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

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1 E X C E R P T

2 (2:15 p.m.)

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

13 SECRETARY CASSELLS: Thank you, Dr.
14 Poland, and thank all of you for coming. As the
15 delegated principal staff assistant and alternate
16 designated federal official for the Defense Health
17 Board, a federal advisory committee to the
18 Secretary of Defense which serves as a continuing
19 scientific body to the Assistant Secretary of
20 Defense for Health Affairs, and the Surgeons
21 General of the military departments, hereby call
22 this meeting to order.

1 DR. POLAND: What I'd like to do then is
2 just go around the table and have each individual
3 introduce themselves. Dr. Cassells, I'll start
4 with you and we'll work our way around.
5 SECRETARY CASSELLS: Ward Cassells, the
6 new Assistant Secretary of Defense for Health, on
7 leave from the University of Texas Health Science
8 Center in Houston where I'm a cardiologist.
9 GENERAL CORLEY: I'm John Corley. I'm
10 one of the Co-Chairs on the Task Force that will
11 be presenting to you today.
12 DR. WILENSKY: Gail Wilensky, the other
13 Co-Chair.
14 COLONEL BADER: Christine Bader,
15 Executive Secretary for the Task Force on the
16 Future of Military Health Care.
17 DR. LAUDER: Tamara Lauder, physical
18 medicine and rehabilitation, member of the Defense
19 Health Board.
20 DR. LEDNAR: Wayne Lednar, Vice
21 President and Director of Corporate Medical,
22 Eastman Kodak, Rochester, New York.

1 DR. MCNEILL: I'm Mills McNeill. I'm
2 from the Mississippi Department of Health and I'm
3 a member of the Defense Health Board.
4 DR. PARISI: Joseph E. Parisi, Mayo
5 Clinic, Rochester, Minnesota.
6 DR. LOCKEY: Jim Lockey, outpatient
7 pulmonary disease, University of Cincinnati, Board
8 Member.
9 DR. OXMAN: Mike Oxman, Professor of
10 Medicine in Pathology, University of California,
11 San Diego, Board Member.
12 DR. PARKINSON: Mike Parkinson,
13 Executive Vice President and Chief Medical Officer
14 of Lumenos, which is a subsidiary of WellPoint.
15 DR. PRONK: Niko Pronk, Vice President,
16 Health and Disease Management, Health Partners,
17 Minneapolis, Board Member.
18 DR. SHAMOO: Adil Shamoo, Professor,
19 University of Maryland School of Medicine.
20 DR. SILVA: Joe Silva, Professor of
21 Internal Medicine, the University of California,
22 David, and Board Member.

1 DR. MILLER: Mark Miller, Associate
2 Director for Research, Fogarty International
3 Center at NIH, Board Member.
4 MR. HALE: I'm Bob Hale, Executive
5 Director of the American Society of Military
6 Comptrollers and a member of the Task Force.
7 GENERAL MYER: Dick Myers, Task Force
8 member.
9 DR. MADISON: John Madison, Task Force
10 member.
11 MAJOR GENERAL ADAMS: Nancy Adams, Task
12 Force member.
13 MAJOR GENERAL SMITH: Bob Smith, Task
14 Force member.
15 LIEUTENANT GENERAL ROUDEBUSH: Jim
16 Roudebush, Task Force member.
17 DR. HALPERIN: Bill Halperin, Chair,
18 Preventive Medicine, New Jersey Medical School;
19 Chair, Quantitative Medicine, School of Public
20 Health, and I'm a Board Member.
21 DR. GARDNER: Pierce Gardner, Professor
22 of Medicine and Public Health, the State

1 University of New York at Stony Brook, consultant
2 to the Board.
3 REAR ADMIRAL SMITH: Dave Smith,
4 incoming Joint Staff Surgeon.
5 MAJOR GENERAL KELLEY: Joe Kelley,
6 outgoing Joint Staff Surgeon, and Task Force
7 member.
8 COLONEL GIBSON: Colonel Roger Gibson.
9 I'm the Executive Secretary of the Defense Health
10 Board.
11 DR. POLAND: And I'm Greg Poland,
12 President of the Defense Health Board, Professor
13 of Medicine and Infectious Diseases at the Mayo
14 Clinic, in Rochester, Minnesota, and Vice Chair of
15 the Department of Medicine.
16 We normally do this in the very
17 beginning of our session but because in essence we
18 have convened a meeting this afternoon, we have a
19 tradition that was established when I became
20 President of the Board that prior to each meeting
21 we stand for a moment of silence which both
22 symbolic and real in terms of recognizing the

1 sacrifices that men and women in uniform perform
2 for our country and our recognition that we are
3 here to serve them.
4 (Moment of silence.)
5 DR. POLAND: If I could ask Colonel
6 Gibson then to make some administrative remarks
7 and the I will make some remarks and we'll get
8 started.
9 COLONEL GIBSON: Please sign the
10 attendance roster that's on the table over here in
11 the corner. This is a Federal Advisory Committee
12 meeting and one of the requirements for that
13 Federal Advisory Committee is that we keep track
14 of the attendees. Restrooms are located outside
15 the back door here. If you have telephone, fax,
16 copy, or message needs, please see Ms. Karen
17 Triplett or Ms. Lisa Jarrett who will take care of
18 that.
19 The next meeting of the Defense Health
20 Board will be September 19 and 20 in San Antonio,
21 Texas. At that meeting we will complete
22 deliberations on a number of open board business

1 items and receive briefings on the Defense
2 Disability System, amputee patient care, and we
3 will also tour the Amputee Center at Brooke Army
4 Medical Center.
5 The Board will also conduct a day-long
6 administrative session on September 18. As a
7 reminder, this meeting is being transcribed to
8 please speak clearly into the microphones and
9 state your name before you begin. Also, turn off
10 pagers, Blackberries, cell phones, et cetera.
11 They may interfere with the sound system.
12 Finally, my personal thanks to the staff
13 at the Holiday Inn National Airport at Crystal
14 City for their help in making the meeting
15 arrangements. Also thanks to the Defense Health
16 Board staff, Ms. Jean Ward, Ms. Lisa Jarrett, and
17 Ms. Karen Triplett, for the behind-the-scenes
18 work. And I would also add thanks to Colonel
19 Bader and her staff for the corollary work that
20 they've done in making this all happen on the
21 right day at the right time. Thank you.
22 DR. POLAND: Before we begin our

1 deliberations, I would like to thank the Co-Chairs
2 and members of the Future of Military Health Care
3 Task Force. The Task Force functions as a
4 subcommittee of the Defense Health Board and
5 therefore is directed by the Federal Advisory
6 Committee Act. We are required to deliberate the
7 Task Force's findings and recommendations in an
8 open session as we are doing.
9 Since their appointment by the Secretary
10 of Defense on 12 December 2006, the Task Force has
11 been fully engaged in gathering information to
12 fulfill their charge of providing an assessment of
13 and recommendations for sustaining the military
14 health care services being provided to members of
15 the armed forces, retirees, and their families.
16 The congressional language that directed the
17 establishment of the Task Force and define the
18 element of its charge are available to the Board
19 Members under Tab 7 of our notebook.
20 I would also like to personally comment
21 the efforts of the Task Force and their staff for
22 all of their hard work.

1 I speak for the entire Board when I say
2 that we believe sustaining medical benefits for
3 all DOD beneficiaries is an absolute necessity
4 with long-term national-security implications.
5 The history of this country is that back in the
6 1600s in the Plymouth Colony, among the first laws
7 passed were the laws protecting the medical
8 benefits in essence of those involved at the time
9 in the Pequot Indian Wars, so there is a long
10 history in our country of providing for those who
11 serve.
12 Health care finance and delivery is
13 complex as we all recognize at any level and
14 exponentially more so for the largest military
15 health care system in the world. Military health-
16 care system in the world with a global reach
17 serving a population that is constantly on the
18 move.
19 The deliberations that we will undertake
20 today will focus on the Task Force Interim Report
21 which the Board all has a copy of. Due to the
22 Secretary of Defense and Congress on 31 May 2007,

1 keep in mind during these deliberations that while
2 the questions and comments during these
3 deliberations will help to inform the report, the
4 report itself is a product of the Task Force.
5 I wanted to mention that biographies for
6 the Board Members and Task Force Members are under
7 Tab 2 of our notebooks. For those who are in
8 attendance, the session is intended to provide an
9 opportunity to deliberate the draft findings and
10 recommendations in a forum that is open to the
11 public. The discussions will be between the
12 members of the Defense Health Board and the Task
13 Force on the Future of Military Health Care. If
14 time allows, we will take questions and statements
15 from the public at the end of the session. If
16 that is your desire as a member of the audience,
17 we ask that you register to speak at the desk
18 right at the end of the room here. Everyone,
19 however, has the opportunity to submit written
20 statements to the Board, and those statements may
21 be submitted today at the registration desk or by
22 email at dhb@ha.osd.mil, or may be mailed to the

1 Defense Health Board office. The address is
2 available on fliers located at the registration
3 desk or you can go our website.
4 What I would like to do is first start
5 by asking the Co-Chairs for any opening remarks
6 they have, so I will ask General Corley and then
7 Dr. Wilensky to make any comments you would like.
8 GENERAL CORLEY: Good afternoon and
9 thank you, Dr. Poland and other distinguished
10 members of the Defense Health Board. Dr.
11 Wilensky, myself, as well as the Task Force
12 members who were introduced just moments ago join
13 me in presenting if you will our interim report.
14 If I could, I'd ask that you allow me to
15 provide just a brief bit of context and perhaps a
16 brief discussion of the problems set as well. If
17 we were to examine back in the 1970s a movement
18 toward our all-volunteer force, we created a group
19 of magnificent career military individuals who
20 along with the active-duty members, our
21 appropriate Reserve component, their dependents
22 have all been receiving health care and many of

1 them move into retirement increasingly so. Along
2 with that I would say that there has been a
3 commitment to very high-quality health care and
4 that has been linked to recruitment and to
5 retention this all-volunteer force.
6 As we move the clock forward, in 2006
7 the rising cost of that military health system led
8 the Department to develop a legislative proposal
9 which also included some increases in premiums,
10 the first proposed in fact in 10 years. That
11 proposal met with resistance from the Congress who
12 in turn directed the creation of this Task Force.
13 The Task Force's charter of which you
14 have a copy in the appendix to the report as
15 broadly defined addresses 10 areas, some of which
16 I will talk about. They include wellness
17 initiatives, disease management programs, the
18 ability to account for true and accurate costs of
19 military health care, and the cost-sharing
20 structure required to sustain the military health-
21 care benefits over the long term. In addition,
22 the charter requested an interim report which is

1 what we are going to present today that will have
2 preliminary findings and recommendations regarding
3 cost-sharing under a Pharmacy Benefit Program.
4 To do this, the Task Force adopted a set
5 of guiding principles that are also included in
6 the report for you, and that was really a way that
7 we began to examine and assess the recommendations
8 and try to measure them.
9 The Task Force concluded that
10 recommended changes should focus on the health and
11 well-being of the beneficiaries but so in a
12 fiscally responsible manner. Perhaps to provide
13 more detail and more specificity on the interim
14 report, I would like to introduce Dr. Gail
15 Wilensky. Dr. Wilensky is truly a phenomenal
16 resource and has been for our Task Force in terms
17 of providing both unique insight as well as
18 guidance. As you have known and have seen from
19 her and have read from her bio, she has extensive
20 experience in terms of developing public policy
21 relating to health-care writ large, its reform,
22 and to the ongoing changes in terms of the health-

1 care environment. Dr. Wilensky?

2 DR. WILENSKY: Thank you very much,

3 General Corley. I would like to note that two

4 more of our Task Force members have arrived, which

5 are Shay Assad and Mr. Henke, and that means that

6 we have 11 of our 14 Task Force members present.

7 I would like to add briefly to the

8 comments that General Corley has made. We have as

9 you can tell from the bios in your book a broad-

10 based group of experts from inside and outside of

11 the Department of Defense who are represented on

12 the Task Force. The nonmilitary members represent

13 extensive experience and knowledge in terms of

14 health-care financing and delivery as well as some

15 of the best practices that are used in business

16 and elsewhere in government.

17 Our military colleagues bring a vast

18 knowledge of the military health-care systems and

19 the systems that support it. This group has

20 functioned extremely well together assisted by the

21 very able leadership of General Corley. As

22 someone like myself who has chaired or co-chaired

1 four other commissions and task forces, my
2 experience working with General Corley has
3 exceeded my experiences in the past and I would
4 like to publicly thank him for his support and
5 help. He has also spoiled me for future co-
6 chairs, so they can stand alerted as of now.
7 We are all committed on this Task Force
8 to making sure that the best health-care system is
9 available for those who are and have served in the
10 military and for their families, and also to make
11 sure that the military medical mission is well
12 accomplished. We have approached our charge
13 recognizing the importance of achieving greater
14 efficiencies by using best practices both learned
15 in government and elsewhere in the private sector
16 and suggesting some ways that the military can
17 become yet better stewards of the enterprise that
18 it runs.
19 We also recognized the appropriateness
20 of adjusting financial incentives and cost-shares.
21 The recommendations that we have included in the
22 report that is in front of you are focused in four

1 areas, improving business and management
2 practices, altering incentives in the pharmacy
3 benefit, cost-sharing and realignment of fee
4 structures, and ensuring that TRICARE is a
5 secondary payer. Let me just summarize briefly
6 these recommendations in each of these four areas.
7 In terms of improved business and
8 management practices, we are recommending that
9 pharmacy acquisition strategies be reviewed to be
10 sure that they are written to as to allow for the
11 best business practices from the private sector,
12 and also to conduct eligibility audits regarding
13 the accuracy of eligibility measures in the DEER
14 (?) system. The second area is altering
15 incentives in pharmacy benefits. We are
16 recommending that there be a change in the co-pay
17 for prescriptions filled outside of the military
18 treatment facility. To increased use of the most
19 cost-effective alternatives, we want to encourage
20 greater outreach to be done to encourage the use
21 of the mail-order pharmacy and other best
22 practices of private companies, and will provide

1 greater specificity on precisely we think this
2 should be done in our final report.
3 With regard to the third area that we
4 were asked to opine on with regard to the interim
5 report, it relates to issues concerning cost-
6 sharing and realignment of fees. We have been
7 mindful of the need to both be fair to taxpayers
8 in addition to recognizing the years of demanding
9 service that military retirees have provided to
10 the nation. We want to be sure to continue to
11 provide generous benefits when compared either to
12 public plans or to private plans, but to recognize
13 the very large expansions in benefits that have
14 occurred since TRICARE was introduce in the mid-
15 1990s. The portion of the costs borne by
16 beneficiaries should be increased to levels that
17 are below the Federal Employees Health Care Plan
18 or those of generous private-sector plans and set
19 at or below the share that existed when the
20 program first started in 1996. Again, this is an
21 area where we will provide greater specificity in
22 our final report.

1 Increases that are made should be phased
2 in over a period of 3 to 5 year and if the
3 Congress is concerned about the impact that that
4 has on retirement pay, it could consider having a
5 one-time increase in retirement pay if it thought
6 that was appropriate. We are recommending that
7 there be an annual indexing of premiums and
8 deductibles for the under-65 retirees. Again, the
9 specificity of that will be outlined in our final
10 report. We also think there should be periodic
11 adjustments to the catastrophic cap. Again, if
12 Congress is concerned that this may have an
13 adverse effect on retiree pay, it could make a
14 one-time or several-time adjustment if it believes
15 that to be appropriate.
16 We think DOD should increase premiums
17 and cost-sharing in a manner for the under-65
18 retirees which we have dubbed TRICAP like the
19 MEDIGAP policies that wrap around the Medicare
20 program. We are also recommending that the
21 payment structure be tiered so that enrollment
22 fees, deductibles, and co-pays reflect difference

1 circumstances of retirees such as the retirement
2 pay grade, and again we will provide more
3 specificity in our final report.
4 The fourth area that we have made
5 recommendations in concerns ensuring that TRICARE
6 remains the secondary payer that it is by law. We
7 are recommending that independent audits be done
8 to ensure TRICARE is in fact the secondary payer.
9 This was true both for services provided in the
10 MTF and also with private payers who are involved
11 in TRICARE.
12 There are several areas that we will
13 explore in the future. We are presently outlining
14 them. They include looking more at the role that
15 the Reserve and Guard has played in terms of the
16 types of benefits that they receive and their
17 transitions into and off of active-duty care. We
18 will also be addressing the issues that were in
19 our charge that we have not yet addressed in the
20 interim report in some manner in the final report.
21 With that let me turn the microphone back to you.
22 DR. POLAND: Thank you very much,

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

1 their health care?

2 DR. WILENSKY: I'll answer the first

3 part, but I would like to turn it over to one of

4 our surgeons general for the second piece of that

5 with regard to those who are injured, but also

6 they are welcome to comment on the first part as

7 well.

8 The issue about maintaining the promise

9 is one which we raised among ourselves, had many

10 discussions in open meeting in our meetings in

11 Washington but also as part of our 2-day activity

12 in San Antonio where we had a town meeting and

13 panels of individuals who were speaking before us.

14 We are very mindful of the issue as an emotional

15 and important one.

16 What we have looked at is to try to

17 within the context of the benefits that were

18 promised particularly the start of the TRICARE

19 program, looked at them in terms of a package of

20 benefits and looked at them in terms of the

21 expansion in benefits that have been made since

22 the program was initiated. It is why when we

1 talked about altering the deductibles or fees we
2 have left to not exceed the share of costs that it
3 started in 1995 but to be mindful of the very
4 substantial benefits that have occurred without
5 any changes of any sort with regard to fees and
6 co-pays.
7 As you know, my background is from
8 Medicare and financing of health care and the
9 notion of having small annual changes in
10 deductibles and premiums are integral to the
11 entitlement that exists for our senior population.
12 So while we had a lot of discussion about the
13 issue, we believed that what we are proposing now
14 with both the gradual introduction, the
15 maintenance well beyond what exists in the public
16 or private sector, and not to require a cost-share
17 that would be greater than what was initiated in
18 the 1995 is very consistent with the notion of
19 keeping the promise that individuals were given.
20 LIEUTENANT GENERAL ROUDEBUSH: Yes, if
21 might speak to your second question relative to
22 the care of individuals wounded in combat or in

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

1 beneficiaries certainly be within our purview.
2 DR. POLAND: Dr. Silva, did you have a
3 comment or question?
4 DR. SILVA: I found the report very
5 interesting and very much up to date and struggled
6 with some of these problems when I used to be dean
7 -- health care system at the University of
8 California, Davis. We went through much of the
9 same logic.
10 I think the main beneficiary is the
11 American taxpayer because there are wasted dollars
12 by the way the military distributes its drugs. So
13 the mail-order business I think is a no-brainer
14 and even how one uses TRICARE and forces TRICARE
15 to be secondary and not primary, I am a little
16 concerned about the co-pay and I wanted to know
17 from the committee how raucous was the meeting
18 that was held with the enlisted panels or spouses?
19 How much heat is going to be generated?
20 DR. WILENSKY: I think there was less
21 pushback to the notion if it was regarded as
22 reasonable. We repeatedly heard acknowledgement

1 that some change in premiums were likely and the
2 question would be at what level, at what type of
3 indexing, and how quickly would it be phased in.
4 I think there has been widespread recognition that
5 zero change which has resulted by the way in
6 having individuals who were initially paying 11-
7 percent of health-care now paying 4 percent for
8 the under under-65 retirees, again that's the
9 focus of our attention, is very a unusual
10 experience in this day and age.
11 There was some discussion but very
12 interesting as it evolved over time about the
13 notion of tiering, of having different fee
14 increases or fees for individuals according to
15 their grade at retirement or some other
16 distinction. There were some group who did not
17 believe that that was appropriate, representative
18 groups, but we found far more individuals at both
19 the low end and the highest levels who supported
20 the notion as being fair and appropriate since
21 their pay when they were in the military was
22 differentiated and their pay at retirement was

1 differentiated, and this seemed very consistent.
2 But there were certainly representations from some
3 groups not to go this direction, but not the
4 majority of comments.
5 MAJOR GENERAL ADAMS: I think the
6 comment I would make is at least I think three of
7 the groups were all active duty and of course the
8 issue of co-pays is not relevant to the active
9 duty, so that really wasn't one of their primary
10 focuses in terms of communicating with us.
11 DR. POLAND: I did want to call
12 attention to one thing that I found very
13 innovative actually and I suppose reflective of
14 what happens in the private sector. That is as
15 was pointed out there had been I think four
16 expansions or so of the benefits with not
17 necessarily a long-term view to what the
18 cumulative impact of those would be, and the
19 report on page 3 calls for when making changes in
20 practice or policy, pilot studies or demonstration
21 projects should be used and I think that was a
22 fabulous idea and an innovative one. In fact, I

1 even wondered about strengthening the language and
2 saying would be required, but that's nit-picky.
3 I would hear a little bit or be informed
4 a little bit about the discussion around that
5 because it really relates to I think sort of a
6 capstone statement that occurs throughout the
7 report particularly on page 15 where it talks
8 about not diminishing the trust. That decision
9 almost gets taken out of one's hands if a
10 cumulative expansion of benefits occurs that is
11 not well coordinated and for which there are not
12 long-term projections, you have no choice but to
13 pull back from some of those. How would you view
14 that as happening? And it almost relates to an
15 idea I had for a principle of there being
16 something in place that would help guide the
17 evolution of the system. Characteristically, what
18 we all do is we set what we think is a really good
19 system in place and then tamper with it temporally
20 over time but not really in a directed, principled
21 way that allows one to predict how things will
22 evolve and what the processes used would be.

1 DR. WILENSKY: The call for pilots was
2 particularly focused to the adoption of strategies
3 that were either new to the military or new,
4 period. Actually had a discussion about whether
5 to make it mandatory as opposed to suggested and
6 one of the reasons not to do that is some of our
7 suggestions are so commonplace in our sectors,
8 either other public or the private sector, there
9 seemed to be less reason to have a pilot whereas
10 other strategies that might be thought to be
11 significantly different for this population or
12 just innovative in their own ought not to be
13 attempted without pilots.
14 The comments with regard to the
15 attention to the financial implications of benefit
16 expansions was more in the nature of a plea to the
17 Congress to be mindful of the longer-term
18 ramifications but recognizing that there really is
19 no way we can force that to occur.
20 GENERAL CORLEY: That was really what
21 was reflected if you will at the top of page 5 and
22 although principally under the Cost-Sharing

1 Realignment Fee Structure section where it says,
2 "Benefits have been expanded but it really wasn't
3 clear whether the expansions as implemented were
4 done based on some assessment of the impacts or
5 the effects." We could find no empirical evidence
6 to suggest and no one has presented themselves yet
7 to say that that was the case, there was just a
8 rapid expansion of benefits especially over a
9 given period of time. Then in fairness, there
10 were decisions on the part of the Department not
11 to make increases where they did possess authority
12 which resulted in the share basis for example that
13 Dr. Wilensky talked about before falling from an
14 11 percent to a 4 percent which was
15 counterintuitive when in the larger population
16 those percentages in increases was in fact
17 increasing or in some respects up as high as 25 to
18 28 percent.
19 DR. POLAND: Then the last of my
20 question about would it be appropriate, this one
21 focuses more on a certain set of the large charge
22 that you received, to have something in there that

1 would guide the process by which future changes
2 would be made so that 10, 15, to 20 years from now
3 we're not back, it won't be us anyway, with
4 somebody else trying to get their hands around a
5 system that had changed substantially maybe in
6 piecemeal fashion in trying to reinvent it yet
7 again.
8 DR. WILENSKY: At some level you can say
9 that that occurs now because CBO has to score any
10 legislative change if it is a change that occurs
11 through legislation.
12 It is possible although we have not
13 considered it as our group to put floors in place
14 as for example happens in the Medicare program
15 Part B premium where Congress when it was not
16 inclined to do annual increases to keep the senior
17 share constant, put a floor of 25 percent below
18 which the seniors' share cannot fall. So there
19 are ways to try to put boundaries on the financial
20 ramifications, but I think there was enough
21 sophistication around the table to recognize that
22 it is hard to effectively tell Congress it can't

1 do things, we can only try to alert people of the
2 consequences of their actions.
3 DR. POLAND: I try to do that as a
4 parent of adolescents too.
5 Another question that I have pending
6 others that come from the Board, I really pondered
7 this one, and that was the idea that evidently it
8 turns out that a number of people ineligible for
9 benefits were receiving benefits which on the
10 surface it seems like an easy fix, but as I
11 thought of it more and I want to be educated a
12 little bit here, and the Board too, we might think
13 that way from the private sector where we are in
14 fixed installations and relatively small numbers
15 of people, but I was really struck by the idea of
16 the complexity of this system and the largest
17 military health-care system I suppose we could say
18 in the history of mankind. How difficult will it
19 be to fix that part of it? I really didn't see an
20 easy solution to what seems like an easy problem.
21 It would be interesting to hear a little of the
22 discussion of that.

1 DR. WILENSKY: We don't know that it's a
2 problem. It was raised as an issue that is known
3 to exist in the private sector. We have suggested
4 two areas where we might there may be problems one
5 of which does have some empirical support and one
6 of which does not.
7 I don't think any of us were aware that
8 there is an eligibility problem with regard to the
9 DEERs system, but the fact is the types of checks
10 that occur which is checking I.D. at the time of
11 use is different from the kind of spot audits that
12 could be done to make sure that the eligibility is
13 in fact appropriate. What our recommendation is
14 to do those see whether or not there is a problem.
15 There is some evidence with regard to
16 the other area that we have suggested for a right
17 for audit that has to do with whether TRICARE is
18 truly serving as a secondary payer. The GAO has
19 indicated in the past that some of the treatment
20 that is provided through the MTF may in fact have
21 private payment available for funding. But there
22 has also been the issue that it is not clear that

1 people are reporting when they have private
2 insurance. It is a field that is frequently left
3 blank when individuals use care. So the suspicion
4 is that they may not be reporting private
5 insurance where private insurance exists, but they
6 use it some of the time and they use the TRICARE
7 Extra or Standard other times. This again is a
8 problem that Medicare faces when Medicare is
9 supposed to be a secondary payer and people who
10 are over 65 and are working with private
11 insurance. So there is a little more indication
12 there that there actually may be a problem. The
13 other was more as a best-practice strategy, we
14 ought to look and make sure there's not a problem,
15 but we don't really have any indication there is a
16 problem.
17 GENERAL CORLEY: To pile on, the thought
18 process was with an eligible population of 9
19 million people, we need to at least establish a
20 baseline. I agree and I believe the other Task
21 Force members do and even Dr. Galvin who may have
22 identified this issue for us to start with that

1 there could be an area that would potentially
2 worth an examination from a control measures
3 standpoint, from a best-business, not a best
4 health practices, but a best-business practice
5 worthy of examination.
6 DR. LOCKEY: I was just curious, in the
7 pharmacy acquisition process, and I'm not
8 knowledgeable in this area, but would that be open
9 to pharmaceutical houses within the United States
10 only or would you suggest that that should be
11 something that can go across borders?
12 DR. WILENSKY: This is an issue where we
13 are not sure whether we have a problem. There is
14 a single pharmacy benefits manager at Express
15 Scripts who holds the contract for all of TRICARE.
16 We heard from some of the other large PBMs that
17 there are provisions in the language that would
18 preclude from their viewpoint the use of best
19 practices in the private sector. We had some
20 discussion among ourselves and I think we are not
21 positive we either sufficiently understand or
22 agree whether or not that is the case. We have

1 the advantage of having Shay Assad on our Task
2 Force.
3 But we indicated that if these large
4 PBMs believe there are provisions that are
5 precluding them from doing their best practices,
6 that in and of itself may be a problem and that we
7 need to make sure that we don't have that. We had
8 heard similar generalized comments with regard to
9 some of the contracting issues in TRICARE in
10 general, just the plea to make sure that the
11 contractual language allowed for best practices
12 most integration of care. We have started now for
13 example in our meeting yesterday listening to
14 various proposals for disease management and
15 wellness and those are issues as we go forward
16 that will be both incentives in making sure that
17 incentives are aligned for best practices and that
18 contractual language allows for the adoption of
19 best practices. It quickly gets very complicated
20 and we had a little bit of dueling views of this
21 issue.
22 GENERAL CORLEY: If I can, and then I

1 might ask Shay to comment on this as well, the
2 recommendation was to go back and have an
3 assessment of the acquisition strategies and
4 that's why we're asking for an acquisition
5 strategy expert to try to provide some help to us,
6 because we don't really understand whether this is
7 a legitimate procurement process problem or
8 whether or not we had companies that testified in
9 front of the Task Force that had either an
10 inappropriate or an improper interpretation of a
11 legal provision in terms of the governing of the
12 beneficiary contract. So we did not to the first
13 portion of your question examine other countries
14 and other pharmacies. This was more acquisition
15 strategy procurement process. Shay, do you want
16 to comment on that?
17 MR. ASSAD: Yes, sir, I think that's an
18 accurate portrayal of the situation. What we're
19 going to do is most of the industrial companies
20 that testified suggested I believe that the
21 contracts were structured in a manner that
22 prevented them from implementing best practice,

1 and obviously we want to take advantage of
2 commercial best practice whenever we can. So
3 we're going to go back and examine the details of
4 our acquisition strategy as we go forward in our
5 next set of contracts to see if in fact that's the
6 case.
7 As Gail mentioned, on first blush we
8 don't think that's a problem, we think it may just
9 be an issue of interpretation, but we need to go
10 back and relook at it. In any case, we also are
11 going to expand the opportunities for companies to
12 come in and talk to us about the concerns that
13 they may have with that process so that they
14 understand it and therefore will be able to
15 compete in an environment where they feel they're
16 getting a fair shake.
17 DR. POLAND: Dr. Parkinson, and then Dr.
18 Pronk. I'm sorry.
19 GENERAL CORLEY: Just one more quick
20 response to that. There is a law that requires
21 that all of the pharmaceuticals and devices that
22 are used with military members be FDA approved so

1 that limits the amount of overseas acquisition
2 that could be looked at at the start.
3 DR. POLAND: Mike?
4 DR. PARKINSON: Thank you. Mike
5 Parkinson. I think the report is good as it
6 stands. It's a good report because it answers the
7 interim mail which was they want you to comment on
8 the pharmacy and on cost-sharing, but I just want
9 to make a comment and then about two or three
10 questions if I can. My experience in working with
11 now hundreds of companies, and I know Bob is in
12 your Task Force, and Dr. Wilensky you have a lot
13 of experience with this, is it's the tyranny of
14 the stovepipe benefit plans. Employers are now
15 realizing that if I've got PBM vendor and I've got
16 a health plan vendor and I've got a wellness
17 vendor and I've got a disease-management vendor,
18 I'm probably overpaying in every stovepipe and
19 that no one has really integrated it for me in a
20 way that makes sense to my consumer, and by the
21 way, how much does it really cost.
22 My urge to the Task Force is to be a

1 relentless purchaser with the taxpayer's dollars
2 to get rid of stovepipes and also to get rid of
3 fees and hidden things that frankly military
4 retirees and beneficiaries really don't care
5 about. What I'm concerned about, we've had some
6 conversation over here about reviewing of the
7 acquisition process because I think it's key, so
8 this is a great interim report. I love the broad
9 scope of the charge here. But in answering just
10 this narrow mail, I hope that we maintain our eye
11 on the prize which is true integration and
12 absolute efficiency that may or may not be
13 stovepipe purchasing of these benefits that we
14 have historically done under TRICARE.
15 To wit, with pharmacy I go back to that
16 in three buckets, the purchasing of the
17 pharmaceuticals themselves, the benefit design
18 around the pharmaceuticals, and third is the
19 utilization around the pharmaceuticals. What I
20 didn't see in the report is a magnitude of the
21 problem of the pharmacy purchasing. Do we know
22 what proportion of generics for example that DOD

1 beneficiaries use to relative to best-practice
2 civilian populations? Is that small delta, is it
3 a big delta? It alluded to the fact that it's an
4 issue and we are not optimizing it. Do we know
5 the dollar value of that or the proportion of
6 generics that we're shooting for?
7 DR. WILENSKY: Let me response a little
8 bit to this first part that you've raised, and I
9 think my colleagues are very sensitive to the
10 issue of the stovepipe. A decision was made for a
11 variety of reasons in the last contracting to have
12 the pharmacy benefit separate from the TRICARE
13 contracts. This will be an issue I don't know
14 where we will come out, but there obviously are
15 tradeoffs involved in terms of integration which
16 would suggest having them be part or in terms of
17 leverage of having them be together, and we will
18 have to deal with that issue. But we have already
19 started that discussion. I'm not sure how
20 specific our recommendations in that area will be,
21 but we will certainly consider that as an issue.
22 And as I've said, we have already started on

1 discussing issues such as wellness and disease
2 management and how one integrates into their plans
3 and making sure that the incentives are such that
4 if they are separate that they are aligned so that
5 you don't have a push not to do this because of
6 the financial incentives that are in place.
7 With regard to the generic issue, the
8 military as you probably know is in somewhat of a
9 different position than most other utilizers. It
10 is basically more akin to a state that's a
11 mandatory generic substitution state like
12 Massachusetts for example where the nature of the
13 formulary is where there are generics, generics
14 are used, so it's the ultimate incentive.
15 Our concern had been more with regard to
16 either making sure that there was best practice
17 with regard to preferred drugs and that the
18 tiering was appropriate. And particularly where
19 we thought there was a lot of potential which is
20 the mail order for chronic meds which has not been
21 used very extensively although there has been some
22 attempt toward outreach and there are some users.

1 So that was why our focus at this point was to go
2 for the lowest-hanging fruit available and by
3 differentiating financially as well as encouraging
4 the outreach to try to drive much higher use. The
5 question about how do you integrate better
6 prescribing into physician and hospital care is an
7 issue that we will deal with in the final report.
8 DR. POLAND: General Kelley, did you
9 want to make a comment?
10 MAJOR GENERAL KELLEY: Just to expand
11 that a little bit. Because of the mandatory
12 substitution, we have a very high use of generics,
13 even higher than most plans in states where they
14 have substitution. As far as the tiering goes, we
15 are pushing currently to use generics based on the
16 tiering, but the cost differential between the
17 tiers is such that it doesn't provide an
18 incentive. And generics may not be the best drug
19 for the patient but the patient may chose that
20 because generics have one co-pay and if there is a
21 newer drug that is only in the brand-name status,
22 it has a higher co-pay. So many of the plans that

1 we saw used a tiering based on best clinical
2 practices and because you get a better outcome,
3 overall costs are decreased, although pharmacy
4 costs may be increased, but you have a better
5 overall outcome. So that is an area that we
6 wanted to look at in greater detail also.
7 DR. POLAND: Dr. Corley?
8 GENERAL CORLEY: If I can, there is a
9 limited amount of additional information in one
10 aspect of your question I believe back to
11 utilization and point of service and why we think
12 there is a substantive delta between where we are
13 today in the Department of Defense and potential
14 best practices that exit.
15 If you look in just about the past 4 or
16 years' worth of our eligible population, we're
17 seeing of that eligible population an increase in
18 the use of the pharmacy benefit, so more people
19 are taking advantage of that benefit. Where are
20 they going in terms of point of service to obtain
21 that pharmacy benefit? Here is where I think some
22 of the statistical data is a little bit

1 disturbing.

2 If we look at areas where we have a

3 degree of control inside of our military treatment

4 facilities, getting that pharmacy benefit there is

5 decreasing and has substantively. If we take a

6 look inside of mail order, regrettably, it too is

7 going down, a bit counterintuitive in terms of the

8 testimony that we received from some others that

9 might be considered best practices.

10 Where we are seeing a remarkable

11 expansion is in the retail side and as you can

12 obviously tell, with a pretty substantial economic

13 impact there, so to one aspect of it that does

14 give you some trend information that suggests we

15 need to get after this point of service incentives

16 how we deal with the issue.

17 DR. PARKINSON: If I can just follow on

18 that because those points led right what is very

19 helpful, and again just to share our experiences,

20 in companies that I've worked work with that start

21 moving towards what I would call heavy-handed mail

22 order, mandate is too strong a word, but painful

1 incentives get pretty closer to it, the employee
2 pushback is oftentimes pretty considerable, and
3 oftentimes what we find is that giving a broader
4 array of choices with a true market exposure and
5 transparency of price is pretty well received.
6 As you know, the private sector, not the
7 health plan or the PBMs, are coming up new
8 innovative alternative delivery models called Wal-
9 Mart for $4. It won't be too long in this rapidly
10 moving space I predict that the retailization of
11 the pharmacy outside of the PBM industry and
12 perhaps such things as General Kelley mentioned,
13 the value-based benefit designs which are all
14 about if you know anything about the consumer-
15 driven movement, it's to differentiate the things
16 that work and are evidence-based and those things
17 that are largely discretionary and not evidence-
18 based and to float those prices to whatever the
19 consumer and the doctor thinks it's worth, but
20 when you post the real price, it drops like a
21 rock.
22 So all of my comments are here about to

1 stay one step ahead of a dramatically changing
2 pharmaceutical marketplace and not be too beholden
3 to our acquisition process thinking or the current
4 vendors and stovepipes because I think this train
5 is moving very fast. As many of you know on the
6 panel, Dr. Wilensky, I don't mean to replace that,
7 but DOD could lead this movement with some
8 innovative purchasing models that are really not
9 even out there yet as much as building on the ones
10 we already have. So I think it's great.
11 The final comment is that the military
12 has led this in the past. It's called the PEC,
13 the Pharmacoeconomics Center. We were one of the
14 first to compare drug/drug because the FDA doesn't
15 do it to what works. So you've already got an
16 infrastructure inside DOD to do pharmaceutical
17 analysis and then translate that into vigorous
18 purchasing models.
19 The last question and I assume it's
20 politically off the table because it gets to much
21 press, and that is the VA purchases drugs I guess
22 very differently at the point of source of the

1 manufacturer versus the way DOD can or does do it.
2 Is that just off the table completely given the
3 current political climate around that issue?
4 DR. WILENSKY: We think it is actually
5 well reflected in the differentiation that is
6 being proposed and that exists now which is the
7 MTF and the mail order have access to the Federal
8 Supply Schedule and like the VA take over the
9 distribution costs. While the retail pharmacists
10 and the PBMs or those who would like to have that
11 contract would like to have that lower price
12 enforced by law, the fact is they don't take over
13 that distribution cost. So I think politically
14 Congress can do as it will on that, but at an
15 economic and policy level, it is hard to justify
16 enforcing a low price when the functions are
17 fundamentally different. The fact is that a
18 retail pharmacy is a more expensive distribution
19 source because the distribution costs are not
20 being absorbed. And some of the groups who had
21 not come in claimed that they could substantially
22 beat the Federal Supply Schedule anyway, and our

1 attitude was great, go for it.
2 So I think the notion of trying to
3 design to try to achieve best practices very much
4 fits in with the notion of considering a pilot
5 that would differentiate tiered payments with
6 value-based design. I am personally a big fan of
7 the value-based design and tying it with
8 comparative clinical effectiveness, but we would
9 have to be mindful that this really is not being
10 used elsewhere and it would be terrific to try it
11 and make sure that we were comfortable. It would
12 not be wise to try to impose it on a system as
13 large as the DOD health-care system.
14 DR. POLAND: Dr. Pronk?
15 DR. PRONK: Thank you. I read the
16 report with much interest and thought that
17 actually most of the focus was on financial issues
18 related to pharmacy use rather than medical-
19 management issues that really provides
20 opportunities as well. In particular I was
21 thinking about the use of PBM data that can be
22 used in terms of crafting strategies in the

1 medical-management area to stimulate the
2 appropriate use of pharmaceuticals rather than
3 seeing overuse, misuse, or underuse, such that the
4 data can used by an intervention team if you will
5 that crafts strategies in the area of medication
6 possession rations or compliance data can be used
7 for that. Could you tell us a little bit did you
8 discuss those kinds of approaches or do they fall
9 more under the disease-management kind of
10 strategies?
11 DR. WILENSKY: The first answer is we
12 focused where we did because we were directed by
13 the Congress to report on these issues in the
14 Interim Report, so that was a practical concern
15 that we needed to address.
16 And the answer is yes with regard to the
17 second, that is, we think that the proper or best
18 use of pharmaceuticals in support of medical
19 management is an important issue. We have already
20 begun to discuss this in the last two sessions
21 when we've dealt with wellness and disease
22 management, and we will have it as well as several

1 others areas that we will be looking at over the
2 course of the next 6 months as we prepare for the
3 final report.
4 MAJOR GENERAL KELLEY: I think that in
5 answer to that also, one of the direct things that
6 you talked about integrating and using the
7 pharmacy data either for disease management or
8 even increase the use of the TMA pharmacy, the
9 contractors felt that there were prohibitions from
10 doing that based on the current contract. That
11 may not be true and we're looking at that, but
12 that was one of the things that also was
13 addressed, that is the contract design preventing
14 because it separated disease management and
15 pharmacy benefits and health care delivery, was
16 that actually inhibiting doing the best practices.
17 That's one example of that.
18 DR. POLAND: Dr. Shamoo?
19 DR. SHAMOO: Adil Shamoo. Most of these
20 questions are on medical economics and obviously
21 they influence everything. As you all know, there
22 is a Mental-Health Task Force and I was wondering

1 if you have built in some safeguards in the
2 application of this in the future so it will not
3 perpetuate the stigma and the bias toward
4 acquisition of mental-health services.
5 LIEUTENANT GENERAL ROUDEBUSH: If I may
6 again, in some similarity to Dr. Prong's question
7 relative to the care of the wounded, the work that
8 is being done within the Mental-Health Task Force
9 I think is addressing some of those issues very
10 directly and in a way that I think again will
11 inform our deliberations and our discussions so
12 that we an assure that that's properly reflected
13 and that our deliberations and any recommendations
14 that we might provide either incorporate those
15 aspects are or assured not to impede the kinds of
16 things that I think you very correctly referred to
17 in terms of moving ahead in the area of mental-
18 health treatment and prevention.
19 DR. WILENSKY: It is also in the area
20 that the presidential commission which I also
21 serve on is looking at in a very focused way. So
22 I would hope between these two other efforts that

1 we can incorporate whatever is appropriate to make
2 sure that we not exacerbate a problem.
3 GENERAL CORLEY: Joe, do you want to
4 comment at all on the seven lines of action and
5 the integration of a number of task forces that
6 you have currently ongoing inside the Department,
7 although your question in large measure has not
8 been addressed and is not inside of the scope of
9 this charter, that is not to say that it is not
10 being assessed in other task forces. The dilemma
11 and the concern is, to Jim's point, how do we make
12 sure we have an integrated effort, how do we make
13 sure we don't impede some efforts?
14 MAJOR GENERAL KELLEY: Yes, sir. There
15 is a Senior Oversight Committee that has been
16 meeting now for 3 weeks chaired by the Deputy
17 Secretary of Defense and the Deputy Secretary of
18 the VA and all the senior leaders from the
19 departments both DOD and the services, the Joint
20 Staff, as well as the VA, and both representatives
21 from the health side as well as from the benefits
22 side. This Task Force when we were chartered did

1 not deal with VA issues, so if it was a VA issue,
2 it was outside the scope of this Task Force.
3 However, that Senior Oversight Group is within
4 those issues and so that will be the area where we
5 work on resolving those things. I think it goes
6 back to Dr. Poland's first question about are we
7 dealing with that, and the issue of differential
8 pay is probably more a VA issue, but it certainly
9 is a combined issue to be worked between the two
10 and that was an actual discussion item at the
11 meeting that was this week.
12 So those wider issues that involve
13 interagency issues are being addressed and I think
14 in the next few weeks there will be some more
15 information coming out about those, but there are
16 seven different areas that are being looked at and
17 there is a specific group that is looking at
18 traumatic brain injury and posttraumatic stress
19 disorder and in that is the whole stress
20 relationship thing and the mental health. So I
21 think that those will be addressed in that forum
22 across the departments.

1 DR. POLAND: Dr. Parkinson?
2 DR. PARKINSON: I apologize for coming
3 back again, but some more questions what I think
4 is very constructive. I would hope that the
5 demonstration authority or the demonstration
6 thoughts that you have include a major commitment
7 to at least pilot a consumer-driven model. Most
8 employers will be implementing consumer-driven
9 plans this year. They are uniquely suited I think
10 to the military philosophy of primary emphasis on
11 prevention with evidence-based care with
12 incentives, and I've provided as background
13 material to Colonel Bader some of the experience
14 that we've had in over 100 companies doing this.
15 But the importance is the total
16 transparency of the cost and that the consumer
17 sees the resources spent on their behalf as his or
18 her own whether or not they are in an HRA or
19 whether they really are in an HAS. What it does
20 is a couple of things. We only focus on
21 prescription drugs, we take over-the-counter
22 alternatives which in many cases are the same drug

1 off the table because the OTCs actually cost more
2 than the current no co-pay of a prescription drug.
3 We have seen this where essentially I'll get my
4 purple by prescription but I've got Prilosec OTC
5 which under the perverse incentives of a co-pay
6 model actually is cheaper to get the prescription
7 than the OTC which is biologically equivalent. So
8 somewhere in the discussion should be OTC
9 alternatives to the most-commonly prescribed
10 drugs, and looking at all 100 companies we look
11 at, in DOD I'm sure the top three categories of
12 drugs are some version of a purple pill which is
13 going to be your Nexium and Prilosec, that group,
14 because it is in all the companies we look,
15 antidepressants, antienceolitics (?) and sleeping
16 pills for which often times there is very few
17 generic equivalents and they certainly aren't
18 pushed, so it's very high, and the third group of
19 course is all your statin drugs. If we can look
20 at the OTC piece equivalence to some of this in
21 the dialogue, it would be useful.
22 MAJOR GENERAL KELLEY: And I think that

1 that was looked at in the same concept that we
2 talked about, the value tiering, and so some of
3 the companies that presented to us did use a small
4 number of OTCs because of the cost differential
5 and the equivalence in treatment capability,
6 Prilosec being one.
7 DR. PARKINSON: Look into some of those.
8 MAJOR GENERAL KELLEY: Yes, and so that
9 is the value proposition.
10 DR. PARKINSON: Perfect. Thank you.
11 DR. WILENSKY: We will definitely look
12 at the HSA issue. It is an issue that we have
13 indicated we will consider. It will be important
14 to look at the likely economic effects. It is not
15 clear. As somebody who is an HSA proponent in
16 general, I think we need to do some financial
17 estimates and make sure that it would actually be
18 the soundest strategy for the particular
19 population that we have here. It is very
20 different because of the distribution of users,
21 and particularly the distribution for the under-65
22 retirees between the Prime, Extra, and Standard

1 make it not clear that you would be financially
2 better off within HSA with that population. So it
3 is something that we have on the table but I think
4 we would want to do careful both financial
5 analysis as well as look at the incentive
6 structure as the effective medical case use and to
7 make sure that was the best way to try to get
8 responsible behavior as opposed to potentially
9 other strategies.
10 DR. PARKINSON: I might just add my
11 experience in dealing with this issue, and we
12 spend some time on the Hill not surprisingly
13 during this time of the year, I think the HSA is
14 overly politicized or certainly can become overly
15 politicized particularly in a very benefit-rich
16 environment. The HRA with incentives gets pretty
17 much the same economic return and result with just
18 the consumer seeing the money spent on their
19 behalf by DOD as their own money with some
20 rollover potential and that I think is probably
21 more powerful and appropriate as it is for most
22 employers than at HSA. So down the road as you

1 get to that juncture, you may want to opt for some
2 experience and thoughts there, but I do think it's
3 very powerful because it removes the third party
4 from saying you must do a tiered anything, here's
5 the cost, here's the options, talk to your doctor,
6 and we immediately see a 15-percent reduction in
7 pharmaceutical with zero to no friction compared
8 to a PPO with three to five tiers. Pharmaceutical
9 companies and PBMs are looking at this movement
10 very suspect because it produces some dramatic
11 results.
12 DR. WILENSKY: And I think while we look
13 at it, the formulary-driven nature of the DOD
14 really is very different both in terms of the use
15 of generics but also the limited use of other
16 brand products because of the Pharmacoeconomic
17 Advisory Group that goes through a lot of these
18 activities where in other companies it is a much
19 more open vista of what you can choose, but it is
20 certainly worth exploring.
21 DR. POLAND: I also invite any other
22 members of the Task Force if any thoughts come to

1 mind regarding the questions that have been asked.
2 LIEUTENANT GENERAL ROUDEBUSH: If I
3 might just add one comment for Dr. Parkinson's
4 thoughts, I think it is a very valuable construct
5 to look at. We have had some very wide ranging
6 and I think very interesting and productive
7 discussions within the Task Force, but in some
8 aspects, HSA begins to alter the pay and benefit
9 package that the fundamental compensation package
10 certainly for active duty and retires. So the
11 impact on that baseline to keep equity across the
12 system if in fact we took a slightly different
13 tact in that would be a consideration so it begins
14 to move out of the health benefit and into the
15 broader pay and benefit scheme. So it's just an
16 aspect that also comes into play when we discuss
17 opportunities or options such as that.
18 DR. POLAND: Dr. Silva?
19 DR. SILVA: One thing raised, a
20 question, which is how much of an audit will count
21 for false billing? Do you have any notions of
22 what that is? Because people are on military

1 bases and who's using their I.D. cards, it did
2 creep into the record as a recommendation and I
3 was surprised at that. Are there going to be
4 substantial savings here?
5 DR. WILENSKY: I don't think we know,
6 and we are not suggesting a full audit by any
7 means as much as a spot audit to see what we find.
8 We don't know that this is an issue. It was
9 suggested that it has been an issue in even the
10 most carefully structured private plans, you ought
11 not to assume it's not an issue unless you go
12 look. As I've indicated, I think the potential as
13 a secondary payer problem seems more likely, but
14 that again we are assuming a limited audit and the
15 results of a limited audit will suggest whether
16 further audit seems appropriate. If it doesn't
17 produce a lot of return or more return than the
18 cost, then we'd certainly stop. In general, we
19 don't know what we don't know.
20 DR. SILVER: Thank you.
21 DR. POLAND: Dr. Lednar?
22 DR. LEDNAR: Wayne Lednar. Obviously a

1 very complex issue and a tremendous amount of
2 understanding to get to this point. It seems that
3 for a lot of us, and I am from Eastman Kodak, we
4 get sort of depleted of our energies after we get
5 through the blocking and tackling, the mechanical
6 and structural aspects, how do we set up co-pay
7 and cost-sharing structures, how do we source it,
8 who do we buy it from, how do we distribute it,
9 mail order or retail. But I think there's an
10 opportunity here to really improve the clinical
11 quality and therefore the value to the DOD
12 beneficiaries that I hope can remain in view.
13 For example, in the area of
14 pharmaceuticals, we spend a tremendous amount of
15 money as an employer in paying for the employer
16 portion of prescription drugs including specialty
17 pharmacy. It is a very sobering and disappointing
18 figure to find out how many of those pills we paid
19 for never leave the bottle, never get out of the
20 medicine cabinet, never get taken, and we wonder
21 why clinical improvement does not occur.
22 So to the extent that whatever we

1 purchase can be more fully utilized, whether it's
2 adherence, compliance, helping patients through
3 side effects, I think there are resources that we
4 have not yet effectively engaged to help us get
5 the value out of the money we have already spent.
6 We have found that it isn't necessarily self-
7 evident how the resources of the structural parts
8 can best be put together. For example, PBMs have
9 clinical pharmacists, health plans have behavioral
10 health programs and resources, and how does it fit
11 together? And these stovepipes don't talk to each
12 other.
13 So it is really our job I think in
14 managing the system to structure it in a way that
15 the parts coordinate, and in fact in our thinking
16 to put enterprise level, supply channel level
17 performance metrics that put all elements of the
18 supply chain at risk for the same performance, the
19 performance of the combined supply chain including
20 fees at risk. So I think we have purchasing
21 technologies that if we full deploy we can get a
22 whole lot more value out of the monies that we're

1 already spending.

2 DR. WILENSKY: There is a real problem

3 that exists in the current way benefits are

4 structured for retirees. I think that is and

5 should be a matter of some importance and is of

6 some importance for the active duty and their

7 dependents. And it is also easy to see that for

8 the retiree Prime program which is MTF based. The

9 problem is that so much of the resources are and

10 will in the future be going to under-65 retirees

11 who are part-time users of the Department of

12 Defense TRICARE system because they have Extra or

13 Standard so they use the military system on a

14 part-time but not full-time basis for the most

15 part with these individuals. In addition, we have

16 even higher users of the over-65 population which

17 use Medicare and TRICARE and attempting to get

18 integrated delivery becomes extremely difficult

19 because these are individuals who depending on

20 where they live may sometimes use the Medicare

21 private system, may sometimes use the MTF, and

22 they sometimes use the VA, and it really will be

1 challenging as to how you integrate care when you
2 have people bopping in and out of systems.
3 I don't know whether this Task Force
4 will look into the issue about whether or not to
5 consider piloting models that would incent people
6 to choose a system and take their money with them
7 or otherwise try to unify where they get care, but
8 as it now stands outside of the activity and their
9 families who are not the expensive part of the
10 users and particularly not the projected expensive
11 part of the users, this is going to be a big
12 challenge to getting the best medical value and
13 the best quality of health care for individuals
14 that have these various points when they use
15 different health-care systems that have nothing to
16 do with each other and don't talk to each other.
17 DR. POLAND: Any other questions or
18 comments from the Board?
19 DR. PARKINSON: Yes, Parkinson again.
20 Dealing with many companies that do a lot of
21 business with DOD, they're delighted when they get
22 DOD retirees to come work for them because as you

1 just said, they've got a bargain and they are not
2 going to have anybody picking up their health-care
3 benefits. So I would encourage your committee
4 because you're given such a broad legislative
5 charge to think creatively about how you deal with
6 military corporate partners around innovative ways
7 to perhaps voucherize a DOD benefit that they can
8 spend. There might be something out there that is
9 not currently on the table that would be very
10 attractive to the 15 companies that you could name
11 right now off the back of your head that make our
12 weapons systems and our intelligence systems and
13 our IT systems that would be attractive and a win-
14 win because they are going to be government
15 contractors for a long period of time and yet the
16 walk away at $460 a year versus what they're
17 spending which is $14,500 for a family of four
18 this year is far apart, but there may be a new
19 business model out there that they create every
20 day in thinking about news ways of doing
21 contracting. So I would encourage you to do that
22 because we see the other side where frankly they

1 count on the ghosts or the antighosts or whatever
2 the military calls them, somewhere in between
3 there might be a middle ground which makes good
4 clinical sense for us and business sense for them.
5 DR. WILENSKY: If you have any ideas, we
6 are already struggling. I've struggled on and off
7 for the last couple of years with this issue and
8 have found it very vexing, so any of you who would
9 like to suggest ideas, please send them to us and
10 we'll gladly consider your thoughts.
11 DR. POLAND: Are there any other
12 questions from the Board Members, from the Task
13 Force Members? Did I miss one? Sorry, Dr.
14 Shamoo?
15 DR. SHAMOO: When there is military, at
16 least this is just a point of information since
17 I'm not as expert as you are, there is a job being
18 cost in medical care somewhere. First, is that
19 insignificant, or how does it get covered, or do
20 you just cut everybody else just like it shifts
21 towards a balloon and then everybody else gets
22 shallow?

1 MAJOR GENERAL KELLEY: For most of the
2 costs that come from a combat operation are
3 covered separately from the budget in
4 supplementals. So there is a big piece of health-
5 care dollars that are being discussed in the
6 supplemental that's on the Hill right now and has
7 been in the news. There is a big chunk of
8 providing extra care that happens which
9 predominantly related to activating Reservists and
10 Guardsmen who were not eligible for care before
11 and now are with all their families, but it also
12 includes other aspects of the care of the injured.
13 DR. POLAND: General Smith?
14 MAJOR GENERAL SMITH: That was one of
15 the main points I wanted to drive out as we active
16 besides supplemental one of the vectors that we're
17 looking is with the increased use of the Guard and
18 Reserve in more and more operational phases of the
19 military and then coming with their families where
20 are we going with that? We more had a steady
21 state, but now with the increased use of the Guard
22 and Reserve, we've got to understand of the cost

1 vectors. So some of the things that we are doing
2 in the Task Force by looking at what are possible
3 cost vectors and pressures on the military health-
4 care system as we look to the future.
5 We have already stated one was the
6 expansion of some benefits that in 1995 were not
7 there that we are now covering that we weren't
8 covering before where this vector of the Guard and
9 Reserve is more of an operational force and you
10 can be talking about a million-plus when you talk
11 about Guard and Reserve resources coming to the
12 system, there are going to be increased cost
13 vectors that we're still dealing with.
14 DR. POLAND: The Board will now open the
15 meeting for comments from the public. I think we
16 do have one. Ms. Jarrett, if you would call that
17 individual up.
18 MS. JARRETT: Steve Strobridge?
19 MR. STROBRIDGE: My name is Steve
20 Strobridge. I'm the Director of Government
21 Relations for the Military Officers Association of
22 America, and I also Co-Chair the Military

1 Coalition. We had testified before the Task Force
2 a little bit earlier. The one question I would
3 have is about cost, and particularly when we're
4 talking about a percentage cost-share it is easy
5 to figure out what the numerator is, it's not so
6 easy to figure out what the denominator is.
7 For example, when the government goes to
8 war and we ship the doctors to Iraq, we send more
9 people to the private sector which costs more
10 money. That is a cost of war. It's not a benefit
11 value to the beneficiary. So our concern is what
12 costs do you exclude, and did the Task Force
13 address that? In other words, what's the cost to
14 the government versus value to the beneficiary?
15 One other example, when we talk about
16 the costs that we had when TRICARE first came in
17 in 1995, that was when a large share of the care
18 was being delivered in military facilities at no
19 cost to the beneficiaries. We have subsequently
20 downsized all those hospitals and clinics, the
21 services have downsized their medical corps which
22 again drives more beneficiaries to the private

1 sector which costs the government more money.
2 On the pharmacy side, we've talked a lot
3 about the benefits of using the mail-order
4 pharmacy and that is one thing the military
5 associations have been very concerned about.
6 We're trying to hold down costs because we're very
7 sensitive that the rising cost creates pressures
8 to say let's charge the beneficiaries more. We
9 have gone to work with the Department of Defense.
10 We have approached them and said let's do a
11 partnership to try to find ways to encourage more
12 beneficiaries to use the mail-order system which
13 we all recognize saves the Department of Defense
14 much more money. The Department of Defense
15 refused to partner with us to do that.
16 Last year Congress passed a provision,
17 or the Senate did, mandating federal pricing in
18 the retail system. The administration opposed
19 that and it was defeated. The question that we
20 had to the Department of Defense is now since
21 those things cost the government hundreds of
22 millions of dollars, are you now going to deduct

1 those costs from the DOD cost-share from the
2 denominator of this fraction so that beneficiaries
3 don't have to pay a share of costs that the
4 government imposes on itself by its own
5 inefficiencies?
6 I'm just anxious to hear whether the
7 Task Force tried to identify the distinction
8 between costs the government imposes on itself
9 versus costs that actually deliver value to the
10 beneficiaries.
11 DR. WILENSKY: Let me start, and then
12 any of our other Task Force Members are welcome to
13 chime in.
14 The issue about what actual costs are in
15 the government system are not easy to allocate and
16 it is not clear to me that some of the statements
17 that you've made are correct, and in at least one
18 case with regard to the Federal Supply Schedule, I
19 reject your assumption that it was not taking
20 advantage of an efficiency by not mandating by law
21 that retail pharmacies have access to the Federal
22 Supply Schedule. It is correct that the

1 government, the administration, did not choose to
2 push for a price control on a retail system that
3 has higher costs than the MTF and the mail order
4 to be given to the retail sector. I would say
5 that is appropriate because in fact the costs of
6 providing care in that sector are distinctly
7 higher because there is not another group taking
8 over the distribution costs as occurs in these
9 other two places.
10 Furthermore, with proper incentives it
11 is sometimes observed or at least claimed by the
12 PBMs that they can do as well or better. So I
13 would say our strategy has been to both welcome
14 outreach and to suggest incenting users to go to
15 the lower-cost facilities which include the MTF
16 for pharmacy and mail order as appropriate
17 strategies.
18 With regard to the issue about how to
19 properly allocate costs and whether or not the
20 costs of care in an MTF environment are greater
21 than or lesser than the private sector, I would
22 just tell you the answer is not obvious. It is

1 very difficult to calculate because among other
2 things the MTFs are run by people who are serving
3 an alternative mission which are seeing now which
4 is military readiness and that has its own costs
5 and consequences. The issue about how much to
6 provide in terms of health care within the bases
7 and how much outside is far more complex than
8 where care used to be provided, and particularly
9 when we are looking at populations that we are
10 discussing which are the over-65 retirees and who
11 are for the most part working, what we are
12 suggesting is to begin to index on an annual basis
13 still providing care that is substantially greater
14 than the more generous private plans or the public
15 plans I think really goes against this notion that
16 we are ignoring the consequences of these actions
17 that go on in an interim process.
18 So I think we're mindful and we have
19 repeatedly indicated the importance of having the
20 Department be good stewards of trying to get the
21 efficiencies that are possible, to get better
22 value in the pharmacy area, but in other areas

1 that we will be addressing like disease management
2 and wellness programs. But at the same time, when
3 we look at the financial implications that have
4 occurred with repeated expansions in the program
5 and absolutely zero change in the costs borne, not
6 the costs shared, just the literal costs borne
7 since the program was introduced in 1995, that
8 also suggests itself as being ripe for change.
9 So we are very interested in finding
10 efficiencies where they exist, but I would not say
11 imposing price controls by law on a more-expensive
12 meets at least my economist's view of an
13 efficiency.
14 MR. STROBRIDGE: I was giving that as an
15 example rather than an assertion. The frustration
16 I think that the beneficiaries have and the reason
17 very frankly why this Task Force was the formed
18 was the lack of transparency in, as you said, the
19 very uncertainty of what should be counted in
20 calculating these costs.
21 When we went to the Department of
22 Defense to discuss these kinds of things, and I

1 think most of our associations would be in the
2 camp that we're not naïve enough to think the
3 costs are going to stay flat forever. On the
4 other hand, it was a conscious DOD decision to
5 keep those costs flat for one thing, and when
6 there is a proposal to raise fees by discussing
7 restoring a percentage of DOD costs that existed
8 at some time in the past, that is what gives rise
9 to the question what exactly are those costs and
10 what are we counting.
11 I certainly agree with you about the
12 difficulty of saying how do you attribute the
13 costs of care in military facilities when part of
14 our facility is built to care for those who go to
15 war, to address their wounds, and that's exactly
16 one of the reasons why we're saying we do think
17 that to have credibility with beneficiaries if
18 we're going to base some cost-sharing on
19 percentage of DOD costs, we do have to be clear
20 and have a reasonable and understandable agreement
21 on what costs we're talking about, what is
22 attributed.

1 I certainly concede the difficulty. If
2 it were easy, there wouldn't be a Task Force. All
3 I'm asking is that the Task Force try to address
4 that.
5 DR. WILENSKY: One correction. I said
6 over 65 when I meant that our focus is on the
7 under-65 retiree population. You have spoken to
8 us. As you know, our deliberations are open. We
9 have begun to hear from and will continue to hear
10 from individuals to help guide us in terms of
11 understanding what projections reflect what's in
12 the numerator and denominator. We have not
13 suggested tying the co-pay to a particular
14 percentage of DOD costs. What we have noted is
15 that there has been a precipitous decline which I
16 would say however you're going to define the
17 numerator or denominator would show up since the
18 numerator has been flat dollars and the
19 denominator like every health-care cost has not
20 been. So that it is directionally clear and what
21 we have proposed in our Interim Report is the
22 importance of picking an amount, deciding on an

1 index which we discussed the various indices that
2 we are inclining toward although have not chosen
3 one, and that we will make sure that at the end
4 what we have done will not make individuals worse
5 off in terms of having the share of costs that
6 were covered when this program started before the
7 several expansions are not at least that good. So
8 we have not suggested a system that literally
9 keeps it at an X percent of DOD cost irrespective
10 of what else has gone on.
11 But mainly our deliberations are open
12 and anyone who is interested should come and
13 listen to where we are and send in whatever
14 comments or otherwise involves themselves as they
15 wish.
16 DR. POLAND: I think a couple of the
17 Task Force Members also have comments.
18 MAJOR GENERAL ADAMS: I think Steve you
19 actually gave us more of an answer than you think
20 and I think it's in the second part of your
21 statement specific to the value to the
22 beneficiary. That is much easier for us to

1 quantify and I think we just heard a number from
2 the other side of the table where the value of the
3 health benefit to outside corporations is around
4 $14,000 a year for what we in TRICARE are paying
5 around $400 a year. So I think we need to look
6 then what is the value to our beneficiaries and
7 then what is reasonable and fair in relationship
8 to the value of the care they're receiving. The
9 health-care benefit that we're giving today is
10 much better and different than what the promises
11 were made for in the mid-1950s when we talked
12 about space-available care in military treatment
13 facilities. Now it's not space available, it's I
14 dare say universal access between the network
15 physicians at our MTFs and it's the highest
16 quality of a benefit with very few limitations.
17 So I think if we start looking, because we can
18 argue the costs and the variables, they change
19 almost daily in terms of the deliverable, but what
20 doesn't change is the value of the benefit and
21 what is represented there.
22 MAJOR GENERAL SMITH: A couple things

1 that we have been doing on this getting arms
2 around the costs in our deliberations in some
3 other meetings, one, we have had all the Surgeons
4 General in and we have discussed like efficiency
5 wedges and the processes of Six Sigma to see if we
6 can help validate some of the costs and get some
7 of this transparency understood. We have been
8 working those processes. We have also had the
9 head of the GAO and the GAO is due out this month
10 where we had demanded from the Military Coalition
11 about an independent report Senator Lindsey Graham
12 had of the costs that were going on in DOD both
13 from procedures being paid and what are we paying
14 for procedures and equipment. That report is due
15 in at the end of May according to Dave Walker
16 which will also give us an insight about the costs
17 that are in this DOD formula. And yes, we are
18 trying to understand. We know that there's war
19 costs which are going to be a little different
20 with supplementals and things, but we've also got
21 to figure out as we alluded to earlier that
22 military readiness, what does that really cost us

1 as part of the formula. It's not clear that when
2 you have to have doctors and nurses and people in
3 place what that cost is for military readiness.
4 It is not the same cost you're just having people
5 in place to do a process.
6 But those issues are being addressed and
7 we've had several meetings getting into the DOD
8 costs from several different aspects. As a matter
9 of fact, we even brought back one of the people
10 who testified at the very first hearing for
11 another session of going through costs. So I can
12 at least think of three or four times we have had
13 DOD in going through their costs and trying to
14 understand and increase our awareness of
15 understanding before we propose any type of
16 possible fee structure changes because we're
17 trying to make ourselves sure that we understand
18 as you said numerators and denominators. So there
19 are significant efforts going on in that range.
20 DR. POLAND: In the interests of time,
21 what I'm going to now ask is if Dr. Wilensky,
22 General Corley, and then Secretary Cassells have

1 any summary comments to make, I'll make some
2 summary comments, and then we'll be adjourned.
3 DR. WILENSKY: Dr. Wilensky, do you have
4 any summary? General Corley? Secretary Cassells?
5 SECRETARY CASSELLS: Thanks, Dr. Poland,
6 Dr. Wilensky, General Corley. I'm new at this but
7 I can see -- I thought I was getting a handle on
8 this so I came to this meeting. This is a very,
9 very complicated topic, but on behalf of Secretary
10 England and Secretary Gates, I want to thank the
11 members for putting so much effort into this,
12 thoughtful effort, and obviously passionate
13 effort. And to have this much time from our
14 Surgeons General and General Myers, it's fantastic
15 for health affairs. We are just delighted with
16 this help, and I'm sorry Ellen Embry can't be
17 here. I want to acknowledge her work on this.
18 And particularly Admiral Arthur who is serving on
19 two other Task Forces as well, mental health and
20 traumatic brain injury, when he really could be
21 sharpening up his putting now, and here he is
22 serving on all these task forces.

1 We have had a big strategic planning
2 process at Health Affairs over quite a few months.
3 Many of you have participated. It's triggered
4 lots of light and a little bit of heat and the
5 ball has moved pretty down the field. A couple
6 principles that really are guiding our thinking
7 right now have been alluded to already,
8 transparency as Mr. Strobridge said, keeping our
9 casualties and their families first and foremost
10 in your minds, shifting the locus of control as
11 much as possible over time to the patient and
12 their family so that they have ownership of the
13 process so that they have more choices, and that
14 is not as strong a tradition in the paternalistic
15 military health system as it is in some other
16 systems, and Mr. Parkinson alluded to this and I
17 appreciate that.
18 As we move forward with your electronic
19 records, we hope to be more informative, more
20 transparent, and to give patients the tools they
21 need and many of them want already to drive their
22 own health care. I think you said patient-driven

1 health care, Mr. Parkinson, I'm certainly on board
2 on that. And we hope to give them for example
3 web-based tools for triage. As some of the
4 spouses said at Fort Bragg yesterday, when my
5 husband is away I don't want to spend 6 hours in
6 the ER and then go home with Tylenol, I'd like to
7 be able to get some guidance on the web and avoid
8 that visit to the ER. I'm a part-time teacher, I
9 got kids in school, this is a pressing need for
10 me. So a personalized health record that they own
11 and take control, triage tools, educational tools,
12 and I think Dr. Wilensky said incentives for
13 prevention, incentivizing certain outcomes, paying
14 not by the number of patients you've seen, but by
15 whether they're lost weight, whether they've got
16 their blood pressure down, whether their
17 cholesterol is down and their sugar, whether
18 they're getting their mammograms and their
19 vaccinations. Incentives for the doctor, for the
20 patient, for the nurse and her team, for the
21 system, these are all doable now. We're moving in
22 this direction not as quickly as any of us would

1 like.
2 When we have that system in place we
3 will see that there are opportunities beyond the
4 pharmacological, someone alluded to this and thank
5 you for that. Pharmacy is a big item in our
6 budget. Half of those ladies at Fort Bragg, I
7 think if I could get them going out and exercising
8 every day in the sun we would have stronger bones,
9 better cardiovascular fitness, better balance,
10 fewer falls. Secretary Gates has charged me with
11 reducing accidents in the military. And better
12 mood. These kinds of things are not pharmacologic
13 and we need to keep some of these things in mind.
14 So Dr. Wilensky, thank you saying you're going to
15 tackle the wellness issue, you've tackled so many
16 tough topics, and I look forward to your guidance
17 on that. Thank you, Dr. Poland.
18 DR. POLAND: As I read the report and
19 listened today, a couple of sayings came to mind.
20 One is that any idiot can make something complex,
21 but genius occurs when a complex problem is broken
22 down into actionable, feasible, focused action

1 items, and certainly that is my impression of what
2 the Board has done, or the Task Force. The other
3 saying that came to mind is that what gets
4 measured gets done, and in that regard, the Task
5 Force to my way of thinking has diligently sought
6 and examined the data and suggested some objective
7 metrics by which solutions could be devised and
8 then progress measured.
9 So from the point of view of the Defense
10 Health Board, you are to be congratulated on what
11 is and remains a complex task, we are grateful for
12 your work and your expertise, we are very
13 supportive of your interim findings and
14 recommendations, and we look forward to the final
15 report. We also stand ready to assist in many
16 manner that you as chairs or as a Task Force would
17 deem helpful. Thank you very much for your work
18 on a complex topic.
19 (Applause.)
20 DR. POLAND: Dr. Cassells, could we ask
21 you to close and adjourn the meeting?
22 SECRETARY CASSELLS: As the Delegated

1 Principal Staff Assistant and Alternate Designated
2 Federal Official for the Defense Health Board, I
3 hereby adjourn this meeting.
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