

UNITED STATES DEPARTMENT OF DEFENSE

DEFENSE HEALTH BOARD

OPEN MEETING

Arlington, Virginia

Tuesday, December 11, 2007

1 P R O C E E D I N G S

2 (9:10 a.m.)

3 DR. POLAND: Good morning, everybody.

4 Welcome to this meeting of the Defense Health
5 Board. My name is Dr. Poland. I am President of
6 the Board. We have a variety of extremely
7 important topics to discuss today, so we'll go
8 ahead and get started, and I'll ask Ms. Embrey to
9 call the meeting to order.

10 MS. EMBREY: Thank you, Dr. Poland. As
11 the Delayed Designated Federal Official for the
12 Defense Health Board which is a federal advisory
13 committee to the Secretary of Defense, the
14 Surgeons General, and the Assistant Secretary of
15 Defense for Health Affairs, I hereby call this
16 meeting of the Defense Health Board to order.

17 DR. POLAND: Thank you, Ms. Embrey. A
18 tradition that we have established with the board
19 is a moment of silence to honor and remember those
20 who have served and those who particularly during
21 this season are away from their families and are
22 sacrificing on our behalf. So if all in the room

1 would please stand and observe a moment of
2 silence.

3 (Moment of silence.)

4 DR. POLAND: Thank you very much. I
5 particularly want to welcome Dr. Ward Cassells who
6 is the Assistant Secretary of Defense for Health
7 Affairs. It's an honor to have you here with us
8 today, and we want to thank you for your support
9 of the board and interest in the board's
10 activities and joining us today. I understand you
11 have some welcome remarks, but let us greet you
12 formally.

13 SEC CASSELLS: Dr. Poland, I don't have
14 any prepared remarks. I'd just like to thank you,
15 Ellen Embrey, and Roger Gibson, for your service
16 here and all the board. This is a tremendous
17 turnout and testament to the importance of what we
18 all collectively are doing. And Gail Wilensky,
19 there aren't words to thank you for the work that
20 you did on the other task force and this task
21 force which you had led. This is the final of the
22 six major task forces. It is keenly awaited, and

1 you will find not just me but the whole defense
2 department taking notes and working toward
3 implementation of these results. So we thank you
4 for the tremendous numbers of hours you've put
5 into this working long and working hard and
6 working smart. And I am sure that the board will
7 be able to add their perspectives too and they are
8 very, very welcome. So Dr. Poland, thank you so
9 much for doing this.

10 DR. POLAND: Colonel Gibson will have
11 some administrative remarks I think and then we'll
12 begin.

13 COL GIBSON: I want to thank the staff
14 at the Crystal City Sheraton for helping make the
15 arrangements for the board members and also thanks
16 to my staff, Karen Triplett and Lisa Gerrett for
17 all their hard work in preparing for this, and Ms.
18 Ward back home.

19 If you haven't done so, please sign the
20 attendance roster that is on the table outside the
21 room. There are also rosters for those folks who
22 want to make statements, and there is a roster for

1 the press.

2 For those who are not seated at the
3 tables, for this afternoon's sessions we'll have
4 handouts available for the briefings that are
5 given at that time. Restrooms are around the
6 corner outside to your left when you leave this
7 room. And if you need telephone, fax, copies, et
8 cetera, see Ms. Triplett. The next meeting of the
9 board will be April 23rd and 24th in Tacoma,
10 Washington. Our host will be Mattigan Army
11 Regional Medical Center at Fort Lewis. At this
12 meeting we'll complete deliberations on a number
13 of open board business items.

14 Through the Uniform Services University
15 we have been able to get 2.6 continuing education
16 credits for this meeting. To receive the credits
17 you need to sign the CME attendance roster and
18 complete the evaluation form and attestation
19 statement for the meeting and hand it in to Ms.
20 Gerrett or Ms. Triplett. For board members, your
21 evaluation forms are in your notebooks. We will
22 mail out the CME certificates when we receive them

1 USU. Refreshments are available for both the
2 morning and afternoon sessions. We will have a
3 catered working lunch for the board members,
4 preventative medicine officers, distinguished
5 guests, and speakers. There are a number of
6 hotels right around here for others who will be
7 breaking for lunch.

8 Finally as a reminder, this meeting is
9 being transcribed so please speak clearly into the
10 microphones and state your name before you begin.
11 And please turn off your pagers, Blackberries, and
12 cell phones. The Blackberries, for the board
13 members, keep them below the table. They do
14 interfere with the microphones from what I am
15 told.

16 DR. POLAND: Our first order of business
17 today is the deliberation of the draft findings
18 and recommendations of the task force on the
19 future of military health care. As the board
20 members will recall, the task force was formed
21 last year at the direction of Congress and charged
22 with examining matters related to the future of

1 health care with the Department of Defense. The
2 task force was to make assessment of and
3 recommendations for sustaining the health care
4 services being provided to members of the armed
5 forces, retirees, and their families. A copy of
6 the congressional language is at Tab 2 of your
7 briefing books.

8 As a subcommittee of the Defense Health
9 Board, the task force and board are required by
10 federal advisory committee statutes to deliberate
11 task force findings and recommendations in an open
12 session before they are finalized. The task force
13 will deliver the final report to the Secretary of
14 Defense in the very near future. The report is a
15 product of the task force. The board as a part of
16 the committee will provide any comments regarding
17 the task force report in a separate document.

18 All of the members have received a copy
19 of the task force draft findings and
20 recommendations. I remind you that this document
21 is a draft and not yet a public document. Our
22 discussions today will center on primarily the

1 general findings and recommendations and not on
2 for example specific numbers recommended by the
3 task force.

4 For those in attendance, the discussions
5 today will be between the members of the Defense
6 Health board and the Task Force on the Future of
7 Military Health Care. If time allows, at the end
8 we'll take questions and statements from the
9 public. We ask that you register to speak at the
10 desk right outside this room. Everyone however
11 has the opportunity to submit written statements
12 to the board. Those statements can be submitted
13 today at the registration desk or by email at
14 dhb@ha.osd.mil, or they mailed to the Defense
15 Health Board office. The address is also
16 available on fliers located at the registration
17 table.

18 I'd like for us now to go around the
19 table and introduce ourselves, and I'd like to
20 start by having our newest member, Colonel Retired
21 Reverend Robert Certain introduce himself.

22 COL CERTAIN: I think you just did, sir,

1 but I'm Robert Certain, retired Air Force
2 Chaplain, Colonel. During Vietnam I was a B-25
3 crew member POW.

4 DR. POLAND: Thank you and welcome.
5 Other distinguished guests today include Dr.
6 Floabel Mullick, principal director of AFIP,
7 Brigadier General William Fox, a member of the
8 Board's Panel for the Care of Individuals with
9 Amputations and Functional Limb Loss, Major
10 General Retired Mary Ann Matthewson, Chaplain for
11 the V.A., and Mr. Larry Leitner from USAMRID here
12 representing Mr. Bill Howell.

13 So if we could, we'll go around and
14 introduce ourselves and I'll turn to Ms. Embrey
15 and then Dr. Wilensky.

16 MS. EMBREY: I'm Ellen Embrey. I am the
17 Designated Federal Official for the board, and in
18 my real job I am the Deputy Assistant Secretary
19 for Force Self- Protection Medical Readiness.

20 MS. WILENSKY: I'm Gail Wilensky. I'm
21 Co-Chair of the Task Force on the Future of
22 Military Health Care. And since Bill Fox is here,

1 I'd better also indicate I have a real day job
2 which is a Senior Fellow at Project HOPE, although
3 for the last year I have thought my day job is
4 actually worrying about military health care.

5 RADM SMITH: I'm Dave Smith. I'm the
6 Joint Staff Surgeon and a member of the task
7 force, and I am also a customer of the Defense
8 Health Board.

9 MS. BADER: Good morning. Christine
10 Bader, Executive Secretary.

11 MR. HALE: I'm Bob Hale, task force
12 member, former Comptroller of the Air Force.

13 MR. HENKE: Bob Henke, task force
14 member, CFO to V.A.

15 MG ADAMS: Nancy Adams, Major General,
16 U.S. Army Retired, task force member.

17 RADM MATECZUM: John Mateczum, task
18 force member.

19 GEN MYERS: Dick Myers, General Retired,
20 task force member.

21 LTG ROUDEBUSH: Jim Roudebush, task
22 force member, Surgeon General of the Air Force.

1 MG SMITH: Bob Smith, Major General
2 Retired Reserves, and task force member and former
3 international controller of Ford Motor Company.

4 MG KELLEY: Joe Kelley, task force
5 adviser and retired Major General.

6 MR. GARDNER: Pierce Gardner, Defense
7 Health Board member and a professor of medicine
8 and public health at the State University of New
9 York at Stony Brook.

10 DR. WALKER: David Walker, Defense
11 Health Board member, chair of pathology,
12 University of Texas Medical Branch at Galveston.

13 BG FOX: Bill Fox, subcommittee member
14 for the Amputee Care and Functional Limb Loss
15 Subcommittee, and Chief Operating Officer for
16 Project HOPE.

17 DR. SILVA: I'm Joe Silva, professor of
18 internal medicine, dean emeritus, University of
19 California at Davis School of Medicine.

20 DR. SHAMOO: Adil Shamoo, professor of
21 bioethics, University of Maryland School of
22 Medicine.

1 DR. PARKINSON: Mike Parkinson,
2 president, American College of Preventive
3 Medicine, member of the Defense Health Board.

4 DR. PARISI: Joe Parisi, member of the
5 Defense Health Board, Chair of the Subcommittee
6 for Pathology and Laboratory Services, and
7 professor of pathology at the Mayo Clinic.

8 DR. OXMAN: Mike Oxman, member of the
9 Defense Health Board and professor of medicine and
10 pathology at the University of California at San
11 Diego.

12 DR. MILLER: Mark Miller, member of the
13 Defense Health Board and associate director for
14 research at the Fogarty International Center,
15 National Institutes of Health.

16 DR. MCNEILL: Mills McNeill, board
17 member, and Director of the Public Health
18 Laboratory at the Mississippi State Department of
19 Health.

20 DR. LEUPKER: I'm Russell Leupker, and
21 I'm a board member and a cardiologist and
22 epidemiologist from the University of Minnesota.

1 DR. LOCKEY: Jim Lockey, professor of
2 international medicine and environmental health at
3 the University of Cincinnati and a board member.

4 DR. LEDNAR: Wayne Lednar, member of the
5 Defense Board and global chief medical officer for
6 Dupont.

7 DR. HALPERIN: Bill Halperin, member of
8 the board, chair of preventive medicine, New
9 Jersey Medical School, Newark, New Jersey, and
10 chair of quantitative methods, School of Public
11 Health, Newark, New Jersey.

12 DR. CLEMENTS: I'm John Clements. I'm a
13 member of the health board. I am the chairman of
14 microbiology and immunology at Tulane University
15 School of Medicine in New Orleans.

16 COL GIBSON: I'm Colonel Roger Gibson.
17 I'm the Executive Secretary for the Defense Health
18 Board.

19 DR. POLAND: And I'm Greg Poland,
20 professor of medicine and infectious disease and
21 vice chair of the department of medicine at the
22 Mayo Clinic, in Rochester, Minnesota. I am going

1 to read a statement I wrote, and it is better to
2 come clean. I just flew in from Amsterdam last
3 night so hopefully what I have to say is coherent,
4 but we'll give it a try here.

5 It was of interest in that it gave me
6 about 10 hours in a coach seat to read through
7 this report in detail. I was amazed as I think
8 you will be to learn that in fiscal year 2001 the
9 cost of the military health mission was \$19
10 billion, and by fiscal year 2007 it had increased
11 by more than 100 percent to \$40 billion serving 9
12 million beneficiaries. Pharmacy benefits have
13 gone up from \$1.6 billion to \$6.5 billion in a
14 7-year time period. And the task force has
15 estimated that at its current rate of growth, the
16 military health system costs will be \$64 billion
17 by 2015 which will be 12 percent of the DOD
18 budget. To give you a number or an anchor with
19 which to understand that 12 percent, that number
20 was 4-1/2 percent in 1990.

21 The military health system includes
22 133,000 personnel, 86,000 military medical folks,

1 and 47,000 civilians, working at over a thousand
2 geographic locations. This morning the DHB will
3 as the parent board vet the report produced by the
4 task force on the future of military health care.
5 The task force you will recall delivered an
6 interim report focusing primarily on pharmacy
7 benefits in May 2007. The report before you is
8 now the draft of their final report. It's obvious
9 that much work and thought have gone into its
10 formulation and we thank the co-chairs General
11 Corley and Dr. Wilensky for such a deep dive into
12 a complex topic as this one and the very honest
13 assessment that came from it. Thank you very
14 much.

15 I have read it with interest and indeed
16 selfish interest. By way of disclosure, my family
17 since 1955 have been beneficiaries of the military
18 health care system, and 5 days ago my son Eric
19 received his letter of acceptance from the Air
20 Force Academy. So we are fully in this one. The
21 changes proposed and the implications of it will
22 affect him and all other beneficiaries long after

1 virtually every one of us in this room have
2 retired. So this is an important step on the
3 never-ending journey needed to provide for those
4 who ensure our safety and security while being
5 financially prudent.

6 I also want to just by overview talk a
7 little bit about the recommendations of the task
8 force. I was pleased that they started with a set
9 of guiding principles, something you often do not
10 see in a task force, and those included three
11 overarching ones, that DOD must maintain a health
12 care system that meets readiness needs, that they
13 must make changes in business and health care
14 practices aimed at improving effectiveness of the
15 military health care system, and that veterans and
16 their dependents, and I like the word they chose,
17 deserve a generous health care benefit.

18 They had a series of specific
19 recommendations, and I will just read the topics
20 of those without going into detail of them. I
21 guess maybe the co-chairs will read some of those.
22 That's fine. The one area that the task force

1 addressed but did not give recommendations on for
2 very good reasons is this issue of the DOD
3 organizational structure and the committee noted
4 that the lack of an integrated system here
5 resulted in a "cumbersome disintegrated system
6 with adverse effects primarily related to
7 fragmentation, the inability to coordinate,
8 manage, and implement best practices, and the lack
9 of a uniform cost-accounting system."

10 I want to now move us as a board to
11 discussion of the task force's report. Costs and
12 fees are not really within the board's sphere of
13 decision making and I would ask that we not focus
14 on these but, rather, spending our time on
15 discussion of the substantive issues before us.
16 Similarly, issues outside of the task force's
17 charge would be less relevant or fruitful in our
18 discussion this morning. Finally, while those in
19 attendance as I mentioned earlier are welcomed and
20 encouraged to listen, this first discussion is
21 between the task force and the Defense Health
22 Board, and later is there is time and if you have

1 registered, we will provide time for the public to
2 make statements.

3 So if I can, I will move to Rear Admiral
4 Smith who is here representing General Corley, and
5 then Gail Wilensky for their opening remarks.

6 RADM SMITH: Good morning, Dr. Poland,
7 Defense Health Board, Dr. Cassells, Ms. Embrey,
8 task force members, and guests, welcome. And on
9 behalf of the task force, thank you for the
10 opportunity to appear before you this morning to
11 share Task Force on the Future of Military Health
12 Care's final report, findings and recommendations.

13 General Corley, our co-chair, sends his
14 regrets. He could not be here this morning, and I
15 think it is telling of senior flag officer and
16 general officer schedules that even a four star
17 cannot control his schedule because he sincerely
18 wanted to be here but has to be overseas at this
19 time. So Dr. Wilensky will carry on without him.

20 Earlier this year in our interim report
21 the task force provided you preliminary findings
22 and recommendations relative to DOD health care

1 costs in general, and recommendations concerning
2 cost sharing in the pharmacy program in
3 particular. Those preliminary findings and
4 recommendations have been further developed and
5 supplemented in the final report. Congress asked
6 the task force to address a broader array of
7 elements in its final report such as the DOD
8 wellness initiatives, disease management programs,
9 the ability to account for true and accurate costs
10 of health care in the military health system, the
11 adequacy of military health care procurement
12 systems, as well as an assessment of the
13 government cost-sharing structure required to
14 provide military health benefits over the
15 long-term.

16 Earlier in our term as Dr. Poland
17 pointed out, we adopted a set of guiding
18 principles presented in our interim report that
19 have remained the same and helped us frame our
20 final assessments and recommendations. With those
21 in mind, we have sought to preserve the best
22 aspects of the current system, which has many, and

1 to identify ways to further enhance delivery of
2 acceptable quality health care for the long-term.
3 With that short introduction, I will now turn over
4 the presentation and the discussion to our
5 co-chair, Dr. Gail Wilensky, for her remarks.

6 DR. WILENSKY: Thank you very much
7 Admiral Smith. As he indicated and as I have had
8 email correspondence with General Corely, he very
9 much wishes he could be here today but has been a
10 very active member of the task force.

11 It has been just about exactly a year
12 that the task force has been meeting to assess and
13 make recommendations for sustaining military
14 health care services for members of the armed
15 forces, retirees, and their families. The work
16 that we have been engaged in has been a very large
17 task indeed. The 14 members of the task force and
18 our executive director and very able staff have
19 worked very hard to make this actually come to
20 fruition within the course of 12 months. We have
21 during the last 12 months convened some 15 public
22 meetings in order to gather information. We have

1 visited areas in different parts of the country to
2 try to better inform ourselves. Several of us had
3 the opportunity to travel to Qatar, Iraq, and
4 Germany, to better understand some of the
5 forwarding- operating base health care delivery
6 operations and morale issues that our servicemen
7 and -- women are facing.

8 We would like people to understand that
9 in trying to look at these very complicated issues
10 that Congress asked us to address, we did it
11 within the context of the U.S. health care system
12 since it is impossible to assess what is going on
13 in any other way. The task force is independent.
14 All of us came on to this activity agreeing that
15 we would have not preconceived outcomes or
16 opinions or recommendations, but would let
17 ourselves be guided by what we heard and the facts
18 as we know them, and that is what we have done.
19 As has been indicated, this is a final piece in
20 what has been a deliberative, open, and
21 transparent process and it is important that it is
22 regarded in that way.

1 In looking at the issues that we have
2 been asked to address with regard to the future of
3 military health care, we understand that health
4 care in the military is increasing just as it is
5 increasing everywhere else in the United States.
6 It is a problem that has been an issue for this
7 country. In making sure that we get both the best
8 value and find ways to moderate spending on health
9 care has been an issue for all of health care as
10 well as the Department of Defense. We also note
11 that the Tricare premiums and cost-sharing
12 provisions have been level, that is flat in actual
13 dollar terms, for nearly a decade and that has
14 been contributing to some of the issues that we
15 have been facing.

16 As Dr. Poland indicated and as we very
17 much believe, that looking at the role of the
18 military and the role of military health care
19 places it in a unique position. The deployments
20 and duties of people who are part of the military
21 is different from that which most of the rest of
22 us face in this country. Military health care has

1 been an important part of the compensation and
2 benefits system. In trying to go forward as you
3 heard again, we set out some guiding principles
4 that we felt were important to articulate at the
5 beginning at our first formal document, our
6 interim. That is that the Department of Defense
7 must maintain a health care system that meets
8 military readiness, appropriately sized and
9 resourced; able to withstand and support the long
10 war on terror as well as the support of
11 conventional war; and that equally it is important
12 that quality, accessible, cost-effective health
13 care is available and provided for the long-term.
14 We have recognized and we have said it in our
15 interim report and say it again multiple times as
16 we go forward that it is important that we have a
17 generous health care benefit in recognition of the
18 importance service that our members, retirees, and
19 their families have provided.

20 But we also recognize that it is
21 important for the American taxpayers to be
22 comfortable that there is some balance in terms of

1 quality and efficiency, fiscal responsibility, and
2 affordable cost. What we have attempted to do
3 over the course of these last 12 months is to
4 bring some balance.

5 We believe that many of the
6 recommendations if implemented will affect how
7 health care is provided through the military
8 health care system and that it is important that
9 the recommendations that we are making to the
10 extent that they involve changes in cost will not
11 affect active- duty personnel or their families
12 for health care and we thought this was an
13 important principle that we should maintain.

14 I am going to describe the major
15 recommendations that we have come to agreement on
16 as a task force. The action items will be
17 something that we can discuss in greater detail as
18 we come to complete deliberation for this report.
19 But the recommendations themselves have been
20 discussed sufficiently that we feel comfortable
21 saying this is where the task force now is and
22 reflects the best belief of this group as ways to

1 go forward.

2 In our final report we will indicate
3 those activities that can be accomplished
4 administratively by the Department of Defense, and
5 those relatively few items that will require
6 congressional action. As a member of the
7 Dole-Shalala Commission, I have learned two
8 important strategies over the course of this year.
9 The first is to try to limit the number of
10 recommendations that we are making. We are making
11 12, and actually in many ways 10 with the last two
12 of a somewhat different level of order. And also
13 to indicate those areas that can be accomplished
14 administratively, therefore we can try to pressure
15 the Department of Defense to go do what it is able
16 to do now without waiting for congressional action
17 but highlight those things which will require
18 congressional action and try to have that occur in
19 as expeditious manner as is possible.

20 The recommendations are the following.
21 The first and in many ways the most overarching
22 recommendation is to develop a strategy for

1 integrating direct and purchased care. That is,
2 the department needs to have a more deliberate
3 planning and management strategy that integrates
4 the direct health care system with the purchased
5 health care system and to promote the integration
6 at the level where health care is being provided.
7 We understand the need for having flexibility and
8 the desire for optimizing the delivery of health
9 care to all DOD beneficiaries and we think that it
10 will be very difficult to have this function well
11 without better integration at the local level
12 where care is actually provided than occurs in the
13 current environment.

14 Our second recommendation is that there
15 be a better collaboration with other payers on
16 best practices. Specifically, we think there
17 should be an advisory group to enhance military
18 health care collaboration with the private sector
19 and other federal agencies in order to share,
20 adopt, and promote best practices. There are some
21 areas where the Department of Defense and the
22 Veterans Administration already represent best

1 practices, but there are other areas where there
2 is much to be learned from best practices that go
3 on in the private sector and we think more needs
4 to be done here.

5 The third is that there should be an
6 audit of financial controls. DOD should request
7 this audit to determine the adequacy of the
8 processes by which the military ensures that only
9 those who are eligible for health benefit coverage
10 receive such coverage and that there is compliance
11 with law and policy regarding Tricare as a
12 secondary payer and that it be done in a uniform
13 way. While we do not have explicit indication
14 that there is a problem, we are that when such
15 audits have been done elsewhere in the private
16 sector they have usually indicated a possibility
17 for improved processes and we think that is likely
18 to be the case in the military and will only know
19 that when such audit occurs.

20 The fourth recommendation is that there
21 should be wellness and prevention guidelines
22 implemented. That is, the department should

1 follow the national wellness and prevention
2 guidelines and promote the appropriate use of
3 resources through standardized case management and
4 disease management programs. It is not that these
5 do not occur in any way, they do not occur in a
6 sufficiently uniform way across all of the health
7 care delivery sites.

8 The fifth is that there should be
9 priority given to acquisition at the Tricare
10 management activity. DOD needs to restructure the
11 Tricare management activity in order to place
12 greater emphasis on its role in acquisition.

13 The sixth recommendation has to do with
14 implementing best practices in procurement.
15 Because the Department of Defense is such a large
16 procurer of health care services, it is important
17 that ways be found to aggressively assess and
18 incorporate the best practices that go on in both
19 the public and private sectors with respect to
20 health care purchasing.

21 The seventh recommendation has to do
22 with existing contracts. We are recommending that

1 the department reassess requirements for purchase
2 care contracts to determine whether more effective
3 strategies can be implemented to obtain those
4 services and capabilities.

5 The eighth recommendation is to improve
6 medical readiness of the Reserve component. We
7 believe it is important that the department
8 improve the medical readiness for the Reserve
9 component recognizing that its readiness is a
10 critical aspect of overall total force readiness
11 and that it is not operating in that way during
12 the current environment.

13 The ninth recommendation is that there
14 should be a change in the incentives in the
15 pharmacy benefit. Congress and DOD need to revise
16 the pharmacy tier and co-pay structures based on
17 what is known about clinical and cost-effective
18 standards in order to promote greater incentives
19 to use preferred medication and more cost-
20 effective points of service.

21 The tenth recommendation has to do with
22 revising enrollment fees and deductibles for

1 retirees. It is a multiple-part recommendation.
2 We believe that the department should propose and
3 Congress should accept phased-in changes in
4 enrollment fees and deductibles for retirees under
5 the age of 65 that would restore cost- sharing
6 relationship put in place when Tricare was
7 created. We believe that most of these fees and
8 deductibles should be tiered so that they are
9 higher for those receiving higher retirement pay.
10 The task force also recommends changes in other
11 features such as co-payments and a catastrophic
12 cap which should be phased in over a period of
13 years and which should be reassessed in a periodic
14 manner.

15 In addition, we believe that the
16 department should propose and Congress should
17 accept a modest enrollment fee for Tricare for
18 Life beneficiaries. This is not being proposed in
19 order to reduce the department's cost but, rather
20 to foster personal accountability and consistent
21 with the task force's philosophy that military
22 retiree health care should be very generous but

1 not free. It is also a change even though there
2 is a very modest enrollment fee that should be
3 phased in over a number of years. The task force
4 believes in addition that DOD should propose and
5 that Congress should accept automatic annual
6 indexing of enrollment fees that maintain the
7 cost-sharing relationship put in place when
8 Tricare was created to account for future
9 increases in per capita military medical records.
10 Unless there is an automatic indexing put in
11 place, the cost shares restored at any one point
12 in time in terms of retiree cost sharing will not
13 be maintained. Other elements of cost sharing
14 such as deductibles and co-payments should not be
15 indexed annually, but they should be reassessed at
16 least every 5 years.

17 The eleventh recommendation is that
18 pilot programs be considered and studied that
19 would aim at having a better coordination between
20 Tricare and private insurance coverage. The
21 department should commission a study and then
22 consider pilot programs aimed at better

1 coordinating insurance practices among those
2 retirees who are eligible for private health care
3 insurance as well as for Tricare.

4 Finally, as the twelfth recommendation,
5 we believe that metrics need to be developed so
6 that the success of the military health care
7 system's transformation can be assessed
8 appropriately. That is, as these changes are
9 being implemented, the department should develop
10 metrics so that the success of any of the planned
11 transformations of the command-and-control
12 structure of the military health care system which
13 is now in process of occurring will be able to be
14 considered along with its costs and benefits.

15 In summary, what we are suggesting is a
16 focus on strategy integration, preserving what we
17 regard as the best aspects of the current system,
18 creating efficiencies by streamlining operations,
19 improving effectiveness and the accessibility of
20 quality care, borrowing where appropriate the best
21 practices from both the public and private
22 sectors, and changing in ways that will not

1 diminish the trust of beneficiaries or lower the
2 current high quality of health care services
3 provided military personnel, family members,
4 retirees, and their families. We believe it is
5 urgent that the department and the Congress act
6 now. Given the current and likely future military
7 commitments, there needs to be a sense of urgency
8 in resolving the persistent problems that the
9 department has been facing and is likely to face
10 in terms of new challenges. Thank you.

11 DR. POLAND: Thank you very much, Dr.
12 Wilensky. I would also like to give an
13 opportunity for members of the task force to make
14 any comments that they would like to make or any
15 additions.

16 DR. WILENSKY: I would like to indicate
17 though the enormous amount of work that the task
18 force has provided in coming to the
19 recommendations and in writing up the various
20 chapters. This has very much been a collective
21 effort and it would have been impossible to
22 produce a document such as you have seen in draft

1 form without the very hard work of the task force
2 members in addition to the very able staff
3 supporting them.

4 DR. POLAND: Yes, ma'am?

5 MG ADAMS: Actually I was going to say
6 almost the same thing that Dr. Wilensky said.
7 This task force really did our homework. We did
8 not take anything at face value. If there was
9 information to be gathered on a topic, we
10 aggressively went after it. There was much debate
11 among the group, but I am proud to say there was
12 total consensus. Everyone's voice was heard and
13 these recommendations reflect our collective
14 support of the recommendations. So it did not
15 come easy, but I think what we put forth is very
16 worthwhile and will stand the test of time, and I
17 want to thank the assistant secretary for the
18 opportunity to work with this group. I cannot think of
19 a better group of professionals who could have
20 come forth with this type of report, so thank you.

21 DR. POLAND: Other comments from members
22 of the task force? We will open it up to the

1 board. I will maybe give my own opinion first. I
2 always have a morbid of being on an airplane
3 without enough work to do and you have prevented
4 that fear from becoming reality. So I really did
5 have time to in-depth look at it several times.

6 I am going to keep this report because I
7 think it is a model of how reports should be
8 written. What I mean by that to reiterate again,
9 I very much like and appreciate that it started
10 with a set of guiding principles and as best I can
11 tell, every recommendation fits under the rubric
12 of those guiding principles. Even more
13 importantly, in a task as complex as this, I
14 appreciate that there was not a simplistic view of
15 let's do these five things and it fixes the
16 system. Indeed, what I saw, and I would almost
17 like to add a subheading to the title of your
18 report, is a roadmap for transformation, and to me
19 that is what this actually provides. It provides
20 12, sounds like a twelve-step problem, but 12
21 steps by which to begin the process of this
22 journey of further improving the health care

1 system.

2 I also want to say my personal opinion
3 is that military health care is one of the crown
4 jewels of DOD and I would not like to have
5 somebody think that this is a task force or a
6 recommendation designed to fix a failing system.
7 I do not believe that to be the case. I have been
8 the beneficiary of military health care. I have
9 seen it as president of this board and as a member
10 of the predecessor board, the AFEB. Members of
11 this board have been for example to the Center for
12 the Intrepid. It is a state-of- the-art facility
13 that is the envy of the world. What is at issue
14 here I believe is how to take this crown jewel and
15 keep it in a way that is fiscally feasible to
16 continue into the future. In a way, maybe to put
17 another word on it, this is sort of a sleeping
18 beauty and it just needs that roadmap to reach the
19 next level of evolution. So again I commend you
20 very much on a superb report, very well thought
21 out. I often approach reports much like reviewing
22 a grant where my job as a reviewer is to fine the

1 hole. I did not find holes. Every recommendation
2 I saw was data driven. The data was transparent.
3 It is available to anybody that would want to have
4 it. So bravo and congratulations for just a
5 superb report.

6 Let me now open it to other members of
7 the board to ask questions or to make comments
8 that you may have. Mike?

9 DR. PARKINSON: Thanks, Greg, and thank
10 you, Dr. Wilensky for the overview of the report
11 and for all the hard work. I agree with Dr.
12 Poland's comments.

13 As a veteran of the DOD and working on a
14 not exactly similar project for the last 2 years
15 of my military career called the MHS Optimization
16 Plan which was designed in many ways to deal with
17 the staffing issues and the financing issues
18 related to Tricare, I know how difficult this is.
19 I really hope that the integrated 12
20 recommendations can make an impact in the
21 department as well as on the Hill.

22 I have some comments that I am going to

1 make in really no particular order and if you deem
2 so to respond or react to them, that is fine, but
3 they are really meant to be constructive in the
4 sense of reading through the report much as Dr.
5 Poland did with a fine-tooth comb.

6 Full disclosure, I spent 6 years as a
7 medical director in a consumer-driven startup plan
8 that was subsequently acquired by the nation's
9 largest health insurer so I come at this a little
10 bit from just having left the inside of a big
11 industry, if you will, and some of the
12 perspectives might be very personal at this point,
13 but they are personal. And also with kind of a
14 long commitment to prevention and behavior change
15 which also is kind of the core sine qua non and if
16 the country is going to get ahead of this it has
17 to do that. So it is really those two recent
18 experiences that I do that.

19 As Dr. Poland mentioned, DOD in certain
20 areas of medicine and health care has been the
21 unparalleled leader in infectious disease, trauma
22 care. Certainly these are the areas that are the

1 foundation of the EPE Board and now the
2 reenergized Defense Health Board. But in other
3 areas where DOD could exert tremendous market
4 power and also clinical innovation and business
5 innovation, for a variety of well-understood
6 reasons we have not done it. I would hope that
7 one of the tones of the report is that DOD commit
8 to being a cutting-edge innovator. Given that
9 there are political challenges with benefit
10 structure, there is no reason that we should not
11 be as innovative in the way we deliver peacetime
12 health care or the way we buy peacetime health
13 care as we are in the way we do trauma care or the
14 way we do preventive medicine. So we have a
15 benchmark, and as Greg noted we have those, and
16 part of what I see us doing not so much in this
17 report, but we should surpass best practices with
18 a very innovative prototyping R&D type of entity
19 just as we would do for new weapons systems to
20 demonstrate to the country that DOD can lead as
21 well as just catch up to whatever the big Fortune
22 500 companies are doing with large health plans.

1 So it is a sense of tone that we should commit to
2 leading perhaps the nation.

3 Daniel Fox who is in at Milbank and came
4 down and saw our effort in 1998 and 2000 said this
5 is important. The military should lead just as
6 they led in such major areas as racism and
7 discrimination under Eisenhower. If we have a
8 country that is amok and a medical industrial
9 complex that will spend all the GDP, maybe DOD can
10 offer something there as well. It is in the
11 report, but the way it is articulated might be a
12 little more proactive and positive. Just a
13 thought.

14 The V.A. is an example, and I am not
15 going to make any comments about the Unified
16 Medical Command except to say somewhere in here
17 there is a best practice and I sometimes opine out
18 loud. If the progress that the V.A. Has made in
19 relatively dramatic fashion around certain quality
20 and standardization across facilities all over the
21 country, a rhetorical question, could they have
22 done that without Ken being the strong head of the

1 V.A. that he was and a structural line of sight
2 that went from him to the visns (?). We will
3 leave that aside, but in an organization that
4 knows command and control, who knows it better
5 than DOD, and I would urge us around this table to
6 go with all the political considerations aside,
7 what is the best practice to get efficiency so
8 that cost goes down faster in DOD than it goes up
9 anywhere in our U.S. health care system? It
10 should. We are blessed with people who come with
11 better risk factors, they are healthy enough to be
12 in the military, 10, 20, 40, 60 years downstream
13 we should benefit from that if you will health
14 capital that we bring in in the way we make them a
15 fit and healthy fighting force.

16 David Walker I saw met with your
17 committee which is great. David is on a campaign
18 as you know as the Comptroller General of the
19 United States going around and essentially saying
20 from a unique platform because he is a relatively
21 free voice which I should we all listen to, is
22 that unless we do three things, it does not matter

1 what system you are in and you are not going to
2 cap costs and hurt the economy any more than it
3 has with health care, and that is true of DOD's
4 overall budget. In DOD we see the tail of health
5 care wagging the dog of DOD rather than vice versa
6 in a way, and that is just the same that every
7 corporate employer has seen.

8 Those three things are align incentives
9 at all levels. So if the individual does the
10 right thing, they should be rewarded for it
11 meaning lower health care costs not higher health
12 care costs, more incentives, premium
13 differentials, whatever that might be, all of
14 which are being pushed and experimented with in
15 the private sector, as you know, Dr. Wilensky.
16 And the tone of their report had in little bit in
17 there about incentives, about smoking cessation,
18 and we don't really cover that, but there is
19 dramatic work being done in the private sector.
20 You do not need to go into it in the report if you
21 do have a best practices panel that says no, many
22 employers have dramatic differentials in smoking

1 and in weight and in things like that you see, and
2 there is some allusion to those in couple of
3 places but it might be stronger around incentives.

4 Number two as David Walker says is
5 foster transparency. That is not co-pays, it's
6 not deductibles, it's the full cost of the
7 services. You do mention in that in your
8 recommendations. We want transparency to the
9 beneficiary not to the doctor or the MTF, but they
10 need to see it as well because they don't have a
11 clue how much a drug costs either I can tell you.
12 But everybody needs to see the full price of the
13 drug, not the co-tiered payment, that's a
14 structure, but even if I pay \$10, you should know
15 that the drug itself is \$180 or whatever the
16 number is. So an emphasis on transparency which I
17 liked in there, but there might be an exclamation
18 point around it because it drives dramatic changes
19 in personal behavior when people see the full cost
20 of a doctor's visit.

21 Then finally, the notion of
22 accountability. So incentives, transparency, and

1 accountability. They are in your report, but I
2 would just hope that as we go forward in this
3 effort that we pull those front and center because
4 those are the reorganization of magnetic fields
5 that drive behavior change throughout the whole
6 system.

7 Specific areas for comment, and I'll
8 just throw these out to get our discussion going.
9 I have spent a lot of time with Fortune 50,
10 Fortune 100, Fortune 1,000 employees over the last
11 6 years and I will tell you that they are not
12 aware and frankly they may not care that Tricare
13 was ever intended as a second payer. They are in
14 business to survive globally and if you find
15 employees who have a \$460 family benefit versus
16 whatever, it is good economic sense for the
17 company to promote that, and they do. From a
18 public good as a citizen, is that bad? If I'm
19 giving a \$187 billion tax exemption to employers
20 and we can debate whether or not we should do away
21 with that and go to an individually purchased
22 which is on the platforms of the presidential

1 campaigns, but I am not sure what to do with that
2 because good employers are saying why in the world
3 would they be on mine if they already are entitled
4 after 20-plus years in the military to a
5 reasonable benefit that is just as good, and as a
6 matter fact, we don't even pay them to move that
7 way? You know, Dr. Wilensky, many people are
8 saying I'll pay you to take somebody off of our
9 coverage. I am glad you raised that issue, but I
10 will tell you after doing this for 6 years there
11 is no awareness among employers that it was ever
12 intended as a second payer, nor I think among the
13 beneficiaries who are now military retirees who
14 understand that. It's just if it's a better deal,
15 why not? So I am think I'm glad you raised that.
16 I do think some specific language around
17 consumer-driven account-based plans would be nice.
18 It doesn't have to be in here.

19 You can underwrite these models even
20 with the Tricare benefit, and the rapid
21 prototyping of a Tricare choice or Tricare
22 consumer model might be something to look at very

1 quickly and roll out and determine how that might
2 fit because even though there's relatively little
3 out of pocket now, particularly if you raise
4 co-pays and deductibles, you could put enough
5 bucket of money together to initially fund a
6 health reimbursement arrangement or health savings
7 account and go forward such that people have the
8 right behavior and they monetize the benefit.

9 Even Medicaid is doing that for Medicaid
10 disabled now, giving the voucher equivalent of
11 purchasing power to Medicaid rather than the usual
12 co-pay models.

13 So, just something to think about. I
14 know it's in your import to have best practices,
15 but it might emphasized because McKinsey will be
16 releasing their second report shortly, looking at
17 the experience of consumer-driven plans. They
18 mitigate healthcare costs faster and, if done with
19 incentives, with higher satisfaction than
20 traditional PPOs or HMOs.

21 One of the questions I had at the end of
22 reading the report is would a DoD beneficiary be

1 able to take advantage, under this scenario, of
2 emerging low-cost, high- value innovations in the
3 provider sector? Can I walk in to Wal-Mart, if I
4 so choose, and get one of the 400 drugs for \$4 if
5 I'm a DoD beneficiary? Isn't that a good deal?
6 Okay?

7 Can I walk into a MinuteClinic and, for
8 60 different services at \$40, pay out of my pocket
9 as an alternative to whatever I might get under
10 one of the big three mega-contracts?

11 So we might want to think because the
12 provider sector is rapidly fleeing some of the
13 practices of traditional managed care contracts.
14 So, 2000 retail clinics staffed by physician
15 assistance and nurse practitioners who, by the
16 way, we started in DoD, are growing all over the
17 country, flat fee, totally transparent, \$40.
18 Those are the types of innovations that I would
19 ask, going forward, do we allow those types of
20 things in our contracts?

21 Just again, positive questions:
22 Reimbursable e- visits; if I want to pay my doctor

1 \$25 over the internet as opposed to waiting to see
2 him through a Tricare support center, can I do
3 that? You've got that in your best practices
4 panel. They can talk about that.

5 Incentives with teeth; as I mentioned
6 before, financial incentives right back into the
7 accounts, premium differentials up-front,
8 additional rewards for care engagement and
9 completion. You've mentioned some of those
10 things, but they're very impactful. I notice that
11 Congress wants to hear a lot about incentives.

12 And, then, you say it in here very
13 nicely, but I would just put an exclamation point.
14 In 2007 or 2010, our big mega national contracts,
15 which are farther away from transparency, farther
16 away from direct interaction of the consumer with
17 a doctor and the consumer with a facility, is that
18 the direction that is going to create a highly
19 efficient that roots out inefficiencies and the
20 consumer, the beneficiary, benefits? If we can
21 find those low- hanging fruit, it may not be
22 possible to do it through mega regional contracts,

1 and you've raised that nicely in the questions
2 through some of the things you've talked about,
3 looking at the best business practices.

4 So, a long-winded way of saying, yeah,
5 there are some things there that I would have
6 liked to see personally a little bit more based on
7 our experience in dealing with a lot of employers,
8 but you hit the mark. It's just yea, verily, you
9 know, exclamation point under the recommendations
10 you did make.

11 So, thank you for the opportunity to
12 comment.

13 DR. POLAND: Thank you, Mike. Other
14 comments from Board members? Wayne?

15 DR. LEDNAR: Wayne Lednar. I'd like to
16 add to Dr. Poland and Dr. Parkinson, my
17 appreciation for the real Herculean task the
18 taskforce took on, and I really like the crispness
19 of the recommendations and how they fall together.

20 I guess a couple of just impressions
21 that I would share: I like the fact that this is
22 data-supported. Decisions really need to be made

1 in a fact-based way.

2 I like the fact that it's
3 mission-focused. Much of healthcare is, in fact,
4 focused on healthcare and not the real question of
5 why do we provide it. So the mission focus for
6 DoD is a very critical area that I think you've
7 brought attention to, and I wish more of our
8 colleagues in the healthcare business would attend
9 to that as you have.

10 We shouldn't forget, as Dr. Poland
11 mentioned, this is an activity which is global in
12 presence. It's not just domestically placed; it's
13 global. In effect, what we want to do is build on
14 the long tradition of success of military
15 healthcare and make it even better for the future.

16 When I think back of some of the
17 evidence of some of that success, the DoD has been
18 a leader in clinical diagnostics and therapeutics,
19 techniques that have been adopted by the private
20 sector because of the response to the need,
21 particularly on the battlefield.

22 I think about providing support for good

1 care management, the electronification of medical
2 records, the challenge of trying to coordinate
3 care from the battlefield and the theater of
4 operations back to the tertiary care medical
5 centers, whether they're in Europe or back in the
6 U.S., a very complex set of moving parts, and I
7 think we want to build from that success in the
8 future.

9 SO, a couple of ideas: One is to really
10 promote and encourage innovation with
11 accountability, not just new ideas but
12 accountability, and accountability in a way that
13 ties the parts together. You mentioned sourcing,
14 and logistics is a very important area of
15 activity.

16 I think that there are some activities
17 in the private sector, perhaps in government,
18 around sourcing which is not only looking at the
19 individual contract and contractor and their
20 performance but rather how do the parts fit
21 together, in fact, to sign up the entire supply
22 chain for a common goal with revenues at risk for

1 the performance of the chain, not just their
2 individual part. This will get parts talking to
3 each other and making decisions that rationalize
4 for the good of DoD rather than the individual
5 contracting company.

6 When we think about metrics, clearly
7 important to know, keep the focus on priorities to
8 make sure progress is being made, but I would
9 encourage that we need more than just metrics on
10 transactional care process. We need more metrics
11 on outcomes. Is it really helping patients? Does
12 it make a difference, and especially does it make
13 an impact on mission? Not just healthcare, health
14 outcomes, does it make an impact for line
15 commanders and to make that link very explicit and
16 to really show that?

17 Then the last thought I'd offer is a
18 solution that has the goal of sustainability.
19 Clearly, we want a system that continues, that can
20 get the mission accomplished, can meet the future
21 needs regardless of what they are. We have an
22 aging healthcare task, a healthcare set of

1 providers. We have an aging set of capital
2 facilities. We have needs for bringing in new
3 technology. How do we develop a system that
4 doesn't just patch it for the ability to continue
5 today but really to thrive as we go into the
6 future?

7 So, thank you from the Board's point of
8 view for your hard work and for these
9 recommendations and the chance to comment.

10 DR. POLAND: Thanks, Dr. Lednar. Mike
11 mentioned his area of expertise in this area. I
12 should also say Dr. Lednar has been a critical
13 mover in first Kodak's and now DuPont's,
14 healthcare delivery transformation too.

15 Other comments? Dr. Silva?

16 DR. SILVA: I want to also add my
17 congratulations to your committee. It took on a
18 lot of tough issues which obviously the civilian
19 community is also dealing with, and there are a
20 lot of different formulations that are corrected.

21 I wonder, was there any thinking within
22 your committee, how to sequence these changes in?

1 Are there some components that are so
2 interconnected that they should be pieced out into
3 a stage one versus stage two or can all these be
4 implemented at variable speeds?

5 Thank you.

6 DR. POLAND: Let me now, before taking
7 further comments, allow Dr. Wilensky or other
8 members of the Board. I'm sure this will have
9 stimulated some thoughts or comments that you may
10 want to make.

11 DR. WILENSKY: Let me respond to a
12 couple of the issues. These are very good,
13 thoughtful points that people have raised and
14 reflect the fact that you have read our drafts and
15 given them a lot of thought, and I appreciate
16 that.

17 One of the areas that we have struggled
18 the hardest with is the notion of coordination
19 with private plans for retirees who are still
20 working. The Congress has made it illegal for
21 employers, as I understand it, to actually pay to
22 push people out of their healthcare plans, but we

1 recognized that there are two issues that are
2 still important to be dealt with. The first is
3 making sure for people who actually carry both
4 Tricare and private insurance, that Tricare does
5 function as the second payor. We think there is
6 some reason to believe that does not happen all
7 the time and that we need to make sure it does
8 happen.

9 There's a comparable issue for employed
10 individuals after the age of 65 where their
11 employer- sponsored insurance is first payor and
12 Medicare is second. In this case, Medicare is
13 also a first payor to Tricare. But to make sure
14 that Tricare, when they're in the face of held
15 existing insurance, is really the second payor and
16 that there are a number of strategies that can be
17 done to make sure that the system is functioning
18 as the Congress intended and as all of us think it
19 should.

20 The more complicated issue, which we've
21 raised -- I think we've raised it more than we've
22 resolved it -- which is why the recommendation was

1 to study, assess and consider doing pilots, is
2 recognition that there are issues of both benefits
3 and economics on the one hand for individuals to
4 consider. We were as worried about the downside
5 of not having a good integrated plan for
6 individuals and believe that having one
7 coordinated plan, whichever that is, Tricare or
8 the private plan, is superior for many times for
9 most people to using two plans.

10 And so, what we are suggesting in our
11 recommendation to assess and do pilots is whether
12 there may be ways to focus on a single plan but of
13 a plan of the choosing of the individuals and to
14 structure in a way that all parties feel they are
15 better off. Not easy to do, but that was the
16 thinking that underlay the recommendation number
17 11 that I mentioned during my presentation.

18 We very much agree with the notion of
19 being an innovator in wellness and in aligning
20 incentives and try to reward the kind of behavior
21 that we think is appropriate and try to indicate
22 the importance of wellness and prevention for DoD

1 to carry on its mission readiness functions as
2 well as providing best healthcare, and so, we'll
3 have to see as to how to best frame it.

4 The notion, I was attracted to the
5 comment you made that we all recognize the
6 innovations in trauma care and surgery that occur
7 during wartime and maybe having that as a model in
8 our minds for the role that the Department of
9 Defense for military healthcare can have in terms
10 of prevention and wellness are to be taken with
11 that same drive. I'm not sure that we quite
12 thought about it that way. I thought that was a
13 very interesting way to look at it.

14 The challenge will be something that
15 we'll think about over the course of the next week
16 or 10 days about the sequencing of activities.
17 Some of them fit together more obviously than
18 others. In changing either some of the benefits
19 or the payments, our interest is in doing so in
20 what we think is a fair and predictable way. So
21 we have a lot of emphasis on phasing in. Our
22 phase-in is presumed to be, for the most part, a

1 four-year phase-in and to have periodic
2 reassessments for those things that don't lend
3 themselves to annual indexing so that, on a
4 regular basis, you look to see where you are.
5 Those, I think, are one set of activities.

6 But with regard to the contracting and
7 the assessment of changes in the unified command
8 and particularly the need with regard to better
9 integration between the purchased care and the
10 direct delivery of care. Those are as soon as at
11 all possible to get started on, but the realities
12 will depend somewhat on the contracting cycles
13 that are beyond the control, basically, of
14 probably anybody in this room, even Dr. Cassells,
15 because they're in motion already in terms of what
16 the contracting schedules are.

17 But we had, as our first recommendation,
18 a better integration between the purchased care
19 and the direct delivery care, not because no one
20 has thought of this before -- we're aware that
21 this type of recommendation has been made to the
22 Department -- but that it is so integral to

1 everything else that comes after, that it is
2 impossible to really have an alignment of
3 incentives at any stage including the interesting
4 one of putting revenues at risk for the
5 performance of the chain.

6 None of this can occur without having a
7 better integration between purchased care and
8 delivery care, and everything that spins off of
9 that, all of the procurement, all of the
10 contracting, all of that is contingent on this
11 notion of what it is you're trying to produce at
12 the end of the day and all of the pieces that
13 move. So, thinking about what has to go together
14 and what not is something we'll have to ask people
15 on the taskforce, particularly those who are more
16 involved in that portion to give us more thought.
17 That is not something I personally have thought
18 about.

19 Are there comments from any of the other
20 taskforce members, specifically about the issues
21 that have been raised thus far? Dr. Roudebush?

22 LTG ROUDEBUSH: I thought Dr. Parkinson

1 provided some very thoughtful points for
2 consideration, and I think many of those were
3 raised during the deliberations relative to
4 various aspects that we addressed.

5 Something I would offer for your
6 consideration as you discussed alignment of
7 incentives, and command and control is an
8 opportunity to drive efficiency. Those are
9 certainly things that we considered. I think
10 efficiency, in and of itself, is obviously an
11 important aspect of what we considered and
12 continue to consider.

13 But, quite honestly, effectiveness is a
14 significant and perhaps more important driver in
15 much of what we do. If you look at what our
16 military medical system is asked to do in terms of
17 providing a healthy, fit force that's protected
18 and prepared to go forward and do what we ask our
19 military to do in virtually any situation around
20 the globe, that's one aspect. Providing medical
21 personnel that are prepared, trained and able to,
22 one, do all that's necessary to produce that

1 healthy, fit force and then support them wherever
2 they find themselves, take care of them and bring
3 them home safely should something adverse occur is
4 an aspect of what we do.

5 Providing the healthcare to our
6 beneficiaries, which, one, provides that healthy,
7 fit force and, two, provides those trained,
8 current and competent and capable medics to go
9 forward, all of these activities with the
10 incentive being that healthy, fit force, that
11 prepared medic, that operationally-effective
12 military, those incentives are not necessarily
13 always efficient. So much of what we considered,
14 we considered on the basis of cost- effective.
15 Managing each resource so that the best benefit
16 was derived in the most responsible and
17 cost-effective way is one of those guiding
18 elements that helped us in our deliberations.

19 So, as we align incentives, the
20 incentive of that operationally-effective force,
21 well supported medically at home and deployed, is
22 not always efficient, and a coalesced command and

1 control does not necessarily drive that kind of
2 effectiveness, particularly as we look at
3 doctrinally-effective forces: Airspace and
4 cyberspace, (off mike) at sea, subsurface.

5 There were aspects of that that we did
6 deliberate on, and I think our considerations
7 drove the report to reflect those considerations,
8 but I think your suggestions relative to
9 opportunities to, in fact, engender efficiency
10 wherever and whenever we can is an important
11 aspect. I think that, as Dr. Wilensky pointed
12 out, really drove the consideration of a strategy
13 that appropriately integrates both the direct care
14 system and the contracted or the private care
15 system, so that we manage those both to best
16 effect, to mutual benefit and to best cost and,
17 most importantly, to best outcome. Whether it's a
18 healthy, fit force, whether it's a healthy family
19 member, whatever that best outcome should be, I
20 think, really drove us in our deliberations and
21 allowed the construct of the recommendations as we
22 provided those.

1 So I think your observations certainly
2 reflect the importance of doing that, and I
3 thought your issues and ideas relative to
4 innovation were also telling and I think should
5 inform the execution and the further deliberations
6 of this report as it's crafted and as it's
7 delivered. So I truly appreciate that. Thank
8 you.

9 DR. POLAND: Dr. Luepker?

10 DR. LUEPKER: Yes, Russell Luepker.
11 Your last point, Dr. Wilensky, talks about metrics
12 and measurement. I guess I'd like to hear a
13 little more. In this very complex system and a
14 multilevel set of recommendations, how would you
15 know you've succeeded here?

16 DR. WILENSKY: That is an excellent
17 question. We were at least clever enough to
18 recognize if we didn't put a directive of setting
19 up metrics so you can assess where you go to in
20 addition to where you've been from, you'll never
21 be able to answer the question of have you
22 succeeded.

1 Well, our concern about metrics was very
2 much focused both at the first recommendation and
3 with the last recommendation but frankly is true
4 all the way through. That is, as I've indicated,
5 we are not the first group to reflect that the
6 incentives driving the direct care system and the
7 purchased care do not always seem to be aligned.
8 Within each, they may be aligned more or less all
9 right. But in terms of being able to produce the
10 desired outcome at the local level that makes the
11 most sense, given the complex missions which is
12 the medical readiness plus delivery of healthcare
13 per se to the people using the system, how do you
14 try to set up an alignment of incentives that has
15 the best outcomes for the costs that you are
16 incurring?

17 What that requires is deciding what
18 defines success. As General Roudebush indicated,
19 it is more a focus on the outcome, the health
20 outcome and the readiness outcome, and not on the
21 inputs specifically that are used. So we
22 recognize that the difficulty of saying this is

1 what you're trying to do and this is how you
2 numerically define that and then try to measure
3 how well you've achieved it or not achieved it.

4 It was also in reflection to a recently
5 released GAO report that had to do with command
6 and control and going to the issues of unified
7 medical control. We recognized that when we
8 started this taskforce, this had been an issue
9 under considerable debate and discussion in the
10 Department for the preceding year or two or maybe
11 decade or two at some levels and that some initial
12 levels of decision-making -- yes, forever.

13 Some initial decisions had been made as
14 to how to proceed going forward, but there had
15 been noted in the GAO report that it wasn't clear,
16 if it occurred, what metrics had been used by the
17 Department in terms of assessing the costs and
18 benefits of the various options under
19 consideration, yet alone the actual choice that
20 was ultimately arrived at. And so, what we were
21 indicating is, given that a process is unfolding
22 now, it is important to establish the metrics of

1 what will define success and then assess how this
2 strategy looks in comparison to those metrics and
3 to the extent that there are other measures of
4 success that could be considered when different
5 strategies or choices are made going forward, that
6 that's clearly defined.

7 So it is trying to be as clear as we can
8 throughout the report that our concern is a focus
9 on clinical outcomes, on meeting the readiness
10 mission first and foremost which makes all of this
11 more complicated to what is already a complicated
12 issue of how do you know when you've had good
13 quality, cost-effective healthcare being provided.
14 As all of you know, this is not a slam-dunk issue.
15 In the private sector that doesn't have to worry
16 about medical readiness, it becomes much more
17 important.

18 Complicated, when you do, but not making
19 the metrics clear and measuring as best you can
20 doesn't resolve anything. We just need to
21 acknowledge the complexity of the combined
22 mission.

1 RADM SMITH: And just to further pile on
2 to that, part of the intent of the first one is
3 that there's been a fair amount of concentration
4 on unit cost but because of the lack of a common
5 accounting system, because we segregate the
6 purchased care from the direct care system, it's
7 difficult to get the whole cost associated and
8 whether or not, as has been shown in other
9 systems, if you spend too much time on the unit
10 cost, you may not actually be reducing the overall
11 whole cost and also may not be helping ultimate
12 outcomes which is clearly our highest priority.

13 DR. WILENSKY: This was in the
14 discussion, some of the discussions we had on
15 pharmacy benefit, for example. Trying to look at
16 this point, that it is important in general when
17 we're looking at military healthcare, as in
18 healthcare all over, to remember that even if you
19 minimize unit cost, however defined, the cost of
20 producing good, healthy outcomes may not be
21 minimized and that it may require not minimizing
22 unit cost but allowing enough flexibility with an

1 alignment of incentives and reward structure so
2 that overall healthcare is provided in the way
3 that makes the most sense.

4 In some instances, that will be
5 different configurations between purchased and
6 direct delivery care and, in some instances, may
7 be to allow for a different view of the use of
8 pharmacy care versus the rest of healthcare and to
9 remember the focus is on the healthcare outcome.
10 It's easy to focus on what you can most easily
11 measure which are the unit costs of care, but that
12 misses the point of what we're trying to do.

13 DR. POLAND: Dr. Walker had a comment,
14 and then we'll have a response and then maybe take
15 a break and come back to the conversation. Go
16 ahead.

17 DR. WALKER: I'm another David Walker.
18 I'd like to address recommendation number eight
19 which I think you did excellent an excellent job
20 of explaining the difficulty and the importance of
21 this problem. Maybe it's my lack of insight, but
22 I don't see the solution. I see the

1 recommendation to do it, but how will it come
2 about?

3 The recommendation is the Department of
4 Defense should provide medical readiness for the
5 Reserve component which seems to me the most
6 detached and difficult group to maintain their
7 health, recognizing that its readiness is a
8 critical aspect of the overall task for the force
9 readiness.

10 MG SMITH: I'll take a stab at that.
11 The genesis behind is that more than 50 percent of
12 the medical assets for readiness and for delivery
13 of medical services around the world is in the
14 Reserve components. If you don't have those
15 people coming to the colors and going forth, we
16 cannot have a future military healthcare system
17 when you've got an asset that's over 50 percent.

18 Recognizing that, we're saying to DoD,
19 you have to ensure that an asset will be in place
20 as we go to the future, and that asset is not
21 always a reach out and touch with an order in 24
22 hours. That asset has to come from the employer,

1 has to come from the families and come from
2 America all over.

3 So what we're saying is what are the
4 inhibitors, whether it be access or the inhibitors
5 for these people coming to the colors. We have
6 found the data at mobilization sites that dental
7 readiness is the number one deterrent for a person
8 being mobilized, and you have other medical
9 things. Well, we don't control the daily lives of
10 the civilians because of their civilian status.

11 And so we're saying, what can we do to
12 help increase the awareness of a Reservist that
13 they need to be medically fit? What are the
14 processes and procedures that we can employ and
15 help them with? So that if their unit is called,
16 they can come, get through the mobilization site,
17 and we can send those units forward as necessary
18 to do what we have to do for the medical
19 readiness.

20 And so, we've recognized that, saying
21 that there are some things that we're seeing that
22 need to be emphasized and implemented. We talk

1 about it. I haven't seen it. We talk about more
2 of the individual understanding that when they
3 sign up for the Reserve components, they're also
4 signing up to say: I want to be medically fit and
5 I'm going to be medically fit and I'm going to do
6 what is necessary through lifestyle, through
7 physical fitness, through eating, diet and various
8 things. So that when our unit is called, I'm
9 going to go forth.

10 So this is what I think we're really
11 addressing is that we can't have an asset for
12 America, but we can't access that asset or then
13 when we access it, it's not there because they're
14 not medically fit. This is I think what we're
15 trying to drive in recommendation eight and the
16 awareness of this asset.

17 DR. WILENSKY: There's also a
18 recognition that there have been a number of
19 changes with regard to the Reserve in the last few
20 years, and so we think it's important to assess
21 whether or not some of the changes that occurred
22 with regard to the Tricare Reserve Select Program

1 have the kind of impact that was hoped for or
2 presumed when they were being implemented. It's
3 something that we think needs to occur but will
4 require a two or three-year period before the
5 effects of having this change occur.

6 It is a very big issue. As you've just
7 heard from General Smith, most of our focus has
8 been on education, trying to make clear the
9 personal responsibility and accountability of
10 medical readiness by the Reservists. Whether or
11 not this is being appropriately engaged in, in
12 terms basically as a condition of participation,
13 both in terms of the individual and the
14 leadership, is important to be able to achieve
15 this sense of medical readiness and assessing
16 whether what has been done both in terms of
17 medical and dental has improved what existed prior
18 to that or not and, if not, what else might be
19 considered.

20 DR. POLAND: I think there was another
21 comment.

22 GEN MYERS: Let me just make one

1 comment, Dr. Wilensky and Bob.

2 I think the context for this is a
3 Reserve component that's used a lot differently
4 today than when it was conceived, and so this
5 medical readiness issue is a huge -- a huge issue.
6 As Gail said, this Tricare Reserve Select is an
7 attempt, another attempt to try to fix the medical
8 readiness in the Reserve components.

9 Whether or not it's going to succeed or
10 not, we don't know, and that's why our
11 recommendation reads as it does. Somebody ought
12 to assess that because there's no question that
13 the Reserve component medical readiness has lagged
14 that of the Active component and, given the way
15 the fundamental shift in the way we use the
16 Reserve component today, that needs to change.

17 We're hoping the changes have already
18 taken place, but we've increased emphasis here,
19 and we recommend that the Department monitor that
20 to see if it's having the effect, the intended
21 effect that Congress wanted when they implemented
22 Tricare Reserve Select.

1 DR. POLAND: Ms. Embry?

2 MS. EMBRY: I'm responsible for medical
3 readiness in the Department. About four years ago
4 we instituted a metric to evaluate individual
5 medical readiness in the services, and it's a
6 metric that every individual is measured in their
7 units by their commanders for their medical
8 readiness. Reserve components are among those
9 that are being tracked.

10 We use those metrics to push
11 accountability and responsibility in the Reserve
12 components, and we implemented a rather aggressive
13 Reserve component health program to institute
14 annual reviews of health and to accomplish the
15 important immunizations, physical assessments,
16 mental health assessments and so forth as required
17 to achieve and monitor readiness in the Reserve
18 components.

19 The catch is that it is the Reserve
20 components that pay for that, not the Defense
21 health program, as is appropriate. And so, I
22 think the issue is, for the Reserve components,

1 there is not enough money. If they actually paid
2 everything they needed to pay for that, they would
3 have little left to pay for the training and
4 readiness of the force to perform the mission. So
5 it's a fiscal issue.

6 But I do think the Department is doing a
7 considerable amount to address the issue of
8 Reserve component readiness. It's a matter of
9 fiscal priority.

10 DR. POLAND: Okay, I think we'll take a
11 brief break here and reconvene about 10 to.

12 Again, if there are members of the
13 public or audience that would like to make
14 comments, if you would register at the desk, I
15 think we should have time in the hour following
16 our reconvening here to entertain those questions.
17 Thank you.

18 (Recess)

19 DR. POLAND: Thank you, everybody.
20 We'll reconvene here and continue our discussion
21 of the Task Force on the Future of Military Health
22 Care Report. From the Board members, any

1 additional questions or comments; Doctor Oxman?

2 DR. OXMAN: First of all, I'd like to
3 thank the Task Force for a fantastic job. As
4 somebody who's relatively the ignorant in the
5 area, I found the reading compelling and the
6 organization fantastic.

7 I wanted to ask if you could expand a
8 little bit upon the -- your thoughts about taking
9 advantage of the enormous buying power of the DOD
10 to minimize -- maximize the quality and minimize
11 the cost, particularly in the area of pharmacy
12 benefits?

13 MG KELLEY: Well, let me just take a
14 stab at that to start off with. And we did talk
15 quite a bit about maximizing the benefits in terms
16 of the ability and using volume for discounts.
17 Most of the people that we discussed that with
18 felt that -- because we talked about it in terms
19 of combining with the VA for even a bigger
20 possibility of a volume, and because of the size
21 of both the VA and the DOD programs, the feeling
22 was that there would be very little marginal gain,

1 because you've already taken the volume discounts
2 and there's not that much. And so there is some
3 pieces of that, and currently the federal pricing,
4 where we get the volume discounts, is only
5 available in the MTF's and also in the mail order
6 pharmacy, and so none of the retail pharmacies
7 provide that. So it's much more expensive to use
8 the retail pharmacy.

9 We certainly don't want to take that
10 ability to use the retail pharmacy away, but we
11 want to incentivize the use where we get the
12 volume discounts.

13 DR. OXMAN: Thank you.

14 MG ADAMS: Another aspect of that that
15 we talked long about, and without getting into
16 specifics, was that we're aware that there are
17 other practices available in the commercial side
18 of it, where you better manage the pharmacy
19 benefit in terms of the therapeutics of the health
20 care that you're providing.

21 And looking at some of those unique
22 arrangements, where you're able to prescribe the

1 drugs, take into effect the clinical efficacy, as
2 well as the cost. And the Department does some of
3 that, but we do it at such a high level that we
4 have not really penetrated the market like we
5 could if we were taking advantage of some of those
6 commercial practices. So I think it was not only
7 the buying power, but also then in terms of what
8 type of new practices based upon the new
9 therapeutics that we're taking advantage of.

10 DR. WILENSKY: This was one of those
11 issues where lowest unit cost may not give you
12 either best outcome or lowest cost for the
13 treatment of care provided, and it was important
14 to look at that, as Nancy was just indicating, as
15 to whether or not there were best practices that
16 either weren't being or could only be adopted with
17 difficulty.

18 But we also have felt that the
19 incentives in place didn't reflect the actual cost
20 differences, and part of the changes that need to
21 go forward is to incent and reward those who make
22 use of the lowest cost therapeutics available to

1 them in the lowest cost setting. And so part of
2 what our recommendations will do is to try not to
3 prevent people from going wherever, but to incent
4 and reward those who make use of the lower cost
5 potentials available.

6 DR. PARKINSON: There are a couple of
7 questions. I was trying to intuit reading through
8 your introduction the level of analysis that
9 you've done, which is obviously exhausted. But a
10 couple of basic questions. Were you able to parse
11 out for the appropriate comparison population
12 whether or not the DOD, particularly our purchase
13 care benefit, is accelerating equal to, greater
14 than, or less than a civilian health care benefit
15 as purchased by a fortune 1000 company, I mean is
16 that possible even to do? So the rate of
17 acceleration that we see and the numbers that
18 Doctor Poland cited, is that greater than, equal
19 to, or less than what we've seen over the seven
20 year period of time for the civilian sector,
21 because that says something I think about how we
22 purchase, maybe, okay.

1 The second question is, in terms of the
2 three major buckets that we look at, pharmacy,
3 out-patient services, and perhaps surgery/advanced
4 imagining, which is right now the focus of most of
5 the traditional managed care industry, is looking
6 at the dramatic growth in out-patient surgeries,
7 dramatic growth in advanced scanning, MRI, CT,
8 things like that; do we have any sense in the
9 reports that we get back through the managed care
10 contracts that we're monitoring at least the major
11 building blocks of what makes up trends?

12 So the first is, our trend versus
13 civilian, and second is components, pharmacy,
14 out-patient services/advanced diagnostics, or
15 scans.

16 RADM MATECZUN: I'll try to answer both
17 of those, Doctor Parkinson, and some of the
18 dialogue that we had. Try to take a look at the
19 cost and the increase in cost. We did -- were
20 able to parse out part of the root causes of that
21 increase over that time span. Number one cause is
22 increased benefit, so that Congress has added

1 benefit over time that has added significant cost
2 to that structure, including the Tricare Reserve
3 Select program as an example that we were talking
4 about, so that's number one.

5 Number two is that as the benefit has
6 not changed in terms of the price structure that's
7 out there, and as people have left the insurance
8 plans that they are in, that has driven an
9 increased population into the benefit population,
10 or at least the population that is actually using
11 the benefit.

12 That seems to have leveled off. But
13 those are the two causes, root causes of the
14 increase in cost. Therefore, over that period of
15 time, with those two things happening, very hard
16 to compare with a civilian population where the
17 benefit hasn't changed in their plan and try to
18 come to any kind of conclusion.

19 The second piece on the components of
20 the contract, I guess in short I would say, no,
21 there is no structured way of looking at that. In
22 fact, that is why we recommended that the

1 Department should have a strategy, to take a look
2 at the components in the purchase care sector,
3 what's going on. I mean there is a cost, we know
4 what the cost is for each of those. But are we
5 able to compare that cost and the effectiveness
6 and efficiency with the cost and the direct care
7 system? No, we are not.

8 DR. LOCKEY: Just briefly to the first
9 part of your question, we looked at a number of
10 indices in connection with our studies, and the
11 rates of growth and things like the defense, the
12 Military Expenditure Panel Survey, the Kaiser
13 Foundation data, are similar especially since 2000
14 than we're seeing in Tricare, they're not
15 identical, but they're in the same mix especially
16 since 2000, so I think that goes to the first part
17 of your question.

18 DR. PARKINSON: Doctor Lockey, a
19 question.

20 MR. LUEPKER: I found this is an
21 incredible work product, and I really enjoyed
22 reading it. One of the questions I had was

1 regarding Chapter 11, and that chapter dealt with
2 the mix of military and civilian personnel, and
3 the Task Force was addressed -- was charged to
4 address this appropriate mixture of military and
5 civilian personnel to meet future readiness and
6 high quality health care service requirements.
7 And the problem is well outlined. The problem was
8 that there's always been a -- retain the high
9 quality personnel, that's been a chronic problem
10 for the Armed Forces, and then this conversion of
11 military to civilian health care professionals has
12 created I guess some problems.

13 But in the conclusions, the issue really
14 was not addressed. It seemed like pending
15 legislative initiatives acted as an impediment in
16 order for the Task Force to address these issues.
17 And it wasn't clear to me why that was the case.
18 I mean it's a very innovative report overall, but
19 in this particular area, there really are no
20 solutions offered.

21 MG ADAMS: I think the reason why we
22 ended up with that conclusion was that

1 historically, the services have approached the
2 military/civilian mix differently. But in recent
3 times, within the last three to five years, all
4 three of the military departments were directed to
5 convert more military positions to civilian
6 positions.

7 And following the direction of Congress,
8 all three military departments significantly
9 increased the number of civilians working in
10 military medicine. However, recently, within the
11 last year to 18 months, the Congress realized that
12 there were problems that were inherent to
13 converting more military to civilian; most
14 importantly, you decrease the rotation base, and
15 therefore, you influence quality of life for those
16 dedicated men and women who are serving in a
17 hostile environment, so they gave the departments
18 permission then to slow down the conversion. So
19 that's -- we're kind of left in the middle flux,
20 where we saw the ramp up with the civilians, but
21 we realize we're not sure how steep that ramp
22 needs to be.

1 We've got a holding action right now, so
2 I think we need also to let the department sort it
3 out in terms of what is going to be the proper mix
4 for the services for the way ahead, taking into
5 account the deployment needs, as well as the
6 recruiting retention implications when you
7 civilianize more of your rotation basis, which is
8 what we have in terms of the civilian places that
9 are back in the United States.

10 DR. WILENSKY: This was one of the areas
11 where I hope we were clear, that it's complicated,
12 we think it needs to be assessed, both in terms of
13 understanding where we are now and particularly
14 the appropriate strategies that are available for
15 the future, and that we just -- we're not able to
16 take the time that it requires in order to be able
17 to provide good strategies and alternatives going
18 forward. So there are a lot of ramifications with
19 regard to future work force needs in terms, not
20 just of the civilian military, but the whole
21 reserve, active duty, particularly as it relates
22 to the medical component that ought to be

1 considered as we go forward, but we really weren't
2 able to do it. So unlike other areas where we
3 thought we understood the issue sufficiently well,
4 that we could make recommendations for a change,
5 this is -- more needs to be done.

6 LTG ROUDEBUSH: If I might add just one
7 additional perspective to that. I think the Task
8 Force made a wise decision in not being
9 prescriptive, because the appropriate balance of
10 military and civilian members within the MHS is
11 something that begins at a very high level in
12 terms of -- and missions, a national strategy that
13 translates into a national military strategy, and
14 all the forces that are required in order to
15 support and execute that strategy, and that's an
16 evolutionary process.

17 There is no one prescriptive mix that
18 allows you to fight today's fight and fight
19 tomorrow's, as well. So I think the
20 recommendations that we made support the ongoing
21 process within the department that will, in fact,
22 drive the appropriate balance and mix to give us

1 the kind of forced structure, both military and
2 civilian, that allows us to meet the mission and
3 deliver the benefit, as well. So I think it
4 almost goes a bit beyond the purview of this Task
5 Force. Although it's clearly within the purview
6 to support and facilitate and help inform that
7 process as it goes forward, with the over arching
8 strategy to appropriately integrate the direct
9 care system and the private sector or contracted
10 care to achieve the best outcome for all the
11 sectors.

12 So I think it is, as Doctor Wilensky
13 points out, a very complex, but it's a very
14 dynamic and evolutionary process, as well, that
15 does not foster a prescriptive or one time
16 solution.

17 DR. LOCKEY: Just one follow-up comment.

18 DR. PARKINSON: Go ahead and follow up
19 and then --

20 DR. LOCKEY: Does that also apply to the
21 statement about recruiting and retaining high
22 qualified health professionals that's been a

1 chronic problem for the military? Is this
2 something the Task Force was not really asked to
3 address?

4 RADM MATECZUN: I'd like to address it a
5 little bit with you right now. The work force and
6 how we get the work force, the necks of the work
7 force are critical questions for us. I think that
8 you heard, we have about 133,000 people working
9 within the military health system. That doesn't
10 include those people that are out there working
11 within the purchase care sector. That's within
12 the direct care system. So it's a very big
13 system, and we have a need for high quality
14 personnel to be able to stay within that work
15 force.

16 We have not done as well in recruiting
17 in the services over the last few years, and, for
18 instance, our scholarship programs for physicians.
19 This is a problem kind of across the services, and
20 the Department needs help, it needs help from
21 people like yourselves as you go back to your
22 institutions.

1 Recruiting and retention has been difficult over
2 the last few years.

3 DR. WILENSKY: But again, these are --
4 we recognize these are major issues for the
5 Department, they are very big issues, and I think
6 somewhere specifically we indicate that we think
7 this ought to be the subject of a separate task
8 force, because there are so many issues that go to
9 recruitment and retention, the mix of civilian and
10 military, the mix of active duty and reservists,
11 and how you try to project where you want to be in
12 the future, that was beyond what we thought we
13 could give any justice to, and therefore, other
14 than laying out what we have recognized as the
15 problem, didn't feel it was appropriate to go
16 forward. But it was not because we don't think
17 it's serious, it's really the opposite, we think
18 it's such a big issue that we didn't want to make
19 recommendations that didn't begin to do justice to
20 this issue, so we hope it will be taken with the
21 seriousness going forward that it deserves.

22 DR. PARKINSON: Let me just point out

1 before I get to you, Kevin, that Doctor, for the
2 record, that Doctor Dan Blazer has joined us.
3 Dan, we went around and introduced ourselves. Do
4 you want to just briefly tell your affiliation?

5 DR. BLAZER: Dan Blazer,
6 psychiatrist/epidemiologist, Duke University, I've
7 been on this Board for a while.

8 DR. PARKINSON: Okay; Kevin.

9 DR. MCNEILL: Thank you. As a former
10 practitioner in the military health care system
11 and now a retiree and beneficiary, I'd like to
12 thank the committee for this excellent report and
13 all of the hard work that went into it. And I
14 mentioned this as -- aside to a couple of members,
15 but I would really like to commend particularly
16 the idea of a better coordination between Tricare
17 and private health insurers. This would be
18 extremely beneficial for retirees such as myself
19 who live in undeserved areas, there's no military
20 installation anywhere around, and there is
21 basically no provider network. And the idea of
22 being able to access either/or, even if it meant

1 additional, you know, financial contributions by
2 me, I would consider that a wonderful improvement
3 to the current system, because even though the
4 benefits are there, gaining access is very
5 difficult, so I commend that idea, and I think
6 it's certainly a mix for the duration.

7 DR. PARKINSON: Doctor Parisi.

8 DR. PARISI: I'd like to echo everyone's
9 congratulations on this very excellent and
10 complete report. I'm impressed with the care and
11 the thought that has been given to many of the
12 issues.

13 One comment is that the report is great
14 at identifying the problems, but my reality part
15 of me asks is, implementation possible or
16 practical. And I'm sure the committee wants to
17 deliberate about maybe legislative activities that
18 are -- legislative actions that would be necessary
19 to allow the implementation of some of these
20 recommendations, and I just would ask for some of
21 your comments about that.

22 DR. WILENSKY: The good news is that

1 relatively few of the recommendations require
2 statutory change, and I regard that at least as
3 the good news. We will be very clear when we
4 issue our final report in terms of the 12
5 recommendations with the action items as to what
6 we believe can be done administratively and what
7 requires new statutory authority. Most of it is
8 able to be done administratively. That doesn't
9 make it easy, it just makes it easier than needing
10 actions by Congress before you can proceed.

11 Probably the more difficult issue is
12 that while we tried to be as specific as we could
13 in the action items underneath each recommendation
14 to give guidance as to where or what would be
15 required in order to achieve the outcome we're
16 recommending. They almost by necessity always
17 stay, if not at 30,000 feet, will probably never
18 get much under about 12,000 feet, except for some
19 of the financial changes that we discuss more
20 explicitly.

21 And therefore, it will require follow-on
22 activity to be embraced by the Department, to pull

1 together individuals appropriate and concerned to
2 try to make these changes happen.

3 It doesn't happen that often with task
4 forces, but it can happen. Again, my experience
5 on the Dole Shalala Commission earlier in the year
6 has resulted in what are enormously gratifying
7 efforts by the Department to try to embrace along
8 with the VA those areas that can be done
9 administratively. So there is clear indication
10 that the Department can take these areas that are
11 identified and begin to implement them in a very
12 quick order if it is agreed that they are
13 important and the kind of interest to do so.

14 So we will make very clear, at least
15 according to the guidance we have, there's always
16 some dispute that goes on as to whose general
17 counsel opines as to exactly who has what
18 authority, but we think probably we will be
19 relatively safe in designating those areas, which
20 probably need legislative change as opposed to the
21 others. But I will tell you, most of what we are
22 recommending, as best we can tell, can be done by

1 the Department directly.

2 DR. PARKINSON: Doctor Shamoo.

3 DR. SHAMOO: Thank you. The military
4 has been at the forefront of issues of equities
5 once they make up their mind. And I think part of
6 my question was asked the last time we were
7 together. There's two types of equity, equity in
8 terms of type of health care services we render,
9 especially behavioral versus other medical ailment
10 issues, and equity, currently it's superb, it's at
11 the peak, and that is equity to, regardless of the
12 service rank, we provide the same health care
13 services. The two part question is, should we
14 have some kind of safeguard, because no one can
15 predict that societal ills don't creep into the
16 system of some inequity, and at the same time, to
17 ensure the equity of the type of health care
18 services we render.

19 DR. WILENSKY: I don't dispute what
20 sounds like an admiral goal. I'm not sure
21 specifically what, other than following metrics
22 that focus on outcome, that recognize that what it

1 takes to produce good health may differ in terms
2 of the health care, how it's provided, and when
3 and where it's provided.

4 That's basically a presumption of
5 medical readiness, that you take individuals as
6 they come in, and achieve a medical readiness so
7 that they can be deployed as the military sees
8 appropriate.

9 And it is -- it functions more on the
10 desired outcome rather than on the specific inputs
11 that might be required in order to get there. So
12 I mean it strikes me in general, that is the
13 function that the military, particular with regard
14 to its active duty, provides.

15 It's a little hard to have quite that
16 same specific focus in terms of retiree care,
17 which you can provide our benefits to individuals
18 after they leave active duty military, but other
19 than putting in safeguards that contractors do
20 what they say they will do, and using metrics to
21 make sure that when you think you've changed the
22 system in a way to improve it, that you monitor

1 the outcomes and not just the input changes. So
2 if you have something else specifically in mind --

3 DR. PARKINSON: General Kelley and then
4 General Adams.

5 MG KELLEY: Doctor Shamoo, I think that
6 we did consider this, and as we talked about
7 discussing adjusting co-pays, enrollment fees and
8 that, we talked about the tiering process, so that
9 those individuals who have retired at lower rank
10 or with lower retirement pay would pay less than
11 other individuals.

12 And so specifically to address your
13 concern about those at economic disadvantage, a
14 disincentive to using the system, we adapted the
15 recommendations to have a tiering process to make
16 it easier for them to use the system.

17 DR. PARKINSON: General Adams, did you
18 want to --

19 DR. SHAMOO: May I comment on that? I
20 appreciate your answers, but inequity -- the
21 current inequity crept in from our society, and
22 that is between behavioral coverage versus

1 non-behavioral coverage. It's in everywhere in
2 this society, and was not by design, and everybody
3 measures out. So contrary to the existing
4 practices, mental health coverage is one-tenth of
5 what ought to be in all health insurance, whether
6 it's -- everywhere, so I am not -- that the
7 outcomes alone will take care of it, any segment
8 of our society.

9 DR. WILENSKY: Well, actually, it's rare
10 that people look at outcomes. They mostly --
11 because they're harder and there's more dispute
12 about measurement. Normally what they do is,
13 focus, if at all, on the amount or the cost of the
14 inputs, and not on the outputs.

15 With regard to the issues relating to
16 mental health, that has clearly become a much more
17 prominent an issue because of the interest and
18 focus on PTSD and also traumatic brain injury. We
19 do not deal specifically with that issue in terms
20 of the overall strategy of the report. Again,
21 there are a number of other task forces that were
22 specifically focused to that issue. So I mean I

1 think those are better places to look to.

2 DR. PARKINSON: Ms. Embrey.

3 MS. EMBREY: Being the designated
4 federal official and not being a member of the
5 Board, I did not have an opportunity to review the
6 draft. But I do want to -- based on the
7 conversation, I would appreciate it if you could
8 elaborate more specifically on what you mean by
9 improving integration between direct and purchase
10 care system. Is this the management of both in
11 the delivery of care, is it system integration, is
12 it provider focused, is it -- I don't understand
13 what integration means.

14 RADM MATECZUN: Ellen, I think that's
15 why we said what the Department needs is a
16 strategy for taking a look at the integration. If
17 the Department defines the outcomes that are
18 desires, all of those things you mentioned, any of
19 those things you mentioned, then you can align the
20 two systems to achieve the outcome and work across
21 them to make sure that you haven't disincentivized
22 or given the wrong incentives.

1 If you're not able to do that, if you
2 don't know, if you don't have a strategy for the
3 outcomes you'd like to achieve, then you're going
4 to achieve the outcomes that you get. So I think
5 that, in part, it was, yeah, the Department needs
6 to take a look at that and say, what are the
7 outcomes that we desire.

8 MS. EMBREY: So the message is then that
9 we have two systems of care that are not focused
10 on the same goals, and we need to figure out what
11 that is?

12 RADM MATECZUN: They may or may not be,
13 but there's no strategy that says that they are.

14 DR. WILENSKY: There was also an intent
15 to recognize the need to make sure there's an
16 alignment of incentives at the place where care is
17 actually delivered, which is at the local level.
18 There may be higher level views of how the
19 integrated -- the purchase care and the direct
20 care align themselves in general, but that doesn't
21 provide the incentive or flexibility to have the
22 best outcomes occur at the place where care is

1 actually divided, which becomes particularly
2 complicated in areas like our own because of the
3 National Capital region has not only multiple
4 providers between the direct and the purchased,
5 but multiple services active in each.

6 So it is not clear it is happening at
7 the local level, even when there is just one
8 installation, and it is particularly complicated
9 in the region of the country where there are
10 multiple installations. We visited San Antonio.
11 That was an obvious one. The National Capital
12 region is an obvious one.

13 But there are others as well. And
14 that's all in addition to making sure that there
15 is a well articulated strategy at the top about
16 what you're trying to do with these two.

17 But even if that occurs, and we think
18 that more needs to be done to articulate that
19 strategy, that doesn't necessarily mean at the
20 local level, where the care is being provided,
21 there's enough flexibility with the right
22 incentives so that the movement back and forth

1 between purchased care and direct care can occur
2 in the most effective way.

3 It's not that there isn't any
4 flexibility. Our sense in interviewing and
5 listening to what people told us is it was very
6 hard and cumbersome to happen, and that was true
7 both from the direct care's point of view and from
8 the contractor's point of view. Thank you.

9 LTG ROUDEBUSH: And it also underpins
10 the requirement for an accounting system that
11 allows you to properly characterize the cost of
12 delivering that particular type of episode of care
13 so that you can look at best outcome and best
14 cost. And the outcome is certainly a favorable
15 health outcome, but it's also a favorable
16 operational outcome so that you can begin to
17 strategize and put that kind of capability in
18 place and leverage each system, which has
19 strengths, in order to get to the best integrated,
20 not coalesced, but best integrated system overall.

21 DR. WALKER: That does raise a question,
22 and, you, of course, being currently serving, we

1 have a joint budgeting process, but we don't have
2 an integrated cost accounting system. Each
3 service has their way of doing that. So from a
4 practical standpoint, is the Committee or is the
5 Task Force recommending that we centralize the
6 cost accounting system for this purpose?

7 RADM MATECZUM: Standardization I think
8 is, how do you cross those systems. Once again,
9 this is part of the Department's strategy. If the
10 Department doesn't do that, it can never arrive at
11 costs that can be accountable.

12 DR. WALKER: Well, as you know, each
13 service has to live within the accounting system
14 of that service in order to get its budgets and
15 manage its people and, you know, operate. And so
16 if we had a separate health accounting system that
17 would divorce you from your service accounting
18 systems.

19 So the challenge is difficult. I would
20 like your views.

21 LTG ROUDEBUSH: I don't think it
22 necessarily separates us from our services'

1 accounting system. I think the standardization
2 across the systems because the health accounting
3 system is something that is a bit set aside from
4 much of what the services do. But in terms of how
5 we're able to compare the military systems, one
6 with another and with the private sector, until we
7 have those standardized methods of characterizing
8 those costs and inputs, we have a very difficult
9 time saying this is the best cost for the best
10 outcome.

11 So I think, as Admiral Madison, points
12 out, it's not so much centralization as it is
13 standardization and getting to a common accounting
14 methodology that allows us to make that
15 comparison.

16 DR. WALKER: It was one of the issues
17 perhaps not emphasized enough in response to the
18 earlier question of how does the Department of
19 Defense compare relative to the civilian sector.

20 Yeah, it would be very difficult to make
21 that comparison because there have been rather
22 extensive changes in the benefits during this

1 decade, and that makes it hard to compare.

2 But even if that hadn't happened, the
3 problems with the accounting system would make it
4 extremely difficult to be able to make that
5 assessment within and across the Department of
6 Defense.

7 DR. LUEPKER: Dr. Walker?

8 DR. WALKER: Thank you.

9 DR. LUEPKER: Yeah, Russell Luepker.
10 I'd like to go back to Dr. Shamoo's question. We
11 heard a report a few minutes ago from the mental
12 health task force. And they suggested that
13 everything wasn't just fine for either active
14 personnel, reserve personnel, and or their
15 families.

16 When you said, well, that's a different
17 committee, and it's true, their recommendations
18 were structural ones about how to better integrate
19 the system and deliver services, and it worries me
20 a bit to hear you not talk much about how this
21 comes together.

22 If we continue to treat behavioral and

1 mental health problems as separate and out there,
2 they will continue to be problems. And I
3 personally see the overlap with what you're doing
4 a hundred percent. It's part of health services,
5 but it's particularly unique in that it's not
6 doing well.

7 MS. EMBREY: In my other job, I serve as
8 the line of action lead for the Department of
9 Defense on the Department's response to the Mental
10 Health Task Force recommendations and many other
11 recommendations relating to the subject of how the
12 Department is organized to address traumatic brain
13 injury and mental health and PTSD, and, as we've
14 re-characterized it, psychological health, which
15 sort of embodies not only the medical, but the
16 pre-clinical and non-medical services that support
17 psychological health. We've made a series of
18 accepted all nine -- well, 94 of 95
19 recommendations coming out of the Mental Health
20 Task Force, and we are actively engaged in
21 implementing many of those as we speak.

22 So they'll become a component of our

1 health system, but frankly, some of the new
2 aspects of those programs were not under
3 consideration by this task force, particularly
4 those on the early intervention and prevention
5 programs and the building of resilience in our
6 service members and their families to address
7 stressful situations, such as a war or financial
8 difficulty or whatever.

9 So I do think that the Department is
10 addressing this issue and expanding capacity, both
11 in personnel and systems.

12 We will be implementing an electronic
13 mental health record as part of our overall health
14 system record, so it will be accessible to primary
15 care providers. We are embedding mental health
16 professionals in our primary care settings, and
17 we're embedding them in our war fighting units;
18 and we are engaging in significant amount of
19 training and outreach to individuals about what it
20 is to have psychological health and how to
21 maintain that health in the same way that we
22 adjusted for physical health and fitness.

1 So the impact that we'll have is we will
2 have an infrastructure to address in the mental
3 health realm anyway, and we also have similar
4 initiatives going on in TBI, but I didn't talk
5 about that.

6 So I think whatever the future of the
7 military health system is going to be, it's going
8 to be part of that infrastructure, and these new
9 programs will have to be addressed as part of
10 that.

11 So I don't think it will be an equity
12 issue because this is focused on the total force,
13 not only the service members, but their families.

14 DR. WALKER: It was also -- I served as
15 the liaison between this four-year task force and
16 the Dole- Shalala Presidential Commission that ran
17 from March to the end of July. PTSD and TDI, its
18 impact in active duty military and in the veterans
19 population and the crossover in between and how to
20 try to have that be better effect and more
21 effective as a health care service was one of the
22 six subcommittees of that presidential commission.

1 We were also aware that there was a task force
2 specifically focused on mental health issues.

3 Our value added was not to be in those
4 areas given the work that was done, but to attempt
5 to look at what was a very large set of issues
6 that we were asked to look at in terms of the
7 congressional language. Now I don't think it's in
8 any way a sense that more effective care and
9 integration of mental health with the rest of
10 health care is a question in our minds. But if
11 we're going to try to focus on the 10 or 12 most
12 important changes going forward, knowing the work
13 that's been done during the course of the year, it
14 wasn't clear what else we would say on that issue,
15 particularly because our expertise was really
16 designed to try to respond to the issues that were
17 in our charge, and it is I think a very unusual
18 mix of private sector, public sector non-
19 military, and military across the service group
20 that we have put together, but not particularly,
21 starting with myself, expert in terms of mental
22 health per se.

1 COL GIBSON: Just as a reminder to the
2 Board, we have established a Behavioral Health
3 External Advisory Subcommittee for the Department,
4 as we all as a TBI, Traumatic Brain Injury
5 subcommittee, so you will be hearing more about
6 this and you folks will be part of that
7 Department's solution to these problems.

8 DR. BLAZER: Just as a member of the
9 Mental Health Task Force, just to make a couple of
10 statements. I think we on the Task Force were
11 very pleased with the initial response of the DoD
12 to the recommendations that we've made. We also
13 are very pleased with the response of Congress in
14 fusing new monies.

15 There are concerns. This is not a small
16 hill to climb that we'll climb this year. This is
17 a long mountain that's going to take quite a while
18 for us to traverse, and so the issues of sustained
19 funding and sustained emphasis I think is going to
20 be important.

21 I don't think now is the time to
22 evaluate the DoD's response to the Mental Health

1 Task Force. I think it's going to take probably
2 three to five years to see how things go.

3 But we do have a steep hill to climb on
4 this, and I just feel like that we need to
5 recognize that and keep that emphasis for a while.
6 This is not a one-time thing.

7 DR. POLAND: Yes. Other comments?

8 RADM MATECZUM: In terms of the question
9 of addressing parity separate from mental health
10 and the benefits that are contained within the
11 current structure, I was trying to think of an
12 example of any time that a coverage has been
13 reduced, and I couldn't think of any.

14 So the parity may change in proportion,
15 but there -- the Congress has never reduced a
16 benefit once it started, once it's in place.

17 DR. POLAND: Roudebush, did you have a
18 comment?

19 LTG ROUDEBUSH: Actually, my comment was
20 a question, and I would direct it back if I would
21 be interested in your thoughts.

22 Do you see anything in this report that

1 would preclude the Department and the military
2 health care system from being responsive to the
3 inputs of this task force and others, which, you
4 know, we anticipate will inform both deliberations
5 and actions in the days, weeks, months, and years
6 ahead?

7 So are you seeing something that takes
8 you in a rather different direction from the work
9 that the task force has provided?

10 DR. LUEPKER: No, I don't. I was
11 looking for some reassurance that this was being
12 integrated. Ms. Embrey provided that, and I'm
13 comforted by the way this is going forward.

14 It again is a unique area that has more
15 difficulties than some of the other health-related
16 areas, and but needs to be integrated desperately.

17 DR. POLAND: Okay. Dr. Halperin, maybe
18 one other comment and then if there are any
19 comments from the public or audience, we'll take
20 those.

21 DR. HALPERIN: Halperin, from the Board.
22 It is very gratifying to hear the prominence of

1 wellness and prevention in the major focus of the
2 report.

3 There has -- and also the idea of
4 creating metrics, and it's also good to know about
5 the implementation of the electronic medical
6 record within the military.

7 But many of these things as far as are
8 there going to mandated offers; are there going to
9 be mandated benefits? Are people participating
10 in? What's the rate of participation compared to
11 other medical systems -- really does hover around
12 the issue of data. And the source of the data is
13 the electronic medical record.

14 So I'm wondering whether someone might
15 want to comment about the issue of the focus on
16 electronic medical records within the various pay
17 orders, if you will, and various systems that are
18 -- that are part of this -- these recommendations?

19 DR. WALKER: We did spend some time with
20 -- in discussions with people from DoD about their
21 progress in terms of the development of the system
22 within DoD and across DoD and VA in terms of where

1 they were in being able to integrate information
2 which is at the moment primarily outside of the
3 hospital rather than inside in the ancillary care,
4 but movement ahead in terms of the development of
5 in- patient record with plans for how that will
6 integrate with the VA system.

7 One of the issues we did not
8 specifically address, but since you've mentioned
9 it, I will at least raise, is that there may well
10 be for some time in the future difficulties in
11 integrating purchased care and direct care so long
12 as much of the outside purchased care is not using
13 electronic medical records, and that is probably
14 an issue too big for DoD per se to resolve,
15 although hopefully other pressures and interests
16 in trying to get electronic medical records and
17 interoperability, and the private sector will help
18 resolve that issue.

19 So we did -- this was not a specific
20 focus, but we did get briefed on where the
21 Department is and how it's progressing and, again,
22 in the Dole-Shalala, we spent more time looking at

1 how each VA and DoD are moving forward. One of
2 the concerns we had is as much as we want to have
3 it pushed faster, it has taken so long to get it
4 going as well as it is now. There's a lot of
5 reluctance to change its course because it will
6 ultimately delay the process even longer, so we're
7 mindful of that.

8 But it will be harder to get direct care
9 or "downtown care." However, you want to
10 categorize it, fully integrated, if they're not on
11 the same information systems or at least
12 interoperable information systems.

13 DR. POLAND: We didn't have anybody sign
14 up, but are there any audience questions or
15 comments?

16 BG FOX: Dr. Poland, I'm a subcommittee
17 member and therefore did not have the opportunity
18 to read this very detailed report, and I will do
19 so in subsequent time following this.

20 I would offer the same applause that
21 everyone has in appreciation for the level of work
22 and intensity that went into this and the

1 recommendations, and the thoughtful health board
2 members who have articulated points back and
3 forth. I would like to come back and illustrate
4 perhaps a little bit that General Roudebush, if I
5 might, sir, your comment about effectiveness,
6 because it's in the understanding of effectiveness
7 of the MSH and what is its purpose that I think we
8 should perhaps put some exclamation points to the
9 unparalleled and Herculean efforts that have been
10 accomplished by the MSH given its primary mission
11 for effectiveness to support a military at war and
12 the defense of the nation. It is a fact that the
13 disease and nonbattle injury rate is the lowest it
14 has ever been in the history of conflict. It is
15 also a fact that the battlefield life- saving
16 capability of our military health system is the
17 best it has ever been in history of conflict. It
18 is also a fact that the military health system
19 that exists today deployed multidisciplinary
20 doctors, nurses, and medics to that battle space
21 and have accomplished that mission in an echelon
22 health care system that is unparalleled by

1 anything that human history has seen to date.

2 At the same time that the MHS system has
3 maintained to my knowledge every hospital passing
4 JACO standards, every hospital integrating in
5 doctors and nurses who are from the civilian
6 sector into a military infrastructure and health
7 care system and yet providing quality. So while
8 this panel has rightfully pointed out perhaps a
9 roadmap as you suggest, Dr. Poland, for future
10 reviews and critical reviews of efficiencies, I
11 hope one does not lose the perspective that
12 effectiveness of that system to deploy doctors and
13 nurses and medical staff to not only deal with the
14 complexities of the military environment
15 themselves but be able to deliver the kind of
16 quality of care that they have heretofore
17 delivered to our soldiers, sailors, airmen and
18 Marines in combat should not be lost. Tomorrow's
19 battlefields will not be the same battlefields of
20 today and we are compelled like all military
21 infrastructure is compelled to look at the future,
22 and the system has to be creative and allow that

1 future to be reviewed and assessed so that we can
2 deploy the right kinds of medical teams to deal
3 with the very flexible and agile battlefields of
4 tomorrow and the very flexible and agile and
5 growing capabilities are combat forces have to
6 deliver combat power in austere places around the
7 globe simultaneously.

8 That infrastructure has to exist and in
9 that is effectiveness. It may not be the most
10 efficient cost- effective system from the
11 perspective of a civilian health care model which
12 looks at maximum efficiency for the dollar. So I
13 only offer that opinion and comment as one who has
14 been a member of that distinguished system and
15 very proud of it and one who has been equally
16 blessed to be a member of a subcommittee who is
17 very focused on taking care of soldiers, sailors,
18 airmen, and Marines who have been wounded in
19 combat. Thank you.

20 DR. WILENSKY: I hope, Dr. Fox, as you
21 have a chance to read the report you will see we
22 went to great pains to try to make exactly that

1 point, that when you look at what is provided by
2 DOD in terms of military health care, you have to
3 be very careful not to judge it by a real cost
4 efficiency point of view because of the complex
5 mission that it has in terms of being able both
6 for the present and in the future to respond to
7 the needs of the military present and retired. So
8 hopefully when you see it you will say, yes, you
9 made that point. If we didn't, we will all feel a
10 little chagrin.

11 DR. POLAND: Let me say thank you for
12 that comment too. It is why I consider it to be
13 one of the crown jewels of DOD. Seeing no other
14 respondents or comments, we are going to end the
15 morning session of the Defense Health Board. I
16 again want to thank Dr. Wilensky and the other
17 members of the task force for your hard work and
18 for coming to address the draft findings. The
19 process from this point is prior to the board's
20 next meeting, the task force will be
21 disestablished but we will take the comments that
22 we receive today, try to synthesize those into a

1 cover letter that will accompany the task force's
2 final report.

3 I would also like as we close here to
4 offer the task force committee members a token of
5 appreciation and remembrance of your service on
6 the task force with the Defense Health Board coin.
7 I will give one of those to each of you as a thank
8 you for the hard work that you have done.

9 One other thing before we close here is
10 the CME form has gotten lost in somebody's stack
11 of papers, and so we do need to find that. Lisa
12 can take that. Colonel Gibson, do you want to
13 make any other comments with regard to lunch?

14 COL GIBSON: The board subcommittee
15 members and task force members will have a working
16 administrative lunch in the break room and the
17 liaison officers and other invited guests are
18 welcome. We will reconvene at the appointed time.

19 DR. POLAND: Very good. 1:30.

20 COL GIBSON: 1:30. That's all I have.

21 (Whereupon, a luncheon recess was
22 taken.)

