
	• Established that reservists who are eligible for the Federal Employees Health Benefit Plan are not eligible to purchase TRICARE coverage

Source: GAO, Military Health: Increased TRICARE Eligibility for Reservists Presents Administrative Challenges, GAO-07-195, 2007, p. 30

The Transition Assistance Management Program

National Guard and Reserve members separated from active duty after being called up or ordered in support of a contingency operation for an active duty period of more than 30 days and their family members can receive transitional TRICARE coverage for 180 days through the Transition Assistance Management Program (TAMP). Under TAMP, former activated reservists and family members are not eligible to enroll or re-enroll in TRICARE Prime Remote or in TRICARE Prime Remote for Active Duty Family Members, because both programs require the sponsor to be on active duty. Under TAMP, the sponsor is no longer on active duty and is treated as an Active Duty family member for benefits and cost-sharing purposes.

The Continued Health Care Benefits Program

Reserve Component members may be eligible for the Continued Health Care Benefits Program (CHCBP) for up to 18 months following release from active duty or the end of their TAMP period. CHCBP is not part of TRICARE, but provides similar benefits and operates under most of the rules of TRICARE Standard. To obtain this coverage, reservists must enroll in CHCBP within 60 days of separation from active duty or loss of eligibility for military health care. The premiums for this coverage are $933 per quarter for individuals and $1,996 per quarter for families.[1]

Line of Duty Investigations and Medical Claims

Reserve Component members serving on duty 30 days or less are not eligible for TRICARE. If a Reserve Component member in one of these duty statuses becomes injured or ill during training and requires medical treatment, he or she is entitled only to treatment for that injury or illness. If not on active duty orders, a reservist's health care condition must have been caused or aggravated by military service before the service member is entitled to health care at government expense.

1 See www.tricare.mil/mybenefit/home/overview/SpecialPrograms/CHCBP/

The Military Medical Support Office (MMSO) approves payment of civilian medical claims. The MMSO[2] is the central location for all military branches and their Reserve Components for pre-approval of civilian medical or dental care and authorization for payment of civilian medical or dental bills. As such, the MMSO verifies eligibility, authorizes civilian care, and authorizes payment on medical claims based on the Line of Duty determination.

Recent Reviews of Military and Veteran Health Care

Veterans Disability Benefits Commission[3]
Established February 24, 2005
Appointed by President George W. Bush and Congress
Chaired by Lt. Gen. James Terry Scott, USA Ret.
Main recommendations Ensure horizontal and vertical equity, compensate for loss of quality of life, update the rating schedule, realign the Department of Veterans Affairs (VA)/DoD process for rating disabilities, simplify and expedite the processing of disability claims and appeals, improve transition assistance.

Independent Review Group[4]
Established March 1, 2007
Appointed by Secretary of Defense Robert Gates
Chaired by Former Army Secretary John Marsh and former Army and VA Secretary Togo West
Main recommendations Assign permanent case managers, reform disability system, focus on traumatic brain injury (TBI), post traumatic stress disorder (PTSD), accelerate transition from Walter Reed Army Medical Center, Washington, D.C., to Bethesda Naval Hospital, Maryland, and Fort Belvoir, Virginia.

Task Force on Returning Global War on Terror Heroes[5]
Established March 6, 2007
Appointed by President George W. Bush
Chaired by VA Secretary James Nicholson, who led a group of cabinet level officials
Main recommendations Build a joint DoD/VA disability system, develop a joint case management system, screen all returning veterans for TBI, develop a joint electronic health record.

Commission on Care for America's Returning Wounded Warriors[6]
Established March 6, 2007
Appointed by President George W. Bush
Chaired by Former Senator Bob Dole and former Secretary of Health and Human Services Donna Shalala
Main recommendations Establish a single military/VA disability rating, upgrade DoD/VA information sharing, create recovery plan for each wounded service member, aggressively prevent/treat TBI/PTSD.

Other Councils/Committees

Senior DoD and VA officials are diligently working to improve coordination between the two departments. Nine working groups led by under and assistant secretaries of the two departments have been meeting weekly since May 2007.[7] The following summarizes DoD/VA joint initiatives.

Senior Oversight Committee

In May 2007, the DoD established the Wounded, Ill, and Injured Senior Oversight Committee (Senior Oversight Committee) to bring high-level attention to addressing the problems associated with the care and services for returning service members, including the concerns that were being raised by the various review groups.[8] The

2 See http://mmso.med.navy.mil
3 See www.vetscommission.org
4 See www.washingtonpost.com/wp-srv/nation/documents/walter-reed/IRG_Report_Final.pdf
5 See www.va.gov/taskforce/
6 See www.pcoww.gov
7 Ann Smythe, Steve Strobridge, "A Hero's Welcome?" Military Officer, October 2007
8 GAO, DOD and VA: Preliminary Observations on Efforts to Improve Health Care and Disability Evaluations for Returning Servicemembers, GAO-07-1256T, 2007, p. 2

Senior Oversight Committee is co-chaired by the Acting VA Secretary and the DoD Deputy Secretary. The committee works in conjunction with the Joint Executive Council to ensure targeted focus on the population of men and women injured in Operation Enduring Freedom and Operation Iraqi Freedom and now returning for treatment. To conduct its work, the committee has established work groups that have focused on specific areas, including case management, disability evaluation systems, traumatic brain injury and psychological health, including PTSD, and data sharing between DoD and VA.

Joint Executive Council[9]

U.S.C. Title 38 mandates the Joint Executive Council.[10] It ensures a senior-level ongoing dialogue of coordination and collaboration between DoD and VA. Every year the council develops a Joint Strategic Plan[11] of strategies, goals, and initiatives in areas where DoD and VA can collaborate. The council holds quarterly meetings and annually reports to Congress on the progress made over the year on the strategic plan. The council is chaired by the Under Secretary of Defense for Personnel and Readiness (P&R) and the Deputy Secretary of Veterans Affairs.

Health Executive Council[12] and the Benefits Executive Council[13]

These are two smaller subcouncils under the Joint Executive Council. The Health Executive Council is chaired by the VA Under Secretary for Health and Assistant Secretary of Defense (Health Affairs). The council serves as the clinical arm of the Joint Executive Council. Under the Health Executive Council are 12 work groups:

- Benefits Coordination
- Clinical Guidelines
- Contingency Planning
- Deployment Health
- Financial Management
- Graduate Medical Education
- Geriatric Care
- Health Information Management & Technology
- Joint Utilization/Resource Sharing
- Medical/Surgical Procurement
- Patient Safety
- Pharmacy

The council is responsible for overseeing all health care policy and sharing initiatives between the two departments.

The Benefits Executive Council is chaired by the VA Under Secretary for Benefits and the Deputy Under Secretary of Defense (P&R). It is the disability compensation and evaluation arm of the Joint Executive Council. It has three working groups: benefits and services, cooperative physical exam, and information systems/information technology.[14]

9 See www.tricare.mil/DVPCO/joint.exe.cfm
10 See www4.law.cornell.edu/uscode/html/uscode38/usc_sec_38_00008111000.html
11 See www.tricare.mil/DVPCO/strategic.cfm
12 See www.tricare.mil/DVPCO/joint.exe.cfm
13 See www.tricare.mil/DVPCO/joint.exe.cfm
14 See www.va.gov/budget/report/2005/html/performance.section/narrative/gao/2.html

Appendix I Previous DoD Pharmacy Cost Control Measures

Mail Order Demonstration Project 1994–1996

In order to achieve economies of scale in pharmaceutical purchases and to decrease overhead costs, DoD conducted a two-site demonstration project to evaluate the advantages/costs of a mail order pharmacy program as part of the DoD Pharmacy Benefit The Logistics Management Institute conducted an evaluation of the project and determined this venue to be a cost-effective alternative and recommended expansion from two sites This effort eventually evolved into the National Mail Order Pharmacy program

National Mail Order Pharmacy Program (NMOP) 1997–2002

DoD decided to capitalize on the cost-effectiveness of the mail order pharmacy program Although the TRICARE managed care support contractors were providing a mail order pharmacy benefit, they could not access Federal Ceiling Prices (FCPs) for pharmaceuticals for which DoD believed it was entitled through the Veterans Health Care Act Consequently the TRICARE Management Activity (TMA) carved out the mail order benefit of the MCSCs and placed it under a single contract awarded and administered by the Defense Supply Center Philadelphia (DSCP) Through this contract, the DoD was able to access FCPs and achieve substantial savings on pharmaceuticals purchased and dispensed through the NMOP Under this initiative, acquisition costs for medications approached that of the Military Treatment Facilities (MTFs)

Federal Ceiling Prices/Federal Supply Schedule NMOP 1997

DoD can access favorable discounts for pharmaceutical purchases through the Federal Supply Schedule under the General Services Administration/Department of Veterans Affairs (VA) contracts and through the Veterans Health Care Act of 1992 These discounts of at least 24 percent off the nonfederal average manufacturer's price of drugs are accessible for pharmaceutical purchases in the MTFs and were implemented in the mail order program in 1997 Consequently, acquisition costs for medications in the mail order program approach those of the MTFs

Pharmacy Benefit Redesign Project 1998–1999

Section 703 of the Fiscal Year 1999 National Defense Authorization Act called for DoD to review the pharmacy benefit and to develop a systemwide redesign to include best business practices of the private sector, formulary management, and an integrated pharmacy information system A workgroup consisting of DoD senior pharmacy leaders, private sector pharmacy benefit management consultants, resource management analysts, and statistical analysts conducted an extensive review and in 1999 submitted a report to Congress that included the following recommendations

- Implement an integrated pharmacy information system to include military pharmacies, the mail order program, and TRICARE retail pharmacies (This was realized in 2001 with the implementation of the Pharmacy Data Transaction Service)
- Standardize policy implementation across all venues (This was realized in 2004, when the retail benefit from the TRICARE Managed Care Contracts [MCSCs] was carved out and placed under DoD pharmacy program oversight)

- Create tiered cost shares to provide financial incentives to influence beneficiary choice of lower-cost alternatives (Two-tier was realized in April 2001, three-tier became effective May 2004)
- Extend best federal pricing for pharmaceuticals to the retail pharmacy venue, comparable to that already available in the mail order program and military pharmacies (This effort is ongoing)
- Impose quantity limitations on certain drugs, require prior authorization for certain drugs, and require higher copayments for nonpreferred drugs (This is in place)
- Aggressively pursue third-party collections (This effort is ongoing)
- Create a centralized Pharmacy Benefits Office to oversee all DoD pharmacy programs (This effort is ongoing)

The redesign report also included recommendations that were not endorsed by DoD because of the perception of benefit erosion or extreme difficulties that would impede implementation

- Impose copayments at military pharmacies, mirroring those in the mail and retail venues
- Centralize funding for military pharmacies

Many of the endorsed recommendations led directly to the efforts detailed below

DoD Pharmacy Board of Directors Chartered by Assistant Secretary of Defense (ASD) in 1997, Rechartered Biannually

Comprised of senior military pharmacists representing each of the Surgeons General, the board is a collaborative advisory body the work of which involves standardizing pharmacy operations policies, medication use, business process improvements, pharmacy management practices, and joint procurements The board serves as a vital link between the ASD and military pharmacies

Federal Pharmacy Executive Steering Committee (FPESC) Chartered 1998, Rechartered Biannually

Created jointly with the DoD Pharmacoeconomic Center and the VA Pharmacy Benefits Management Strategic Health Group, the FPESC was created to capitalize on the economies of scale between the two departments and to integrate and build on the strengths of pharmacy benefit management in each department This forum provides the structure to jointly evaluate high-dollar and high-volume pharmaceuticals It provides oversight to joint agency contracts and increases the clinical and economic outcomes of drug therapy in the DoD and VA health care systems Ongoing DoD/VA joint pharmaceutical contracting initiatives continue to drive common formulary selections for both organizations Cost avoidance for DoD through these joint procurements over the past seven years is illustrated as follows

FY00	$65M
FY01	$78M
FY02	$139M
FY03	$148M
FY04	$185M
FY05	$211M
FY06	$423M

1

1 CAPT William Blanche TMA Information Paper DoD Efforts to Control Pharmacy Benefit Costs Since 1994 January 4 2007

Mandatory Generic Policy NMOP 1996, Retail 1999

Adopting a commercial business best practice, DoD implemented mandatory use of generics in the purchased care sector A recent report states that the national generic utilization rate in large health plans is 43 5 percent The average DoD generic utilization rate across all venues is 46 percent [2]

Basic Core Formulary 1999

The DoD Pharmacoeconomic Center analyzed, evaluated, and developed a list of drugs commonly used in all MTFs regardless of size or medical specialties offered and created the Basic Core Formulary The DoD Pharmacy and Therapeutics Committee approved the list that increased DoD's leverage for obtaining favorable prices for these products The list is routinely reviewed and updated by the committee as it reviews drug classes under the Uniform Formulary

Pharmacy Resource Reallocation Project 2000

The DoD Pharmacy Board of Directors and the TRICARE Management Activity Pharmacy Program Director tasked a tri service workgroup consisting of pharmacists and pharmacy consultants to perform a detailed assessment of how DoD pharmacy resources (equipment, staffing, robotics, etc) were allocated at the time and methods that could be implemented to reallocate those resources to maximize utilization Because of changing demographics of the DoD beneficiary population, some pharmacies were over resourced and some under resourced The result was a redistribution and standardization of pharmacy automation and a contract awarded for an enterprise-wide call-in refill system

Advances in Medical Practice 2000

The pharmacy portion of this limited funding provided money to purchase certain new, high-dollar drugs when they were indicated clinically but unavailable to small MTFs because of cost In the past, these MTFs had no recourse but to send beneficiaries to the far more expensive retail pharmacies Approximately $48 million was provided for these purchases, avoiding far greater costs than if the same drugs had been purchased in the retail sector

Tiered Copays in Retail/Mail Order 2001 and 2004

Adopting a commercial business best practice of using tiered copays to help influence beneficiary choice, DoD restructured and streamlined all pharmacy copays into two tiers based on generic and formulary with the implementation of TRICARE Senior Pharmacy in April 2001 and added a nonformulary third-tier with implementation of the Pharmacy Benefits Program Final Rule directed by 10 U S C 1074g in May 2004

2 Ibid

Pharmacy Data Transaction Service (PDTS) Fully Implemented Worldwide 2001

The Pharmacy Data Transaction Service (PDTS) was created as part of DoD's effort to integrate the disparate pharmacy venues It created a centralized data repository that records information about prescriptions filled for DoD beneficiaries at MTFs, the TRICARE retail pharmacy network, and the TRICARE Mail Order Pharmacy Program The primary purpose of the PDTS is to improve the quality of prescription services and enhance patient safety by reducing the likelihood of adverse drug-drug interactions, therapeutic overlaps, duplicate treatments, and overuse of the benefit Fully deployed since June 2001, it includes overseas MTF pharmacies and was a finalist for the President's Quality Award presented by President Bush in November 2002

TRICARE Mail Order Pharmacy Program 2003

The mail order pharmacy contract was recompeted and awarded to Express Scripts, Inc , on 26 September 2003 [3] At that time, contract oversight was moved from DSCP to TMA, resulting in a $20 million cost avoidance annually through lower administrative costs

TRICARE Retail Pharmacy Program 2004

In 2002, DoD decided to carve the retail pharmacy benefit out of the TRICARE managed care support contractors, allowing TMA pharmacy program oversight and improved management capabilities The retail contract was awarded in September 2003, and service began in June 2004 The single national contract under one Pharmacy Benefits Manager consolidated the retail benefit from the previous multiple managed care support contracts into one management entity, providing a fully portable benefit unrestricted by regional boundaries and centralized pharmacy claims processing, which has reduced administrative fees by more than 70 percent per claim The carve-out enabled the government to establish more favorable/guaranteed reimbursement rates for the network retail pharmacies Outstanding performance by the contractor has resulted in further reductions in the reimbursement rate and increased cost avoidance to the government The contractor has received the maximum monetary incentive award for these efforts Secretary of Veterans Affairs Principal agreed that this new contract and organizational structure meets provisions of the Veterans Health Care Act of 1992 regarding favorable discounts for pharmaceutical purchases by DoD DoD did pursue those discounts, which resulted in refunds to DoD that were stopped by the federal court in September 2006

Pharmacy Commercial Off-the-Shelf (RxCOTS) Award 2004

The RxCOTS award will streamline MTF business practices improve the efficiency of third-party billing, and provide a perpetual inventory system that will promote tighter inventory control and accountability RxCOTS will be implemented along with the worldwide deployment of the Armed Forces Health Longitudinal Technology Application

3 *See www defenselink mil/Releases/Release aspx?ReleaseID=7014*

Marketing Strategy for the TRICARE Mail Order Pharmacy (TMOP) Program 2006

The TMA Marketing Office in conjunction with the Pharmaceutical Operations Directorate implemented a comprehensive TMOP marketing program in February 2006 and has since seen a steady increase in the use of TMOP

Enhanced Utilization Management 2006

A division dedicated to utilization management was created under the Pharmaceutical Operations Directorate in May 2006 This team leverages the wealth of data from the Pharmacy Data Transaction Service, M2, and other Military Health Service data repositories to identify areas in which the delivery of the pharmacy benefit can be improved The team analyzes current utilization trends and explores opportunities to utilize the most cost-effective points of service

Federal Pricing Initiative for TRICARE Retail Pharmacy (TRRx) 2006

The pharmaceutical industry challenged in federal court the legality of the government's request to receive refunds from the pharmaceutical industry for products dispensed through the TRICARE retail network The department lost the lawsuit

Proposed Legislation for TRRx Federal Pricing 2006

Congress did not pass the proposed legislation

Increasing Pharmacy Beneficiary Cost Shares 2006

Efforts to increase pharmacy copayments, including proposed legislation to relieve the maximum cap of 20 to 25 percent currently imposed and to structure the copayments to incentivize use of the TMOP, were rejected by Congress, which has placed a freeze on increasing copayments until October 2007

Implementation of Voluntary Agreements for TRICARE Retail Pharmacy Rebates 2006

In December 2006, TMA notified more than 300 manufacturers of a new initiative called "Voluntary Agreements for TRICARE Retail Pharmacy Rebates" (VARR) The VARR is a new program through which manufacturers can voluntarily offer rebates on certain products based on Uniform Formulary placement or DoD utilization over time The manufacturers are under no legal or contractual obligation to do so, however, many senior industry representatives have indicated that many manufacturers will participate to some degree

Appendix J Synopsis of Proposed TRICARE Enrollment and Deductible Fees—Unindexed

	TRICARE PRIME		TRICARE STANDARD			
	Retiree Pay $0 to $19 999					
	Annual Enrollment Fees		Annual Enrollment Fees		Annual Deductible	
	Single	Family	Single	Family	Single	Family
Current (FY 08)	$230	$460	–	–	$150	$300
FY 08	$285	$570	$15	$30	$175	$350
FY 09	$340	$680	$30	$60	$195	$390
FY 10	$395	$790	$45	$90	$220	$440
FY 11	$450	$900	$60	$120	$245	$490
FY 12+	Adjusted Annually with Index				Relook at 5 yrs	

	Retiree Pay $20 000 to $39 999					
	Annual Enrollment Fees		Annual Enrollment Fees		Annual Deductible	
	Single	Family	Single	Family	Single	Family
Current (FY 08)	$230	$460	–	–	$150	$300
FY 08	$370	$640	$15	$30	$195	$390
FY 09	$415	$830	$30	$60	$235	$470
FY 10	$505	$1 010	$45	$90	$280	$560
FY 11	$595	$1 190	$60	$120	$325	$650
FY 12+	Adjusted Annually with Index				Relook at 5 yr	

	Retiree Pay $40 000 and Above					
	Annual Enrollment Fees		Annual Enrollment Fees		Annual Deductible	
	Single	Family	Single	Family	Single	Family
Current (FY 08)	$230	$460			$150	$300
FY 08	$390	$780	$15	$30	$235	$470
FY 09	$555	$1 110	$30	$60	$315	$630
FY 10	$715	$1 430	$45	$90	$400	$800
FY 11	$875	$1 750	$60	$120	$48	$960
FY 12+	Adjusted Annually with Index				Relook at 5 yrs	

Appendix K Implementing Our Recommendations

The following chart summarizes the focus of responsibility for implementing the action steps that support our recommendations

RECOMMENDATION AND ACTION STEPS	CONGRESS	DOD
1 Develop a Strategy for Integrating Direct and Purchased Care		
Develop a strategy for integrating the direct and purchased care systems		x
Provide incentives to optimize the best practices of direct care and private sector care		x
Fiscally empower the individuals managing the provision of integrated health care and hold them accountable		x
Draft legislative language to create a fiscal policy that facilitates integrated health care	x	x
Develop metrics to measure whether the planning and management strategy produces desired outcomes		x
2 Collaborate with Other Payers on Best Practices		
Align with government and private sector organizations to make health care quality and costs more transparent and accessible to beneficiaries		x
Use performance based clinical reporting		x
Strengthen incentives to achieve high quality and high value performance		x
Implement a systematic strategy of pilot/demonstration programs and identify successes for widespread implementation		x
3 Conduct an Audit of Financial Controls		
Charge the auditor with assessing the most efficacious and cost effective approach		x
Ensure audit recommendations are implemented and followed up		x
Establish a common cost accounting system while ensuring TRICARE is a second payer when other health insurance exists		x
4 Implement Wellness and Prevention Guidelines		
Continue to prioritize prevention programs		x
Implement and resource standardized case management and care coordination beyond the Wounded Warrior and across the spectrum of care		x
Ensure timely and accessible performance feedback to providers, managers, and the chain of command		x
Maintain high level visibility of business/clinical performance for the entire enterprise		x
5 Prioritize Acquisition in the TRICARE Management Activity		
Elevate the level of the Head of the Contracting Activity		x
Ensure acquisition personnel are certified according to the Defense Acquisition Workforce Improvement Act		x
Ensure management of programs is consistent with the Defense Acquisition System process		x
Place acquisition functions under a Chief Acquisition Officer		x
Study possibility of colocating TRICARE Deputy Chief TRICARE Acquisitions organization with acquisition counterparts		x

RECOMMENDATION AND ACTION STEPS	CONGRESS	DOD
6 Implement Best Practices in Procurement		
Examine and implement strategies compliant with Executive Order 13410		x
7 Examine Requirements in Existing Contracts		
Examine benefits/risks of waiving cost accounting standards		x
Examine referral and enrollment processes		x
Test and evaluate through pilot or demonstration projects the effectiveness of carved out chronic disease management programs		x
Examine overarching contracting strategy for purchased care		x
8 Improve Medical Readiness of the Reserve Component		
Assess the impact of TRICARE Reserve Select in three to five years		x
Improve education/information flow about the health care benefit		x
Harmonize/leverage work of other review groups to improve DoD/VA coordination of beneficiary services and reduce administrative seams in the Military Health System		x
Expand efforts in nonprime service areas to improve access		x
9 Change Incentives in the Pharmacy Benefit		
Revise the pharmacy medication tier structure		x
Conduct a pilot program on the impact of total spend and outcomes		x
Grant DoD authority to selectively include clinically and cost effective over the counter medications in the formulary when recommended by the Pharmacoeconomics Center	x	
Grant DoD authority to mandate the point of service for Special Category Medications based on established criteria	x	
10 Revise Enrollment Fees and Deductibles for Retirees		
Increase enrollment fees for non Active Duty TRICARE Prime beneficiaries	x	x
Establish enrollment fees for all other non Active Duty beneficiary categories	x	x
Establish indexing for all non Active Duty beneficiary categories for enrollment fees, copayments, deductibles, and catastrophic caps	x	x
Tier enrollment fees based on retiree pay	x	x
Examine feasibility of establishing other TRICARE options so all retirees can have comparable choices		x
11 Study and Pilot Test Programs Aimed at Coordinating TRICARE and Private Insurance Coverage		
Study and possibly pilot a program to better coordinate insurance practices for those retirees who are eligible for private health care insurance as well as TRICARE		x
12 Develop Metrics by Which to Assess the Success of Military Health System Transformation		
Develop metrics of success for any planned transformation of command and control of the Military Health System		x

Appendix L Acronyms

AFMS—Air Force Medical Service
AHLTA—Armed Forces Health Longitudinal Technology Application
AMEDD—Army Medical Department
AM&S—Acquisition Management and Support
AVS—Automated Voucher System
BRAC—Base Realignment and Closure
BUMED—Bureau of Medicine and Surgery
CHAMPUS—Civilian Health and Medical Program of the Uniformed Services
CHCBP—Continued Health Care Benefit Program
CHCC—Center for Health Care Contracting
CHF—Congestive Heart Failure
CHPPM—U S Army Center for Health Promotion and Preventive Medicine
CMOP—Consolidated Mail Outpatient Pharmacy
CMS—Centers for Medicare & Medicaid Services
CONUS—Continental United States
CPB—Clinically Preventable Burden
DAWIA—Defense Acquisition Workforce Improvement Act
DEERS—Defense Enrollment Eligibility Reporting System
DHP—Defense Health Program
DHS—Department of Homeland Security
DMAA—Disease Management Association of America
DMDC—Defense Management Data Center
DoD—Department of Defense
DoD IG—Department of Defense Inspector General
DPO—Defense Privacy Officer
DSCP—Defense Supply Center Philadelphia
ETP—Enterprise Transition Plan
FEDS_HEAL—The Federal Strategic Health Alliance
FEHBP—Federal Employees Health Benefits Program
FFMIA—Federal Financial Management Improvement Act
FHPO—FEDS_HEAL Program Office
FIAR—Financial Improvement and Audit Readiness
FICA—Federal Insurance Contributions Act
FOH—Federal Occupational Health
FSS—Federal Supply Schedule
GAAP—Generally Accepted Accounting Principles
GAO—Government Accountability Office (prior to name change effective July 7, 2004, was General Accounting Office)
GDP—Gross Domestic Product
GME—General Medical Education
GWOT—Global War on Terrorism
HCA—Head of Contracting Activity
HCAA—Health Care Acquisition Activity
HEDIS—Health Employer Data Information System
HHS—Department of Health and Human Services
HIPAA—Health Insurance Portability and Accountability Act of 1996
HMO—Health Maintenance Organization
ID/IQ—Indefinite Delivery/ Indefinite Quantity
IG—Inspector General
IMR—Individual Medical Readiness
ISA—Individual Set Aside
LOD—Line of Duty
MCC—Member Choice Center
MEB—Medical Evaluation Board
MEDCOM—U S Army Medical Command

MEPRS—Medical Expense and Performance Reporting System
MEPS—Military Expenditure Panel Survey
MERHCF—Medicare-Eligible Retiree Health Care Fund
MHS—Military Health System
MHSPHP—Military Health System Population Health Portal
MilPer—Military Personnel
MMSO—Military Medical Support Office
MRMS—MTF Refill Mail Service
MRR—Medical Readiness Review
MSM—Multi-Service Market
MTF—Military Treatment Facility
NAVMEDLOGCOM—Naval Medical Logistics Command
NAVSUP—Naval Supply Systems Command
NCA—National Capital Area
NCPP—National Commission on Prevention Priorities
NDAA—National Defense Authorization Act
NMCSD—Naval Medical Center, San Diego, California
NMOP—National Mail Order Pharmacy
NOE—Notice of Eligibility
OCHAMPUS—Office of CHAMPUS
OCONUS—Outside Continental United States
OEF—Operation Enduring Freedom
OIF—Operation Iraqi Freedom
O&M—Operations and Maintenance
OMB—Office of Management and Budget
OPM—Office of Personnel Management
OTC—Over-the-Counter
PAR—Performance and Accountability Report
PBD—Program Budget Decision
PDTS—Pharmacy Data Transaction Service
PEB—Physical Evaluation Board
PEC—Pharmacoeconomic Center
PEO—Program Executive Offices
PhRMA—Pharmaceutical Research and Manufacturers of America
PPO—Preferred Provider Organization
PSA—Prime Service Area
PTSD—Post-Traumatic Stress Disorder
QALY—quality-adjusted life years
QDR—Quadrennial Defense Review
RDT&E—Research, Development, Test, and Evaluation
RFI—Request for Information
RFP—Request for Proposal
SCRA—Servicemembers Civil Relief Act of 2003
SMA—Services Medical Activity
STB—Sustaining the Benefit
T3—The Next Generation of TRICARE Contracts
TAMP—Transition Assistance Management Program
TBI—Traumatic Brain Injury
TFL—TRICARE for Life
TMA—TRICARE Management Activity
TMOP—TRICARE Mail Order Pharmacy
TPharm—Combined TRICARE mail and retail pharmacy contract
TPRADFM—TRICARE Prime Remote for Active Duty Family Members
TRO—TRICARE Regional Office
TRRx—TRICARE Retail Pharmacy
TRS—TRICARE Reserve Select
TSC—TRICARE Service Center
TSO—TRICARE Support Office
TSRx—TRICARE Senior Pharmacy
TTAD—Temporary Tour of Active Duty
UMC—Unified Medical Command
UMWA—United Mine Workers of America
USAMRAA—U S Army Medical Research Acquisition Activity
USDA—U S Department of Agriculture
USERRA—Uniformed Services Employment and Reemployment Rights Act
USFHP—US Family Health Plan
USTF—Uniformed Services Treatment Facility
VA—Department of Veterans Affairs
VHA—Veterans Health Administration
WPMC—Wright-Patterson Medical Center

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