THE DEPARTMENT OF DEFENSE

TASK FORCE ON THE FUTURE OF MILITARY CARE
A subcommittee of the Defense Health Board

DELIBERATIONS OF DRAFT INTERIM FINDINGS AND
RECOMMENDATIONS FROM THE FUTURE OF MILITARY HEALTH
CARE TASK FORCE

May 23, 2007
Arlington, Virginia

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180  Fax (703) 519-7190
PARTICIPANTS:

Designated Federal Official

MRS. ELLEN EMBREY
Deputy Assistant Secretary of Defense Force Health Protection and Readiness OASD/FHP&R

Full Board Members

DAN G. BLAZER, II, M.D., M.P.H., Ph.D.
Diplomate, ABPN Fellow, American Psychiatric Association Fellow, American College of Psychiatry J. P. Gibbons Professor of Psychiatry and Behavioral Sciences Professor of Community and Family Medicine Duke University Medical Center Past Dean of Medical Education, Duke University Medical Center

JOHN DAVID CLEMENTS, PhD.
Professor and Chair, Department of Microbiology and Immunology Director, Program in Molecular Pathogenesis and Immunity Tulane University School of Medicine

FRANCIS A. ENNIS, MD
Professor of Medicine, Molecular Genetics and Microbiology Director, Center for Infectious Diseases and Vaccine Research University of Massachusetts Medical School

GENERAL (RET) FREDERICK FRANKS
Chairman: Panel on the Care of Individuals with Amputation and Functional Limb Loss

WILLIAM E. HALPERIN, MD, MPH
Chair, Department of Preventive Medicine New Jersey Medical School Acting Associate Dean New Jersey School of Public Health University of Medicine and Dentistry of New Jersey

EDWARD L. KAPLAN, M.D
Professor, Department of Pediatrics University of Minnesota Medical School
PARTICIPANTS (CONT'D):

TAMARA D. LAUDER, M.D.
Independent Contractor Physical Medicine and Rehabilitation Minocqua, WI

WAYNE M. LEDNAR, MD, PhD
Vice President and Director, Corporate Medical Eastman Kodak Company

JAMES E. LOCKEY, MD, MS
Professor and Director Department of Environmental Health University of Cincinnati College of Medicine Consultant on Employee Health Children's Hospital Medical Center

RUSSELL V. LUEPKER, M.D.
Mayo Professor of Epidemiology Head, Division of Epidemiology Professor of Medicine, School of Public Health University of Minnesota

THOMAS J. MASON, Ph.D.
Director, Global Center for Disaster Management and Humanitarian Action University of South Florida

KEVIN MILLS MCNEILL, MD., Ph.D.
State Epidemiologist, Mississippi Department of Health Director, Mississippi Public Health Laboratory Clinical Professor of Preventive Medicine, University of Mississippi School of Medicine

MARK A. MILLER, M.D.
Associate Director for Research in the Office of the Director Director, Division of International Epidemiology and Population Studies Fogarty International Center National Institute of Health

MICHAEL N. OXMAN, MD
Professor of Medicine and Pathology University of California, San Diego Staff Physician, Infectious Diseases Section Department of Veterans Affairs Medical Center San Diego, CA

ANDERSON COURT REPORTING
706 Duke Street, Suite 100
Alexandria, VA 22314
Phone (703) 519-7180 Fax (703) 519-7190
PARTICIPANTS (CONT'D):

MICHAEL D. PARKINSON, MD, MPH
Executive Vice President Chief Health and Medical Officer Lumenos

JOSEPH E. PARISI, M.D.
Division of Anatomic Pathology Mayo Clinic
Chairman: Scientific Advisory Board for Pathology & Laboratory Services

GREGORY A. POLAND, MD
Fellow of the American College of Physicians
Diplomate, ABIM Director, Mayo Vaccine Research Group Translational Immunovirology and Biodefense
Mary Lowell Leary Professor of Medicine Mayo Clinic and Foundation Defense Health Board President

NICOLAAS P. PRONK, Ph.D.
Vice President HealthPartners Center for Health Promotion and Health Behavior Group Research Investigator HealthPartners Research Foundation

ADIL E. SHAMOO, PhD
Professor Former Chairman Department of Biochemistry and Molecular Biology University of Maryland School of Medicine

JOSEPH SILVA, JR., MD
Dean, Emeritus UC Davis School of Medicine

DAVID H. WALKER, M.D.
Professor and Chairman Carmage and Martha Walls Distinguished Chair, Tropical Diseases Department of Pathology University of Texas Medical Branch

COL ROGER GIBSON, DVM, MPH, PhD. USAF, BSC DHB
Executive Secretary

Ex-Officio Members
PARTICIPANTS (CONT'D):

MARK A. BROWN, Ph.D
Director, Environmental Agents Service Office of Public Health and Environmental Hazards Department of Veterans Affairs CAPT

ALI S. KHAN, MD MPH (USPHS)
Deputy Director (Acting), National Center for Zoonotic, Vector-borne, and Enteric Diseases Coordinating Center for Infectious Diseases DHHS Centers for Disease Control and Prevention Preventive Medicine Liaison Officers and Consultants

CDR DAVID C. CARPENTER, CFMS
Assistant Defence Attache - Health Affairs Canadian Defense Liaison Staff (Washington)

CAPT NEIL NAITO, MC, USN
Director, Preventive Medicine & Occupational Health US Navy Bureau of Medicine and Surgery

CDR ERICA SCHWARTZ, USPHS
Preventive Medicine/Epidemiology Cons. U.S. Coast Guard Headquarters

CDR EDMOND FEEKS, MC, USN
Preventive Medicine Officer Headquarters, U.S. Marine Corps

LTC WAYNE HACHEY, USA, MC
Program Director, Preventive Medicine & Surveillance Assistant Secretary of Defense for Health Affairs

COL PRISCILLA BERRY, USA, MC
Medical Staff Officer Office of Assistant Secretary of Defense for Reserve Affairs

COL MICHAEL SNEDECOR, USAF, MC
Chief, Preventive Medicine Department of the Air Force
PARTICIPANTS (CONT'D):

COL SCOTT STANEK, USA, MC
Preventive Medicine Staff Officer DASG-PPM-NC, OTSG

CAPT SURGEON RICHARD JOHNSTON, USMR4
British Liaison Officer British Embassy

LTC AARON SILVER, MS, USA
Joint Staff Officer Joint Staff Preventive Medicine

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DR. POLAND: Welcome to the afternoon session of the Defense Health Board. I am delighted that we have with us a number of distinguished visitors, but in particular to my right is Dr. Ward Cassells, our new Assistant Secretary of Defense for Health Affairs. Dr. Cassells, welcome. His bio is on your notebooks so that you can read a little bit about his distinguished service to the country. Dr. Cassells, can you open the meeting, please?

SECRETARY CASSELLS: Thank you, Dr. Poland, and thank all of you for coming. As the delegated principal staff assistant and alternate designated federal official for the Defense Health Board, a federal advisory committee to the Secretary of Defense which serves as a continuing scientific body to the Assistant Secretary of Defense for Health Affairs, and the Surgeons General of the military departments, hereby call this meeting to order.
DR. POLAND: What I'd like to do then is just go around the table and have each individual introduce themselves. Dr. Cassells, I'll start with you and we'll work our way around.

SECRETARY CASSELLS: Ward Cassells, the new Assistant Secretary of Defense for Health, on leave from the University of Texas Health Science Center in Houston where I'm a cardiologist.

GENERAL CORLEY: I'm John Corley. I'm one of the Co-Chairs on the Task Force that will be presenting to you today.

DR. WILENSKY: Gail Wilensky, the other Co-Chair.

COLONEL BADER: Christine Bader, Executive Secretary for the Task Force on the Future of Military Health Care.

DR. LAUDER: Tamara Lauder, physical medicine and rehabilitation, member of the Defense Health Board.

DR. LEDNAR: Wayne Lednar, Vice President and Director of Corporate Medical, Eastman Kodak, Rochester, New York.
DR. MCNEILL: I'm Mills McNeill. I'm from the Mississippi Department of Health and I'm a member of the Defense Health Board.

DR. PARISI: Joseph E. Parisi, Mayo Clinic, Rochester, Minnesota.

DR. LOCKEY: Jim Lockey, outpatient pulmonary disease, University of Cincinnati, Board Member.

DR. OXMAN: Mike Oxman, Professor of Medicine in Pathology, University of California, San Diego, Board Member.

DR. PARKINSON: Mike Parkinson, Executive Vice President and Chief Medical Officer of Lumenos, which is a subsidiary of WellPoint.

DR. PRONK: Niko Pronk, Vice President, Health and Disease Management, Health Partners, Minneapolis, Board Member.

DR. SHAMOO: Adil Shamoo, Professor, University of Maryland School of Medicine.

DR. SILVA: Joe Silva, Professor of Internal Medicine, the University of California, David, and Board Member.
DR. MILLER: Mark Miller, Associate Director for Research, Fogarty International Center at NIH, Board Member.

MR. HALE: I'm Bob Hale, Executive Director of the American Society of Military Comptrollers and a member of the Task Force.

GENERAL MYER: Dick Myers, Task Force member.

DR. MADISON: John Madison, Task Force member.

MAJOR GENERAL ADAMS: Nancy Adams, Task Force member.

MAJOR GENERAL SMITH: Bob Smith, Task Force member.

LIEUTENANT GENERAL ROUDEBUSCH: Jim Roudebush, Task Force member.

DR. HALPERIN: Bill Halperin, Chair, Preventive Medicine, New Jersey Medical School; Chair, Quantitative Medicine, School of Public Health, and I'm a Board Member.

DR. GARDNER: Pierce Gardner, Professor of Medicine and Public Health, the State
University of New York at Stony Brook, consultant to the Board.

REAR ADMIRAL SMITH:  Dave Smith, incoming Joint Staff Surgeon.

MAJOR GENERAL KELLEY:  Joe Kelley, outgoing Joint Staff Surgeon, and Task Force member.

COLONEL GIBSON:  Colonel Roger Gibson. I'm the Executive Secretary of the Defense Health Board.

DR. POLAND:  And I'm Greg Poland, President of the Defense Health Board, Professor of Medicine and Infectious Diseases at the Mayo Clinic, in Rochester, Minnesota, and Vice Chair of the Department of Medicine.

We normally do this in the very beginning of our session but because in essence we have convened a meeting this afternoon, we have a tradition that was established when I became President of the Board that prior to each meeting we stand for a moment of silence which both symbolic and real in terms of recognizing the
sacrifices that men and women in uniform perform for our country and our recognition that we are here to serve them.

(Moment of silence.)

DR. POLAND: If I could ask Colonel Gibson then to make some administrative remarks and the I will make some remarks and we'll get started.

COLONEL GIBSON: Please sign the attendance roster that's on the table over here in the corner. This is a Federal Advisory Committee meeting and one of the requirements for that Federal Advisory Committee is that we keep track of the attendees. Restrooms are located outside the back door here. If you have telephone, fax, copy, or message needs, please see Ms. Karen Triplett or Ms. Lisa Jarrett who will take care of that.

The next meeting of the Defense Health Board will be September 19 and 20 in San Antonio, Texas. At that meeting we will complete deliberations on a number of open board business
items and receive briefings on the Defense Disability System, amputee patient care, and we will also tour the Amputee Center at Brooke Army Medical Center.

The Board will also conduct a day-long administrative session on September 18. As a reminder, this meeting is being transcribed to please speak clearly into the microphones and state your name before you begin. Also, turn off pagers, Blackberries, cell phones, et cetera. They may interfere with the sound system.

Finally, my personal thanks to the staff at the Holiday Inn National Airport at Crystal City for their help in making the meeting arrangements. Also thanks to the Defense Health Board staff, Ms. Jean Ward, Ms. Lisa Jarrett, and Ms. Karen Triplett, for the behind-the-scenes work. And I would also add thanks to Colonel Bader and her staff for the corollary work that they've done in making this all happen on the right day at the right time. Thank you.

DR. POLAND: Before we begin our
deliberations, I would like to thank the Co-Chairs and members of the Future of Military Health Care Task Force. The Task Force functions as a subcommittee of the Defense Health Board and therefore is directed by the Federal Advisory Committee Act. We are required to deliberate the Task Force's findings and recommendations in an open session as we are doing.

Since their appointment by the Secretary of Defense on 12 December 2006, the Task Force has been fully engaged in gathering information to fulfill their charge of providing an assessment of and recommendations for sustaining the military health care services being provided to members of the armed forces, retirees, and their families. The congressional language that directed the establishment of the Task Force and define the element of its charge are available to the Board Members under Tab 7 of our notebook.

I would also like to personally comment the efforts of the Task Force and their staff for all of their hard work.
I speak for the entire Board when I say that we believe sustaining medical benefits for all DOD beneficiaries is an absolute necessity with long-term national-security implications. The history of this country is that back in the 1600s in the Plymouth Colony, among the first laws passed were the laws protecting the medical benefits in essence of those involved at the time in the Pequot Indian Wars, so there is a long history in our country of providing for those who serve.

Health care finance and delivery is complex as we all recognize at any level and exponentially more so for the largest military health care system in the world. Military health-care system in the world with a global reach serving a population that is constantly on the move.

The deliberations that we will undertake today will focus on the Task Force Interim Report which the Board all has a copy of. Due to the Secretary of Defense and Congress on 31 May 2007,
keep in mind during these deliberations that while
the questions and comments during these
deliberations will help to inform the report, the
report itself is a product of the Task Force.

I wanted to mention that biographies for
the Board Members and Task Force Members are under
Tab 2 of our notebooks. For those who are in
attendance, the session is intended to provide an
opportunity to deliberate the draft findings and
recommendations in a forum that is open to the
public. The discussions will be between the
members of the Defense Health Board and the Task
Force on the Future of Military Health Care. If
time allows, we will take questions and statements
from the public at the end of the session. If
that is your desire as a member of the audience,
we ask that you register to speak at the desk
right at the end of the room here. Everyone,
however, has the opportunity to submit written
statements to the Board, and those statements may
be submitted today at the registration desk or by
email at dhb@ha.osd.mil, or may be mailed to the
Defense Health Board office. The address is available on fliers located at the registration desk or you can go our website.

What I would like to do is first start by asking the Co-Chairs for any opening remarks they have, so I will ask General Corley and then Dr. Wilensky to make any comments you would like.

GENERAL CORLEY: Good afternoon and thank you, Dr. Poland and other distinguished members of the Defense Health Board. Dr. Wilensky, myself, as well as the Task Force members who were introduced just moments ago join me in presenting if you will our interim report.

If I could, I'd ask that you allow me to provide just a brief bit of context and perhaps a brief discussion of the problems set as well. If we were to examine back in the 1970s a movement toward our all-volunteer force, we created a group of magnificent career military individuals who along with the active-duty members, our appropriate Reserve component, their dependents have all been receiving health care and many of...
them move into retirement increasingly so. Along
with that I would say that there has been a
commitment to very high-quality health care and
that has been linked to recruitment and to
retention this all-volunteer force.

As we move the clock forward, in 2006
the rising cost of that military health system led
the Department to develop a legislative proposal
which also included some increases in premiums,
the first proposed in fact in 10 years. That
proposal met with resistance from the Congress who
in turn directed the creation of this Task Force.

The Task Force's charter of which you
have a copy in the appendix to the report as
broadly defined addresses 10 areas, some of which
I will talk about. They include wellness
initiatives, disease management programs, the
ability to account for true and accurate costs of
military health care, and the cost-sharing
structure required to sustain the military health-
care benefits over the long term. In addition,
the charter requested an interim report which is
what we are going to present today that will have preliminary findings and recommendations regarding cost-sharing under a Pharmacy Benefit Program.

To do this, the Task Force adopted a set of guiding principles that are also included in the report for you, and that was really a way that we began to examine and assess the recommendations and try to measure them.

The Task Force concluded that recommended changes should focus on the health and well-being of the beneficiaries but so in a fiscally responsible manner. Perhaps to provide more detail and more specificity on the interim report, I would like to introduce Dr. Gail Wilensky. Dr. Wilensky is truly a phenomenal resource and has been for our Task Force in terms of providing both unique insight as well as guidance. As you have known and have seen from her and have read from her bio, she has extensive experience in terms of developing public policy relating to health-care writ large, its reform, and to the ongoing changes in terms of the health-
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care environment. Dr. Wilensky?

DR. WILENSKY: Thank you very much, General Corley. I would like to note that two more of our Task Force members have arrived, which are Shay Assad and Mr. Henke, and that means that we have 11 of our 14 Task Force members present.

I would like to add briefly to the comments that General Corley has made. We have as you can tell from the bios in your book a broad-based group of experts from inside and outside of the Department of Defense who are represented on the Task Force. The nonmilitary members represent extensive experience and knowledge in terms of health-care financing and delivery as well as some of the best practices that are used in business and elsewhere in government.

Our military colleagues bring a vast knowledge of the military health-care systems and the systems that support it. This group has functioned extremely well together assisted by the very able leadership of General Corley. As someone like myself who has chaired or co-chaired
four other commissions and task forces, my
experience working with General Corley has
exceeded my experiences in the past and I would
like to publicly thank him for his support and
help. He has also spoiled me for future co-
chairs, so they can stand alerted as of now.

We are all committed on this Task Force
to making sure that the best health-care system is
available for those who are and have served in the
military and for their families, and also to make
sure that the military medical mission is well
accomplished. We have approached our charge
recognizing the importance of achieving greater
efficiencies by using best practices both learned
in government and elsewhere in the private sector
and suggesting some ways that the military can
become yet better stewards of the enterprise that
it runs.

We also recognized the appropriateness
of adjusting financial incentives and cost-shares.
The recommendations that we have included in the
report that is in front of you are focused in four
areas, improving business and management practices, altering incentives in the pharmacy benefit, cost-sharing and realignment of fee structures, and ensuring that TRICARE is a secondary payer. Let me just summarize briefly these recommendations in each of these four areas.

In terms of improved business and management practices, we are recommending that pharmacy acquisition strategies be reviewed to be sure that they are written to as to allow for the best business practices from the private sector, and also to conduct eligibility audits regarding the accuracy of eligibility measures in the DEER (?) system. The second area is altering incentives in pharmacy benefits. We are recommending that there be a change in the co-pay for prescriptions filled outside of the military treatment facility. To increased use of the most cost-effective alternatives, we want to encourage greater outreach to be done to encourage the use of the mail-order pharmacy and other best practices of private companies, and will provide
greater specificity on precisely we think this
should be done in our final report.

With regard to the third area that we
were asked to opine on with regard to the interim
report, it relates to issues concerning cost-
sharing and realignment of fees. We have been
mindful of the need to both be fair to taxpayers
in addition to recognizing the years of demanding
service that military retirees have provided to
the nation. We want to be sure to continue to
provide generous benefits when compared either to
public plans or to private plans, but to recognize
the very large expansions in benefits that have
occurred since TRICARE was introduce in the mid-
1990s. The portion of the costs borne by
beneficiaries should be increased to levels that
are below the Federal Employees Health Care Plan
or those of generous private-sector plans and set
at or below the share that existed when the
program first started in 1996. Again, this is an
area where we will provide greater specificity in
our final report.
Increases that are made should be phased in over a period of 3 to 5 years and if the Congress is concerned about the impact that that has on retirement pay, it could consider having a one-time increase in retirement pay if it thought that was appropriate. We are recommending that there be an annual indexing of premiums and deductibles for the under-65 retirees. Again, the specificity of that will be outlined in our final report. We also think there should be periodic adjustments to the catastrophic cap. Again, if Congress is concerned that this may have an adverse effect on retiree pay, it could make a one-time or several-time adjustment if it believes that to be appropriate.

We think DOD should increase premiums and cost-sharing in a manner for the under-65 retirees which we have dubbed TRICAP like the MEDIGAP policies that wrap around the Medicare program. We are also recommending that the payment structure be tiered so that enrollment fees, deductibles, and co-pays reflect difference
circumstances of retirees such as the retirement pay grade, and again we will provide more specificity in our final report.

The fourth area that we have made recommendations in concerns ensuring that TRICARE remains the secondary payer that it is by law. We are recommending that independent audits be done to ensure TRICARE is in fact the secondary payer. This was true both for services provided in the MTF and also with private payers who are involved in TRICARE.

There are several areas that we will explore in the future. We are presently outlining them. They include looking more at the role that the Reserve and Guard has played in terms of the types of benefits that they receive and their transitions into and off of active-duty care. We will also be addressing the issues that were in our charge that we have not yet addressed in the interim report in some manner in the final report. With that let me turn the microphone back to you.

DR. POLAND: Thank you very much,
General Corley and Dr. Wilensky. What I'd like to
do then is open it up for discussions and
questions from the Board and dialogue then with
the Task Force. What I'd like to do is first
start with any particular comments or questions,
and because our time is limited until about 4
o'clock, we are going to need to focus our
discussions here. First, are there any questions
or discussion about the guiding principles? I
will just start with one and wonder whether there
was some consideration to two things. One, trying
to maintain a set of benefits that are just let me
use the word promised at the time somebody enters
into military service and maintaining those
throughout their service. So they may change and
may in fact be different at different points in
time for different people, but when they come in
if they're told they could count on X. Then
related to that, was there any discussion about
differential benefits for somebody who would be
injured in uniform during an act of war for
example that would have lifelong implications for
their health care?

DR. WILENSKY: I'll answer the first part, but I would like to turn it over to one of our surgeons general for the second piece of that with regard to those who are injured, but also they are welcome to comment on the first part as well.

The issue about maintaining the promise is one which we raised among ourselves, had many discussions in open meeting in our meetings in Washington but also as part of our 2-day activity in San Antonio where we had a town meeting and panels of individuals who were speaking before us. We are very mindful of the issue as an emotional and important one.

What we have looked at is to try to within the context of the benefits that were promised particularly the start of the TRICARE program, looked at them in terms of a package of benefits and looked at them in terms of the expansion in benefits that have been made since the program was initiated. It is why when we
talked about altering the deductibles or fees we have left to not exceed the share of costs that it started in 1995 but to be mindful of the very substantial benefits that have occurred without any changes of any sort with regard to fees and co-pays.

As you know, my background is from Medicare and financing of health care and the notion of having small annual changes in deductibles and premiums are integral to the entitlement that exists for our senior population. So while we had a lot of discussion about the issue, we believed that what we are proposing now with both the gradual introduction, the maintenance well beyond what exists in the public or private sector, and not to require a cost-share that would be greater than what was initiated in the 1995 is very consistent with the notion of keeping the promise that individuals were given.

LIEUTENANT GENERAL ROUDEBUSH: Yes, if might speak to your second question relative to the care of individuals wounded in combat or in

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wartime circumstances, our charter did not guide us in that direction as a specific area of focus, but that care would certainly fall within our purview in the broader sense. The task forces and the commissions that are currently looking specifically at that care, to include the entire spectrum of both care of the wounded and then the disability evaluation process and the subsequent care of those individuals will certainly inform our discussions as we go forward. So while those activities are more narrowly focused and I think are doing some very important and valuable work in illustrating what the issues are and how we can best attend to them, we will be looking to those bodies of work to help inform our processes to assure that there is coherence and consonance across the spectrum of care for all our beneficiaries many of whom will have been injured in combat but many of whom will have significant or very serious illness and injury that would certainly be cared for within the same processes and activities. So all categories of
beneficiaries certainly be within our purview.

DR. POLAND: Dr. Silva, did you have a
coment or question?

DR. SILVA: I found the report very
interesting and very much up to date and struggled
with some of these problems when I used to be dean
-- health care system at the University of
California, Davis. We went through much of the
same logic.

I think the main beneficiary is the
American taxpayer because there are wasted dollars
by the way the military distributes its drugs. So
the mail-order business I think is a no-brainer
and even how one uses TRICARE and forces TRICARE
to be secondary and not primary, I am a little
concerned about the co-pay and I wanted to know
from the committee how raucous was the meeting
that was held with the enlisted panels or spouses?

How much heat is going to be generated?

DR. WILENSKY: I think there was less
pushback to the notion if it was regarded as
reasonable. We repeatedly heard acknowledgement

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that some change in premiums were likely and the
question would be at what level, at what type of
indexing, and how quickly would it be phased in.
I think there has been widespread recognition that
zero change which has resulted by the way in
having individuals who were initially paying 11-
percent of health-care now paying 4 percent for
the under under-65 retirees, again that's the
focus of our attention, is very a unusual
experience in this day and age.

There was some discussion but very
interesting as it evolved over time about the
notion of tiering, of having different fee
increases or fees for individuals according to
their grade at retirement or some other
distinction. There were some group who did not
believe that that was appropriate, representative
groups, but we found far more individuals at both
the low end and the highest levels who supported
the notion as being fair and appropriate since
their pay when they were in the military was
differentiated and their pay at retirement was
differentiated, and this seemed very consistent.  

But there were certainly representations from some 
groups not to go this direction, but not the 
majority of comments.  

MAJOR GENERAL ADAMS: I think the 
comment I would make is at least I think three of 
the groups were all active duty and of course the 
issue of co-pays is not relevant to the active 
duty, so that really wasn't one of their primary 
focuses in terms of communicating with us.  

DR. POLAND: I did want to call 
attention to one thing that I found very 
innovative actually and I suppose reflective of 
what happens in the private sector. That is as 
was pointed out there had been I think four 
expansions or so of the benefits with not 
necessarily a long-term view to what the 
cumulative impact of those would be, and the 
report on page 3 calls for when making changes in 
practice or policy, pilot studies or demonstration 
projects should be used and I think that was a 
fabulous idea and an innovative one. In fact, I
even wondered about strengthening the language and
saying would be required, but that's nit-picky.

I would hear a little bit or be informed
a little bit about the discussion around that
because it really relates to I think sort of a
capstone statement that occurs throughout the
report particularly on page 15 where it talks
about not diminishing the trust. That decision
almost gets taken out of one's hands if a
cumulative expansion of benefits occurs that is
not well coordinated and for which there are not
long-term projections, you have no choice but to
pull back from some of those. How would you view
that as happening? And it almost relates to an
idea I had for a principle of there being
something in place that would help guide the
evolution of the system. Characteristically, what
we all do is we set what we think is a really good
system in place and then tamper with it temporally
over time but not really in a directed, principled
way that allows one to predict how things will
evolve and what the processes used would be.
DR. WILENSKY: The call for pilots was particularly focused to the adoption of strategies that were either new to the military or new, period. Actually had a discussion about whether to make it mandatory as opposed to suggested and one of the reasons not to do that is some of our suggestions are so commonplace in our sectors, either other public or the private sector, there seemed to be less reason to have a pilot whereas other strategies that might be thought to be significantly different for this population or just innovative in their own ought not to be attempted without pilots.

The comments with regard to the attention to the financial implications of benefit expansions was more in the nature of a plea to the Congress to be mindful of the longer-term ramifications but recognizing that there really is no way we can force that to occur.

GENERAL CORLEY: That was really what was reflected if you will at the top of page 5 and although principally under the Cost-Sharing
Realignment Fee Structure section where it says, "Benefits have been expanded but it really wasn't clear whether the expansions as implemented were done based on some assessment of the impacts or the effects." We could find no empirical evidence to suggest and no one has presented themselves yet to say that that was the case, there was just a rapid expansion of benefits especially over a given period of time. Then in fairness, there were decisions on the part of the Department not to make increases where they did possess authority which resulted in the share basis for example that Dr. Wilensky talked about before falling from an 11 percent to a 4 percent which was counterintuitive when in the larger population those percentages in increases was in fact increasing or in some respects up as high as 25 to 28 percent.

DR. POLAND: Then the last of my question about would it be appropriate, this one focuses more on a certain set of the large charge that you received, to have something in there that
would guide the process by which future changes would be made so that 10, 15, to 20 years from now we're not back, it won't be us anyway, with somebody else trying to get their hands around a system that had changed substantially maybe in piecemeal fashion in trying to reinvent it yet again.

DR. WILENSKY: At some level you can say that that occurs now because CBO has to score any legislative change if it is a change that occurs through legislation.

It is possible although we have not considered it as our group to put floors in place as for example happens in the Medicare program Part B premium where Congress when it was not inclined to do annual increases to keep the senior share constant, put a floor of 25 percent below which the seniors' share cannot fall. So there are ways to try to put boundaries on the financial ramifications, but I think there was enough sophistication around the table to recognize that it is hard to effectively tell Congress it can't
do things, we can only try to alert people of the
consequences of their actions.

DR. POLAND: I try to do that as a
parent of adolescents too.

Another question that I have pending
others that come from the Board, I really pondered
this one, and that was the idea that evidently it
turns out that a number of people ineligible for
benefits were receiving benefits which on the
surface it seems like an easy fix, but as I
thought of it more and I want to be educated a
little bit here, and the Board too, we might think
that way from the private sector where we are in
fixed installations and relatively small numbers
of people, but I was really struck by the idea of
the complexity of this system and the largest
military health-care system I suppose we could say
in the history of mankind. How difficult will it
be to fix that part of it? I really didn't see an
easy solution to what seems like an easy problem.
It would be interesting to hear a little of the
discussion of that.
DR. WILENSKY: We don't know that it's a problem. It was raised as an issue that is known to exist in the private sector. We have suggested two areas where we might there may be problems one of which does have some empirical support and one of which does not.

I don't think any of us were aware that there is an eligibility problem with regard to the DEERs system, but the fact is the types of checks that occur which is checking I.D. at the time of use is different from the kind of spot audits that could be done to make sure that the eligibility is in fact appropriate. What our recommendation is to do those see whether or not there is a problem.

There is some evidence with regard to the other area that we have suggested for a right for audit that has to do with whether TRICARE is truly serving as a secondary payer. The GAO has indicated in the past that some of the treatment that is provided through the MTF may in fact have private payment available for funding. But there has also been the issue that it is not clear that
people are reporting when they have private insurance. It is a field that is frequently left blank when individuals use care. So the suspicion is that they may not be reporting private insurance where private insurance exists, but they use it some of the time and they use the TRICARE Extra or Standard other times. This again is a problem that Medicare faces when Medicare is supposed to be a secondary payer and people who are over 65 and are working with private insurance. So there is a little more indication there that there actually may be a problem. The other was more as a best-practice strategy, we ought to look and make sure there's not a problem, but we don't really have any indication there is a problem.

GENERAL CORLEY: To pile on, the thought process was with an eligible population of 9 million people, we need to at least establish a baseline. I agree and I believe the other Task Force members do and even Dr. Galvin who may have identified this issue for us to start with that
there could be an area that would potentially
worth an examination from a control measures
standpoint, from a best-business, not a best
health practices, but a best-business practice
worthy of examination.

DR. LOCKEY: I was just curious, in the
pharmacy acquisition process, and I'm not
knowledgeable in this area, but would that be open
to pharmaceutical houses within the United States
only or would you suggest that that should be
something that can go across borders?

DR. WILENSKY: This is an issue where we
are not sure whether we have a problem. There is
a single pharmacy benefits manager at Express
Scripts who holds the contract for all of TRICARE.
We heard from some of the other large PBMs that
there are provisions in the language that would
preclude from their viewpoint the use of best
practices in the private sector. We had some
discussion among ourselves and I think we are not
positive we either sufficiently understand or
agree whether or not that is the case. We have
the advantage of having Shay Assad on our Task
Force.

But we indicated that if these large
PBMs believe there are provisions that are
precluding them from doing their best practices,
that in and of itself may be a problem and that we
need to make sure that we don't have that. We had
heard similar generalized comments with regard to
some of the contracting issues in TRICARE in
general, just the plea to make sure that the
contractual language allowed for best practices
most integration of care. We have started now for
example in our meeting yesterday listening to
various proposals for disease management and
wellness and those are issues as we go forward
that will be both incentives in making sure that
incentives are aligned for best practices and that
contractual language allows for the adoption of
best practices. It quickly gets very complicated
and we had a little bit of dueling views of this
issue.

GENERAL CORLEY: If I can, and then I
might ask Shay to comment on this as well, the
recommendation was to go back and have an
assessment of the acquisition strategies and
that's why we're asking for an acquisition
strategy expert to try to provide some help to us,
because we don't really understand whether this is
a legitimate procurement process problem or
whether or not we had companies that testified in
front of the Task Force that had either an
inappropriate or an improper interpretation of a
legal provision in terms of the governing of the
beneficiary contract. So we did not to the first
portion of your question examine other countries
and other pharmacies. This was more acquisition
strategy procurement process. Shay, do you want
to comment on that?

MR. ASSAD: Yes, sir, I think that's an
accurate portrayal of the situation. What we're
going to do is most of the industrial companies
that testified suggested I believe that the
contracts were structured in a manner that
prevented them from implementing best practice,
and obviously we want to take advantage of
commercial best practice whenever we can. So
we're going to go back and examine the details of
our acquisition strategy as we go forward in our
next set of contracts to see if in fact that's the
case.

As Gail mentioned, on first blush we
don't think that's a problem, we think it may just
be an issue of interpretation, but we need to go
back and relook at it. In any case, we also are
going to expand the opportunities for companies to
come in and talk to us about the concerns that
they may have with that process so that they
understand it and therefore will be able to
compete in an environment where they feel they're
getting a fair shake.

DR. POLAND: Dr. Parkinson, and then Dr.

Pronk. I'm sorry.

GENERAL CORLEY: Just one more quick
response to that. There is a law that requires
that all of the pharmaceuticals and devices that
are used with military members be FDA approved so
that limits the amount of overseas acquisition
that could be looked at at the start.

DR. POLAND: Mike?

DR. PARKINSON: Thank you. Mike

Parkinson. I think the report is good as it
stands. It's a good report because it answers the
interim mail which was they want you to comment on
the pharmacy and on cost-sharing, but I just want
to make a comment and then about two or three
questions if I can. My experience in working with
now hundreds of companies, and I know Bob is in
your Task Force, and Dr. Wilensky you have a lot
of experience with this, is it's the tyranny of
the stovepipe benefit plans. Employers are now
realizing that if I've got PBM vendor and I've got
a health plan vendor and I've got a wellness
vendor and I've got a disease-management vendor,
I'm probably overpaying in every stovepipe and
that no one has really integrated it for me in a
way that makes sense to my consumer, and by the
way, how much does it really cost.

My urge to the Task Force is to be a
relentless purchaser with the taxpayer's dollars
to get rid of stovepipes and also to get rid of
fees and hidden things that frankly military
retirees and beneficiaries really don't care
about. What I'm concerned about, we've had some
counterpart over here about reviewing of the
acquisition process because I think it's key, so
this is a great interim report. I love the broad
scope of the charge here. But in answering just
this narrow mail, I hope that we maintain our eye
on the prize which is true integration and
absolute efficiency that may or may not be
stovepipe purchasing of these benefits that we
have historically done under TRICARE.

To wit, with pharmacy I go back to that
in three buckets, the purchasing of the
pharmaceuticals themselves, the benefit design
around the pharmaceuticals, and third is the
utilization around the pharmaceuticals. What I
didn't see in the report is a magnitude of the
problem of the pharmacy purchasing. Do we know
what proportion of generics for example that DOD
beneficiaries use to relative to best-practice
civilian populations? Is that small delta, is it
a big delta? It alluded to the fact that it's an
issue and we are not optimizing it. Do we know
the dollar value of that or the proportion of
generics that we're shooting for?

DR. WILENSKY: Let me response a little
bit to this first part that you've raised, and I
think my colleagues are very sensitive to the
issue of the stovepipe. A decision was made for a
variety of reasons in the last contracting to have
the pharmacy benefit separate from the TRICARE
contracts. This will be an issue I don't know
where we will come out, but there obviously are
tradeoffs involved in terms of integration which
would suggest having them be part or in terms of
leverage of having them be together, and we will
have to deal with that issue. But we have already
started that discussion. I'm not sure how
specific our recommendations in that area will be,
but we will certainly consider that as an issue.
And as I've said, we have already started on
discussing issues such as wellness and disease management and how one integrates into their plans and making sure that the incentives are such that if they are separate that they are aligned so that you don't have a push not to do this because of the financial incentives that are in place.

With regard to the generic issue, the military as you probably know is in somewhat of a different position than most other utilizers. It is basically more akin to a state that's a mandatory generic substitution state like Massachusetts for example where the nature of the formulary is where there are generics, generics are used, so it's the ultimate incentive.

Our concern had been more with regard to either making sure that there was best practice with regard to preferred drugs and that the tiering was appropriate. And particularly where we thought there was a lot of potential which is the mail order for chronic meds which has not been used very extensively although there has been some attempt toward outreach and there are some users.
So that was why our focus at this point was to go for the lowest-hanging fruit available and by differentiating financially as well as encouraging the outreach to try to drive much higher use. The question about how do you integrate better prescribing into physician and hospital care is an issue that we will deal with in the final report.

DR. POLAND: General Kelley, did you want to make a comment?

MAJOR GENERAL KELLEY: Just to expand that a little bit. Because of the mandatory substitution, we have a very high use of generics, even higher than most plans in states where they have substitution. As far as the tiering goes, we are pushing currently to use generics based on the tiering, but the cost differential between the tiers is such that it doesn't provide an incentive. And generics may not be the best drug for the patient but the patient may chose that because generics have one co-pay and if there is a newer drug that is only in the brand-name status, it has a higher co-pay. So many of the plans that
we saw used a tiering based on best clinical
practices and because you get a better outcome,
overall costs are decreased, although pharmacy
costs may be increased, but you have a better
overall outcome. So that is an area that we
wanted to look at in greater detail also.

DR. POLAND: Dr. Corley?

GENERAL CORLEY: If I can, there is a
limited amount of additional information in one
aspect of your question I believe back to
utilization and point of service and why we think
there is a substantive delta between where we are
today in the Department of Defense and potential
best practices that exit.

If you look in just about the past 4 or
years' worth of our eligible population, we're
seeing of that eligible population an increase in
the use of the pharmacy benefit, so more people
are taking advantage of that benefit. Where are
they going in terms of point of service to obtain
that pharmacy benefit? Here is where I think some
of the statistical data is a little bit
disturbing.

If we look at areas where we have a degree of control inside of our military treatment facilities, getting that pharmacy benefit there is decreasing and has substantively. If we take a look inside of mail order, regrettably, it too is going down, a bit counterintuitive in terms of the testimony that we received from some others that might be considered best practices.

Where we are seeing a remarkable expansion is in the retail side and as you can obviously tell, with a pretty substantial economic impact there, so to one aspect of it that does give you some trend information that suggests we need to get after this point of service incentives how we deal with the issue.

DR. PARKINSON: If I can just follow on that because those points led right what is very helpful, and again just to share our experiences, in companies that I've worked work with that start moving towards what I would call heavy-handed mail order, mandate is too strong a word, but painful
incentives get pretty closer to it, the employee
pushback is oftentimes pretty considerable, and
oftentimes what we find is that giving a broader
array of choices with a true market exposure and
transparency of price is pretty well received.

As you know, the private sector, not the
health plan or the PBMs, are coming up new
innovative alternative delivery models called Wal-
Mart for $4. It won't be too long in this rapidly
moving space I predict that the retailization of
the pharmacy outside of the PBM industry and
perhaps such things as General Kelley mentioned,
the value-based benefit designs which are all
about if you know anything about the consumer-
driven movement, it's to differentiate the things
that work and are evidence-based and those things
that are largely discretionary and not evidence-
based and to float those prices to whatever the
consumer and the doctor thinks it's worth, but
when you post the real price, it drops like a
rock.

So all of my comments are here about to
stay one step ahead of a dramatically changing pharmaceutical marketplace and not be too beholden to our acquisition process thinking or the current vendors and stovepipes because I think this train is moving very fast. As many of you know on the panel, Dr. Wilensky, I don't mean to replace that, but DOD could lead this movement with some innovative purchasing models that are really not even out there yet as much as building on the ones we already have. So I think it's great.

The final comment is that the military has led this in the past. It's called the PEC, the Pharmacoeconomics Center. We were one of the first to compare drug/drug because the FDA doesn't do it to what works. So you've already got an infrastructure inside DOD to do pharmaceutical analysis and then translate that into vigorous purchasing models.

The last question and I assume it's politically off the table because it gets to much press, and that is the VA purchases drugs I guess very differently at the point of source of the
manufacturer versus the way DOD can or does do it.

Is that just off the table completely given the
current political climate around that issue?

DR. WILENSKY: We think it is actually
well reflected in the differentiation that is
being proposed and that exists now which is the
MTF and the mail order have access to the Federal
Supply Schedule and like the VA take over the
distribution costs. While the retail pharmacists
and the PBMs or those who would like to have that
contract would like to have that lower price
enforced by law, the fact is they don't take over
that distribution cost. So I think politically
Congress can do as it will on that, but at an
economic and policy level, it is hard to justify
enforcing a low price when the functions are
fundamentally different. The fact is that a
retail pharmacy is a more expensive distribution
source because the distribution costs are not
being absorbed. And some of the groups who had
not come in claimed that they could substantially
beat the Federal Supply Schedule anyway, and our
attitude was great, go for it.

So I think the notion of trying to design to try to achieve best practices very much fits in with the notion of considering a pilot that would differentiate tiered payments with value-based design. I am personally a big fan of the value-based design and tying it with comparative clinical effectiveness, but we would have to be mindful that this really is not being used elsewhere and it would be terrific to try it and make sure that we were comfortable. It would not be wise to try to impose it on a system as large as the DOD health-care system.

DR. POLAND: Dr. Pronk?

DR. PRONK: Thank you. I read the report with much interest and thought that actually most of the focus was on financial issues related to pharmacy use rather than medical-management issues that really provides opportunities as well. In particular I was thinking about the use of PBM data that can be used in terms of crafting strategies in the
medical-management area to stimulate the
appropriate use of pharmaceuticals rather than
seeing overuse, misuse, or underuse, such that the
data can used by an intervention team if you will
that crafts strategies in the area of medication
possession rations or compliance data can be used
for that. Could you tell us a little bit did you
discuss those kinds of approaches or do they fall
more under the disease-management kind of
strategies?

DR. WILENSKY: The first answer is we
focused where we did because we were directed by
the Congress to report on these issues in the
Interim Report, so that was a practical concern
that we needed to address.

And the answer is yes with regard to the
second, that is, we think that the proper or best
use of pharmaceuticals in support of medical
management is an important issue. We have already
begun to discuss this in the last two sessions
when we've dealt with wellness and disease
management, and we will have it as well as several
others areas that we will be looking at over the
course of the next 6 months as we prepare for the
final report.

MAJOR GENERAL KELLEY: I think that in
answer to that also, one of the direct things that
you talked about integrating and using the
pharmacy data either for disease management or
even increase the use of the TMA pharmacy, the
contractors felt that there were prohibitions from
doing that based on the current contract. That
may not be true and we're looking at that, but
that was one of the things that also was
addressed, that is the contract design preventing
because it separated disease management and
pharmacy benefits and health care delivery, was
that actually inhibiting doing the best practices.
That's one example of that.

DR. POLAND: Dr. Shamoo?

DR. SHAMOO: Adil Shamoo. Most of these
questions are on medical economics and obviously
they influence everything. As you all know, there
is a Mental-Health Task Force and I was wondering
if you have built in some safeguards in the
application of this in the future so it will not
perpetuate the stigma and the bias toward
acquisition of mental-health services.

LIEUTENANT GENERAL ROUDEBUSH: If I may
again, in some similarity to Dr. Prong's question
relative to the care of the wounded, the work that
is being done within the Mental-Health Task Force
I think is addressing some of those issues very
directly and in a way that I think again will
inform our deliberations and our discussions so
that we an assure that that's properly reflected
and that our deliberations and any recommendations
that we might provide either incorporate those
aspects are or assured not to impede the kinds of
things that I think you very correctly referred to
in terms of moving ahead in the area of mental-
health treatment and prevention.

DR. WILENSKY: It is also in the area
that the presidential commission which I also
serve on is looking at in a very focused way. So
I would hope between these two other efforts that
we can incorporate whatever is appropriate to make sure that we not exacerbate a problem.

GENERAL CORLEY: Joe, do you want to comment at all on the seven lines of action and the integration of a number of task forces that you have currently ongoing inside the Department, although your question in large measure has not been addressed and is not inside of the scope of this charter, that is not to say that it is not being assessed in other task forces. The dilemma and the concern is, to Jim's point, how do we make sure we have an integrated effort, how do we make sure we don't impede some efforts?

MAJOR GENERAL KELLEY: Yes, sir. There is a Senior Oversight Committee that has been meeting now for 3 weeks chaired by the Deputy Secretary of Defense and the Deputy Secretary of the VA and all the senior leaders from the departments both DOD and the services, the Joint Staff, as well as the VA, and both representatives from the health side as well as from the benefits side. This Task Force when we were chartered did
not deal with VA issues, so if it was a VA issue, it was outside the scope of this Task Force. However, that Senior Oversight Group is within those issues and so that will be the area where we work on resolving those things. I think it goes back to Dr. Poland's first question about are we dealing with that, and the issue of differential pay is probably more a VA issue, but it certainly is a combined issue to be worked between the two and that was an actual discussion item at the meeting that was this week.

So those wider issues that involve interagency issues are being addressed and I think in the next few weeks there will be some more information coming out about those, but there are seven different areas that are being looked at and there is a specific group that is looking at traumatic brain injury and posttraumatic stress disorder and in that is the whole stress relationship thing and the mental health. So I think that those will be addressed in that forum across the departments.
DR. POLAND: Dr. Parkinson?

DR. PARKINSON: I apologize for coming back again, but some more questions what I think is very constructive. I would hope that the demonstration authority or the demonstration thoughts that you have include a major commitment to at least pilot a consumer-driven model. Most employers will be implementing consumer-driven plans this year. They are uniquely suited I think to the military philosophy of primary emphasis on prevention with evidence-based care with incentives, and I've provided as background material to Colonel Bader some of the experience that we've had in over 100 companies doing this.

But the importance is the total transparency of the cost and that the consumer sees the resources spent on their behalf as his or her own whether or not they are in an HRA or whether they really are in an HAS. What it does is a couple of things. We only focus on prescription drugs, we take over-the-counter alternatives which in many cases are the same drug
off the table because the OTCs actually cost more
than the current no co-pay of a prescription drug.
We have seen this where essentially I'll get my
purple by prescription but I've got Prilosec OTC
which under the perverse incentives of a co-pay
model actually is cheaper to get the prescription
than the OTC which is biologically equivalent. So
somewhere in the discussion should be OTC
alternatives to the most-commonly prescribed
drugs, and looking at all 100 companies we look
at, in DOD I'm sure the top three categories of
drugs are some version of a purple pill which is
going to be your Nexium and Prilosec, that group,
because it is in all the companies we look,
antidepressants, antienceolitics (?) and sleeping
pills for which often times there is very few
generic equivalents and they certainly aren't
pushed, so it's very high, and the third group of
course is all your statin drugs. If we can look
at the OTC piece equivalence to some of this in
the dialogue, it would be useful.

MAJOR GENERAL KELLEY: And I think that
that was looked at in the same concept that we
talked about, the value tiering, and so some of
the companies that presented to us did use a small
number of OTCs because of the cost differential
and the equivalence in treatment capability,
Prilosec being one.

DR. PARKINSON: Look into some of those.

MAJOR GENERAL KELLEY: Yes, and so that
is the value proposition.

DR. PARKINSON: Perfect. Thank you.

DR. WILENSKY: We will definitely look
at the HSA issue. It is an issue that we have
indicated we will consider. It will be important
to look at the likely economic effects. It is not
clear. As somebody who is an HSA proponent in
general, I think we need to do some financial
estimates and make sure that it would actually be
the soundest strategy for the particular
population that we have here. It is very
different because of the distribution of users,
and particularly the distribution for the under-65
retirees between the Prime, Extra, and Standard
make it not clear that you would be financially better off within HSA with that population. So it is something that we have on the table but I think we would want to do careful both financial analysis as well as look at the incentive structure as the effective medical case use and to make sure that was the best way to try to get responsible behavior as opposed to potentially other strategies.

DR. PARKINSON: I might just add my experience in dealing with this issue, and we spend some time on the Hill not surprisingly during this time of the year, I think the HSA is overly politicized or certainly can become overly politicized particularly in a very benefit-rich environment. The HRA with incentives gets pretty much the same economic return and result with just the consumer seeing the money spent on their behalf by DOD as their own money with some rollover potential and that I think is probably more powerful and appropriate as it is for most employers than at HSA. So down the road as you
get to that juncture, you may want to opt for some experience and thoughts there, but I do think it's very powerful because it removes the third party from saying you must do a tiered anything, here's the cost, here's the options, talk to your doctor, and we immediately see a 15-percent reduction in pharmaceutical with zero to no friction compared to a PPO with three to five tiers. Pharmaceutical companies and PBMs are looking at this movement very suspect because it produces some dramatic results.

DR. WILENSKY: And I think while we look at it, the formulary-driven nature of the DOD really is very different both in terms of the use of generics but also the limited use of other brand products because of the Pharmacoeconomic Advisory Group that goes through a lot of these activities where in other companies it is a much more open vista of what you can choose, but it is certainly worth exploring.

DR. POLAND: I also invite any other members of the Task Force if any thoughts come to
mind regarding the questions that have been asked.

LIEUTENANT GENERAL ROUDEBUSH: If I might just add one comment for Dr. Parkinson's thoughts, I think it is a very valuable construct to look at. We have had some very wide ranging and I think very interesting and productive discussions within the Task Force, but in some aspects, HSA begins to alter the pay and benefit package that the fundamental compensation package certainly for active duty and retires. So the impact on that baseline to keep equity across the system if in fact we took a slightly different tact in that would be a consideration so it begins to move out of the health benefit and into the broader pay and benefit scheme. So it's just an aspect that also comes into play when we discuss opportunities or options such as that.

DR. POLAND: Dr. Silva?

DR. SILVA: One thing raised, a question, which is how much of an audit will count for false billing? Do you have any notions of what that is? Because people are on military
bases and who's using their I.D. cards, it did
creep into the record as a recommendation and I
was surprised at that. Are there going to be
substantial savings here?

DR. WILENSKY: I don't think we know,
and we are not suggesting a full audit by any
means as much as a spot audit to see what we find.
We don't know that this is an issue. It was
suggested that it has been an issue in even the
most carefully structured private plans, you ought
not to assume it's not an issue unless you go
look. As I've indicated, I think the potential as
a secondary payer problem seems more likely, but
that again we are assuming a limited audit and the
results of a limited audit will suggest whether
further audit seems appropriate. If it doesn't
produce a lot of return or more return than the
cost, then we'd certainly stop. In general, we
don't know what we don't know.

DR. SILVER: Thank you.

DR. POLAND: Dr. Lednar?

DR. LEDNAR: Wayne Lednar. Obviously a
very complex issue and a tremendous amount of understanding to get to this point. It seems that for a lot of us, and I am from Eastman Kodak, we get sort of depleted of our energies after we get through the blocking and tackling, the mechanical and structural aspects, how do we set up co-pay and cost-sharing structures, how do we source it, who do we buy it from, how do we distribute it, mail order or retail. But I think there's an opportunity here to really improve the clinical quality and therefore the value to the DOD beneficiaries that I hope can remain in view.

For example, in the area of pharmaceuticals, we spend a tremendous amount of money as an employer in paying for the employer portion of prescription drugs including specialty pharmacy. It is a very sobering and disappointing figure to find out how many of those pills we paid for never leave the bottle, never get out of the medicine cabinet, never get taken, and we wonder why clinical improvement does not occur.

So to the extent that whatever we
purchase can be more fully utilized, whether it's adherence, compliance, helping patients through side effects, I think there are resources that we have not yet effectively engaged to help us get the value out of the money we have already spent. We have found that it isn't necessarily self-evident how the resources of the structural parts can best be put together. For example, PBMs have clinical pharmacists, health plans have behavioral health programs and resources, and how does it fit together? And these stovepipes don't talk to each other.

So it is really our job I think in managing the system to structure it in a way that the parts coordinate, and in fact in our thinking to put enterprise level, supply channel level performance metrics that put all elements of the supply chain at risk for the same performance, the performance of the combined supply chain including fees at risk. So I think we have purchasing technologies that if we full deploy we can get a whole lot more value out of the monies that we're
already spending.

DR. WILENSKY: There is a real problem that exists in the current way benefits are structured for retirees. I think that is and should be a matter of some importance and is of some importance for the active duty and their dependents. And it is also easy to see that for the retiree Prime program which is MTF based. The problem is that so much of the resources are and will in the future be going to under-65 retirees who are part-time users of the Department of Defense TRICARE system because they have Extra or Standard so they use the military system on a part-time but not full-time basis for the most part with these individuals. In addition, we have even higher users of the over-65 population which use Medicare and TRICARE and attempting to get integrated delivery becomes extremely difficult because these are individuals who depending on where they live may sometimes use the Medicare private system, may sometimes use the MTF, and they sometimes use the VA, and it really will be
challenging as to how you integrate care when you
have people bopping in and out of systems.

I don't know whether this Task Force
will look into the issue about whether or not to
consider piloting models that would incent people
to choose a system and take their money with them
or otherwise try to unify where they get care, but
as it now stands outside of the activity and their
families who are not the expensive part of the
users and particularly not the projected expensive
part of the users, this is going to be a big
challenge to getting the best medical value and
the best quality of health care for individuals
that have these various points when they use
different health-care systems that have nothing to
do with each other and don't talk to each other.

DR. POLAND: Any other questions or
comments from the Board?

DR. PARKINSON: Yes, Parkinson again.

Dealing with many companies that do a lot of
business with DOD, they're delighted when they get
DOD retirees to come work for them because as you
just said, they've got a bargain and they are not
going to have anybody picking up their health-care
benefits. So I would encourage your committee
because you're given such a broad legislative
charge to think creatively about how you deal with
military corporate partners around innovative ways
to perhaps voucherize a DOD benefit that they can
spend. There might be something out there that is
not currently on the table that would be very
attractive to the 15 companies that you could name
right now off the back of your head that make our
weapons systems and our intelligence systems and
our IT systems that would be attractive and a win-
win because they are going to be government
contractors for a long period of time and yet the
walk away at $460 a year versus what they're
spending which is $14,500 for a family of four
this year is far apart, but there may be a new
business model out there that they create every
day in thinking about news ways of doing
contracting. So I would encourage you to do that
because we see the other side where frankly they
count on the ghosts or the antighosts or whatever
the military calls them, somewhere in between
there might be a middle ground which makes good
clinical sense for us and business sense for them.

DR. WILENSKY: If you have any ideas, we
are already struggling. I've struggled on and off
for the last couple of years with this issue and
have found it very vexing, so any of you who would
like to suggest ideas, please send them to us and
we'll gladly consider your thoughts.

DR. POLAND: Are there any other
questions from the Board Members, from the Task
Force Members? Did I miss one? Sorry, Dr.
Shamoo?

DR. SHAMOO: When there is military, at
least this is just a point of information since
I'm not as expert as you are, there is a job being
cost in medical care somewhere. First, is that
insignificant, or how does it get covered, or do
you just cut everybody else just like it shifts
towards a balloon and then everybody else gets
shallow?
MAJOR GENERAL KELLEY: For most of the costs that come from a combat operation are covered separately from the budget in supplementals. So there is a big piece of health-care dollars that are being discussed in the supplemental that's on the Hill right now and has been in the news. There is a big chunk of providing extra care that happens which predominantly related to activating Reservists and Guardsmen who were not eligible for care before and now are with all their families, but it also includes other aspects of the care of the injured.

DR. POLAND: General Smith?

MAJOR GENERAL SMITH: That was one of the main points I wanted to drive out as we active besides supplemental one of the vectors that we're looking is with the increased use of the Guard and Reserve in more and more operational phases of the military and then coming with their families where are we going with that? We more had a steady state, but now with the increased use of the Guard and Reserve, we've got to understand of the cost.
vectors. So some of the things that we are doing in the Task Force by looking at what are possible cost vectors and pressures on the military health-care system as we look to the future.

We have already stated one was the expansion of some benefits that in 1995 were not there that we are now covering that we weren't covering before where this vector of the Guard and Reserve is more of an operational force and you can be talking about a million-plus when you talk about Guard and Reserve resources coming to the system, there are going to be increased cost vectors that we're still dealing with.

DR. POLAND: The Board will now open the meeting for comments from the public. I think we do have one. Ms. Jarrett, if you would call that individual up.

MS. JARRETT: Steve Strobridge?

MR. STROBRIDGE: My name is Steve Strobridge. I'm the Director of Government Relations for the Military Officers Association of America, and I also Co-Chair the Military
Coalition. We had testified before the Task Force a little bit earlier. The one question I would have is about cost, and particularly when we're talking about a percentage cost-share it is easy to figure out what the numerator is, it's not so easy to figure out what the denominator is.

For example, when the government goes to war and we ship the doctors to Iraq, we send more people to the private sector which costs more money. That is a cost of war. It's not a benefit value to the beneficiary. So our concern is what costs do you exclude, and did the Task Force address that? In other words, what's the cost to the government versus value to the beneficiary?

One other example, when we talk about the costs that we had when TRICARE first came in in 1995, that was when a large share of the care was being delivered in military facilities at no cost to the beneficiaries. We have subsequently downsized all those hospitals and clinics, the services have downsized their medical corps which again drives more beneficiaries to the private
sector which costs the government more money.

On the pharmacy side, we've talked a lot about the benefits of using the mail-order pharmacy and that is one thing the military associations have been very concerned about. We're trying to hold down costs because we're very sensitive that the rising cost creates pressures to say let's charge the beneficiaries more. We have gone to work with the Department of Defense. We have approached them and said let's do a partnership to try to find ways to encourage more beneficiaries to use the mail-order system which we all recognize saves the Department of Defense much more money. The Department of Defense refused to partner with us to do that.

Last year Congress passed a provision, or the Senate did, mandating federal pricing in the retail system. The administration opposed that and it was defeated. The question that we had to the Department of Defense is now since those things cost the government hundreds of millions of dollars, are you now going to deduct
those costs from the DOD cost-share from the
denominator of this fraction so that beneficiaries
don't have to pay a share of costs that the
government imposes on itself by its own
inefficiencies?

I'm just anxious to hear whether the
Task Force tried to identify the distinction
between costs the government imposes on itself
versus costs that actually deliver value to the
beneficiaries.

DR. WILENSKY: Let me start, and then
any of our other Task Force Members are welcome to
chime in.

The issue about what actual costs are in
the government system are not easy to allocate and
it is not clear to me that some of the statements
that you've made are correct, and in at least one
case with regard to the Federal Supply Schedule, I
reject your assumption that it was not taking
advantage of an efficiency by not mandating by law
that retail pharmacies have access to the Federal
Supply Schedule. It is correct that the
government, the administration, did not choose to
push for a price control on a retail system that
has higher costs than the MTF and the mail order
to be given to the retail sector. I would say
that is appropriate because in fact the costs of
providing care in that sector are distinctly
higher because there is not another group taking
over the distribution costs as occurs in these
other two places.

Furthermore, with proper incentives it
is sometimes observed or at least claimed by the
PBMs that they can do as well or better. So I
would say our strategy has been to both welcome
outreach and to suggest incenting users to go to
the lower-cost facilities which include the MTF
for pharmacy and mail order as appropriate
strategies.

With regard to the issue about how to
properly allocate costs and whether or not the
costs of care in an MTF environment are greater
than or lesser than the private sector, I would
just tell you the answer is not obvious. It is
very difficult to calculate because among other
things the MTFs are run by people who are serving
an alternative mission which are seeing now which
is military readiness and that has its own costs
and consequences. The issue about how much to
provide in terms of health care within the bases
and how much outside is far more complex than
where care used to be provided, and particularly
when we are looking at populations that we are
discussing which are the over-65 retirees and who
are for the most part working, what we are
suggesting is to begin to index on an annual basis
still providing care that is substantially greater
than the more generous private plans or the public
plans I think really goes against this notion that
we are ignoring the consequences of these actions
that go on in an interim process.

So I think we're mindful and we have
repeatedly indicated the importance of having the
Department be good stewards of trying to get the
efficiencies that are possible, to get better
value in the pharmacy area, but in other areas
that we will be addressing like disease management and wellness programs. But at the same time, when we look at the financial implications that have occurred with repeated expansions in the program and absolutely zero change in the costs borne, not the costs shared, just the literal costs borne since the program was introduced in 1995, that also suggests itself as being ripe for change.

So we are very interested in finding efficiencies where they exist, but I would not say imposing price controls by law on a more-expensive meets at least my economist's view of an efficiency.

MR. STROBRIDGE: I was giving that as an example rather than an assertion. The frustration I think that the beneficiaries have and the reason very frankly why this Task Force was the formed was the lack of transparency in, as you said, the very uncertainty of what should be counted in calculating these costs.

When we went to the Department of Defense to discuss these kinds of things, and I
I think most of our associations would be in the camp that we're not naïve enough to think the costs are going to stay flat forever. On the other hand, it was a conscious DOD decision to keep those costs flat for one thing, and when there is a proposal to raise fees by discussing restoring a percentage of DOD costs that existed at some time in the past, that is what gives rise to the question what exactly are those costs and what are we counting.

I certainly agree with you about the difficulty of saying how do you attribute the costs of care in military facilities when part of our facility is built to care for those who go to war, to address their wounds, and that's exactly one of the reasons why we're saying we do think that to have credibility with beneficiaries if we're going to base some cost-sharing on percentage of DOD costs, we do have to be clear and have a reasonable and understandable agreement on what costs we're talking about, what is attributed.
I certainly concede the difficulty. If it were easy, there wouldn't be a Task Force. All I'm asking is that the Task Force try to address that.

DR. WILENSKY: One correction. I said over 65 when I meant that our focus is on the under-65 retiree population. You have spoken to us. As you know, our deliberations are open. We have begun to hear from and will continue to hear from individuals to help guide us in terms of understanding what projections reflect what's in the numerator and denominator. We have not suggested tying the co-pay to a particular percentage of DOD costs. What we have noted is that there has been a precipitous decline which I would say however you're going to define the numerator or denominator would show up since the numerator has been flat dollars and the denominator like every health-care cost has not been. So that it is directionally clear and what we have proposed in our Interim Report is the importance of picking an amount, deciding on an
index which we discussed the various indices that
we are inclining toward although have not chosen
one, and that we will make sure that at the end
what we have done will not make individuals worse
off in terms of having the share of costs that
were covered when this program started before the
several expansions are not at least that good. So
we have not suggested a system that literally
keeps it at an X percent of DOD cost irrespective
of what else has gone on.

But mainly our deliberations are open
and anyone who is interested should come and
listen to where we are and send in whatever
comments or otherwise involves themselves as they
wish.

DR. POLAND: I think a couple of the
Task Force Members also have comments.

MAJOR GENERAL ADAMS: I think Steve you
actually gave us more of an answer than you think
and I think it's in the second part of your
statement specific to the value to the
beneficiary. That is much easier for us to
quantify and I think we just heard a number from the other side of the table where the value of the health benefit to outside corporations is around $14,000 a year for what we in TRICARE are paying around $400 a year. So I think we need to look then what is the value to our beneficiaries and then what is reasonable and fair in relationship to the value of the care they're receiving. The health-care benefit that we're giving today is much better and different than what the promises were made for in the mid-1950s when we talked about space-available care in military treatment facilities. Now it's not space available, it's I dare say universal access between the network physicians at our MTFs and it's the highest quality of a benefit with very few limitations. So I think if we start looking, because we can argue the costs and the variables, they change almost daily in terms of the deliverable, but what doesn't change is the value of the benefit and what is represented there.

MAJOR GENERAL SMITH: A couple things
that we have been doing on this getting arms
around the costs in our deliberations in some
other meetings, one, we have had all the Surgeons
General in and we have discussed like efficiency
wedges and the processes of Six Sigma to see if we
can help validate some of the costs and get some
of this transparency understood. We have been
working those processes. We have also had the
head of the GAO and the GAO is due out this month
where we had demanded from the Military Coalition
about an independent report Senator Lindsey Graham
had of the costs that were going on in DOD both
from procedures being paid and what are we paying
for procedures and equipment. That report is due
in at the end of May according to Dave Walker
which will also give us an insight about the costs
that are in this DOD formula. And yes, we are
trying to understand. We know that there's war
costs which are going to be a little different
with supplementals and things, but we've also got
to figure out as we alluded to earlier that
military readiness, what does that really cost us
as part of the formula. It's not clear that when
you have to have doctors and nurses and people in
place what that cost is for military readiness.
It is not the same cost you're just having people
in place to do a process.

But those issues are being addressed and
we've had several meetings getting into the DOD
costs from several different aspects. As a matter
of fact, we even brought back one of the people
who testified at the very first hearing for
another session of going through costs. So I can
at least think of three or four times we have had
DOD in going through their costs and trying to
understand and increase our awareness of
understanding before we propose any type of
possible fee structure changes because we're
trying to make ourselves sure that we understand
as you said numerators and denominators. So there
are significant efforts going on in that range.

DR. POLAND: In the interests of time,
what I'm going to now ask is if Dr. Wilensky,
General Corley, and then Secretary Cassells have
any summary comments to make, I'll make some
summary comments, and then we'll be adjourned.

DR. WILENSKY: Dr. Wilensky, do you have
any summary? General Corley? Secretary Cassells?

SECRETARY CASSELLS: Thanks, Dr. Poland,
Dr. Wilensky, General Corley. I'm new at this but
I can see -- I thought I was getting a handle on
this so I came to this meeting. This is a very,
very complicated topic, but on behalf of Secretary
England and Secretary Gates, I want to thank the
members for putting so much effort into this,
thoughtful effort, and obviously passionate
effort. And to have this much time from our
Surgeons General and General Myers, it's fantastic
for health affairs. We are just delighted with
this help, and I'm sorry Ellen Embry can't be
here. I want to acknowledge her work on this.
And particularly Admiral Arthur who is serving on
two other Task Forces as well, mental health and
traumatic brain injury, when he really could be
sharpening up his putting now, and here he is
serving on all these task forces.
We have had a big strategic planning process at Health Affairs over quite a few months. Many of you have participated. It's triggered lots of light and a little bit of heat and the ball has moved pretty down the field. A couple principles that really are guiding our thinking right now have been alluded to already, transparency as Mr. Strobridge said, keeping our casualties and their families first and foremost in your minds, shifting the locus of control as much as possible over time to the patient and their family so that they have ownership of the process so that they have more choices, and that is not as strong a tradition in the paternalistic military health system as it is in some other systems, and Mr. Parkinson alluded to this and I appreciate that.

As we move forward with your electronic records, we hope to be more informative, more transparent, and to give patients the tools they need and many of them want already to drive their own health care. I think you said patient-driven
health care, Mr. Parkinson, I'm certainly on board on that. And we hope to give them for example web-based tools for triage. As some of the spouses said at Fort Bragg yesterday, when my husband is away I don't want to spend 6 hours in the ER and then go home with Tylenol, I'd like to be able to get some guidance on the web and avoid that visit to the ER. I'm a part-time teacher, I got kids in school, this is a pressing need for me. So a personalized health record that they own and take control, triage tools, educational tools, and I think Dr. Wilensky said incentives for prevention, incentivizing certain outcomes, paying not by the number of patients you've seen, but by whether they're lost weight, whether they've got their blood pressure down, whether their cholesterol is down and their sugar, whether they're getting their mammograms and their vaccinations. Incentives for the doctor, for the patient, for the nurse and her team, for the system, these are all doable now. We're moving in this direction not as quickly as any of us would
When we have that system in place we will see that there are opportunities beyond the pharmacological, someone alluded to this and thank you for that. Pharmacy is a big item in our budget. Half of those ladies at Fort Bragg, I think if I could get them going out and exercising every day in the sun we would have stronger bones, better cardiovascular fitness, better balance, fewer falls. Secretary Gates has charged me with reducing accidents in the military. And better mood. These kinds of things are not pharmacologic and we need to keep some of these things in mind.

So Dr. Wilensky, thank you saying you're going to tackle the wellness issue, you've tackled so many tough topics, and I look forward to your guidance on that. Thank you, Dr. Poland.

DR. POLAND: As I read the report and listened today, a couple of sayings came to mind. One is that any idiot can make something complex, but genius occurs when a complex problem is broken down into actionable, feasible, focused action.
items, and certainly that is my impression of what
the Board has done, or the Task Force. The other
saying that came to mind is that what gets
measured gets done, and in that regard, the Task
Force to my way of thinking has diligently sought
and examined the data and suggested some objective
metrics by which solutions could be devised and
then progress measured.

So from the point of view of the Defense
Health Board, you are to be congratulated on what
is and remains a complex task, we are grateful for
your work and your expertise, we are very
supportive of your interim findings and
recommendations, and we look forward to the final
report. We also stand ready to assist in many
manner that you as chairs or as a Task Force would
deem helpful. Thank you very much for your work
on a complex topic.

(Applause.)

DR. POLAND: Dr. Cassells, could we ask
you to close and adjourn the meeting?

SECRETARY CASSELLS: As the Delegated
Principal Staff Assistant and Alternate Designated
Federal Official for the Defense Health Board, I
hereby adjourn this meeting.

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