



## Task Force on the Future of Military Health Care Final Report

**Background.** Section 711 of the John Warner National Defense Authorization Act for Fiscal Year 2007 required that the Secretary of Defense establish a task force to examine matters related to the future of military health care. As directed by the Act, in December 2006 the Secretary of Defense appointed 14 members to the Department of Defense Task Force on the Future of Military Health Care. The Task Force includes individuals from within and outside the Department of Defense, with wide expertise in issues related to health care programs and costs.

The Task Force was asked to address ten specific elements relevant to the future of military healthcare and issue a final report with its assessment and recommendations within 12 months. These 10 elements are:

- ◆ Wellness initiatives and disease management programs of the Department of Defense, including health risk tracking and the use of rewards for wellness.
- ◆ Education programs focused on prevention awareness and patient-initiated health care.
- ◆ The ability to account for the true and accurate cost of health care in the military health system.
- ◆ Alternative health care initiatives to manage patient behavior and costs, including options and costs and benefits of a universal enrollment system for all TRICARE users.
- ◆ The appropriate command and control structure within the Department of Defense and the Armed Forces to manage the military health system (MHS).
- ◆ The adequacy of the military health care procurement system, including methods to streamline existing procurement activities.
- ◆ The appropriate mix of military and civilian personnel to meet future readiness and high-quality health care service requirements.
- ◆ The beneficiary and Government cost sharing structure required to sustain military health benefits over the long term.
- ◆ Programs focused on managing the health care needs of Medicare-eligible military beneficiaries.
- ◆ Efficient and cost effective contracts for health care support and staffing services, including performance-based requirements for health care provider reimbursement.

**Guiding Principles.** The Task Force issued its Final Report to Defense Secretary Robert Gates on December 20, 2007. Some of the salient points in the report are shown below. The Task Force had two overriding and guiding principles to shape their recommendations:

- ◆ The Task Force also believes that those treated by this system—military members and retirees as well as their dependents—deserve a very generous health care benefit in recognition of their important service to the Nation, but not free.
- ◆ The system should provide much needed health care while considering fairness to the American taxpayer.

**Beneficiaries.** The Task Force documents the number of MHS beneficiaries in three categories: active duty and their family members, under age 65 retirees and their family members, and over age 65 retirees and their family members.

| <b>Beneficiary Category</b> | <b>Beneficiaries</b> | <b>Percent of Total</b> | <b>Percent of Budget</b> | <b>Out of Pocket Costs</b> |
|-----------------------------|----------------------|-------------------------|--------------------------|----------------------------|
| AD & Family                 | 3,944,861            | 43%                     | 20%                      | \$0                        |
| <65 Retiree & Family        | 3,283,820            | 36%                     | 23%                      | Fees, Co-pays, Deductibles |
| >65 Retiree & Family        | 1,903,387★           | 21%                     | 57%                      | \$0                        |
| totals                      | 9,132,068            |                         | \$39.4 billion           |                            |

★ Includes 936K retirees, 545K spouses, and 422K surviving spouses

**Recommendations.** The Task Force recommends no increases in costs for active duty and their family members. They recommended a modest enrollment fee for >65 retirees and their family members (who are on Medicare and TRICARE for Life—TFL) with waiver provisions if the retiree takes part in wellness programs. The report says that >65 retiree costs will rise by 44% in the next 5 years. They recommend the lion’s share of cost share increases for the <65 retirees and their family members, including enrollment fees based on retired pay, increased co-payments, and increased deductibles based on retired pay.

Other points made by the report are:

- ◆ They compared military health care benefits to those provided by many U.S. employers, and also compared the costs to civilian health care plans.
- ◆ The report states that the MHS cannot be sustained at the current level without some degree of accountability and contribution from military retirees (meaning the <65 age retirees and their families). This “modest contribution” will help sustain the MHS for the future, when today’s war fighters will rely on it for their retirement.
- ◆ The task force takes no position on military to civilian conversions within the medical community.
- ◆ They state that the lack of integrated strategy between direct care and purchased (or managed) care is evident and has a cost to the MHS.
  
- ◆ The report says that DOD is overly focused on controlling unit prices and is not outcome based. DOD is having limited effectiveness in weight management, smoking cessation, disease management, and case management.
- ◆ TRICARE Management Activity (TMA) should be restructured for greater emphasis on acquisition.
- ◆ Medical readiness of the reserve forces is a critical aspect of overall Total Force readiness.
- ◆ Current DOD pharmacy co-payment policies do not provide adequate incentives for patients to use cost-effective alternatives, and do not create effective incentives to stimulate compliance with clinical best practices.
- ◆ The report calls for tiering of cost sharing fees to retired pay, phasing changes in over a four-year period of time. It calls for automatic annual indexing of annual enrollment fees, with deductibles, co-payments, and catastrophic caps reassessed every five years.
- ◆ The Task Force says that 65% of retirees and 58% of dependents are eligible for health insurance from their private employers, yet only 40% of those retirees elect private coverage and 29% elect dependent coverage. 60% of retirees are using TRICARE as their primary payer.

Factors cited in the report that resulted in the increase of DOD health care spending from FY00 – FY05:

- ◆ TFL 48%
- ◆ Medical care inflation 24%
- ◆ Increase in <65 retirees 7%
- ◆ War on Terror 6%
- ◆ Other 14%

The report says that TMA has unauditable financial statements due to financial and information systems problems as well as inadequate business procedures and internal controls. They say that TMA will not be ready for audit until at least FY 2015. It says that MHS financial, cost accounting, and information systems do not comply with Generally Accepted Accounting Principles (GAAP). Further, it says that DOD accounting systems are set up on a budgetary basis and are not designed for accrual basis accounting under GAAP. The Medical Expense and Performance Reporting System calculate unit costs, which is a cost accounting system, which is prone to user errors, reported workload, and unreliable coding effectiveness. Finally, it says that DOD cost problems are persistent and longstanding. Until DOD and MHS correct the overall systems architecture problems and align these systems to support financial reporting and cost accounting across the agency, DOD cannot provide financial statements that are reliable or that account with a high level of confidence the true and accurate cost of health care in the MHS.

The report goes on to say that the current accounting system does not measure the value of true outputs; does not capture all DOD health care costs; is inconsistent in how labor costs are allocated; and is difficult to compare direct care to private care and care among the services.

The Task Force found that a standardized approach to wellness education and disease prevention services is lacking. They said that DOD is not meeting the Healthy People 2010 goal of 88% non-smoking rate, and that TMA does not reimburse members for tobacco cessation program costs.

The Task Force did recommend to DOD that they consider longer duration of managed care support contracts.

**Reserve health care.** The Task Force found that 80% of reservists have civilian health care insurance, but that dental readiness continues to be the greatest obstacle to medical readiness for most of the reserve forces.

| <b>Reserve Force Strength</b> |                         |
|-------------------------------|-------------------------|
| 350,000                       | Army Guard              |
| 200,000                       | Army Reserve            |
| 71,300                        | Navy Reserve            |
| 39,600                        | Marine Reserve          |
| 107,000                       | Air Guard               |
| 74,900                        | Air Reserve             |
| 10,000                        | Coast Guard Reserve     |
| <b>852,800</b>                | <b>Total Reservists</b> |

The take rate for TRICARE dental for reservists is approximately 9-11%, according to TMA.

According to the report, as of early November 2007, participation in TRICARE Reserve Select (TRS) is:

| <b>TRICARE Reserve Select Participation</b> |                         |
|---|-------------------------|
| 5,493                                       | Member only plans       |
| 10,922                                      | Member and family plans |
| 16,415                                      | Total TRS plans         |

TRS participation is equal to about 2% of the eligible population. If the report is correct, and 80% of reservists have civilian health insurance, and 2% are insured by TRS, 18% of the reserve forces (or just over 153K) have no health insurance.

**Pharmacy.** The report states that prescription usage and costs have been the main cost driver contributing to the significant increases in MHS pharmacy costs. Pharmaceutical costs for those under 65 years of age average \$437 per eligible beneficiary, compared to \$1,784 for those who are 65 years of age or older, a difference of \$1,347 per eligible beneficiary. Only 7% of prescriptions are filled through the TRICARE Mail Order Pharmacy, where DOD can save \$24 million in costs for each 1% of the eligible population that switches from retail to TMOP.

**Fee Increases.** The Task Force recommended increases in fees and deductibles for retirees using TRICARE based on retired pay:

**Annual /Monthly Enrollment Fees for Prime Family before Proposed Indexing☆**

| Retired Pay |   |                     |                  |
|-------------|---|---------------------|------------------|
| year        | \$0 - \$19,999                              | \$20,000 - \$39,999 | \$40,000 & above |
| 2007        | \$460/\$0                                   | \$460/\$0           | \$460/\$0        |
| 2008        | \$570/\$50                                  | \$640/\$55          | \$780/\$65       |
| 2009        | \$680/\$55                                  | \$830/\$70          | \$1,110/\$95     |
| 2010        | \$790/\$65                                  | \$1,010/\$85        | \$1,430/\$120    |
| 2011        | \$900/\$75                                  | \$1,190/\$100       | \$1,750/\$145    |
| 2012+       | Annually adjust with index, relook at 5 yrs |                     |                  |

**Annual/Monthly Enrollment Fees for Standard Family before Proposed Indexing☆**

| Retired Pay |   |                     |                  |
|-------------|---|---------------------|------------------|
| year        | \$0 - \$19,999                              | \$20,000 - \$39,999 | \$40,000 & above |
| 2007        | \$0/\$0                                     | \$0/\$0             | \$0/\$0          |
| 2008        | \$30/\$5                                    | \$30/\$5            | \$30/\$5         |
| 2009        | \$60/\$5                                    | \$60/\$5            | \$60/\$5         |
| 2010        | \$90/\$10                                   | \$90/\$10           | \$90/\$10        |
| 2011        | \$120/\$10                                  | \$120/\$10          | \$120/\$10       |
| 2012+       | Annually adjust with index, relook at 5 yrs |                     |                  |

**Annual Deductibles for Standard Family before Any Reassessment☆**

| Retired Pay |   |                     |                  |
|-------------|---|---------------------|------------------|
| year        | \$0 - \$19,999                              | \$20,000 - \$39,999 | \$40,000 & above |
| 2007        | \$0   | \$0                 | \$0              |
| 2008        | \$350                                       | \$390               | \$470            |
| 2009        | \$390                                       | \$470               | \$630            |
| 2010        | \$440                                       | \$560               | \$800            |
| 2011        | \$490                                       | \$650               | \$960            |
| 2012+       | Annually adjust with index, relook at 5 yrs |                     |                  |

☆ **Single would feature an enrollment fee and a deductible that equals half of those for family rates.**

The Task Force reports that retirees using TRICARE Prime should have a cost share that gradually restores their out of pocket cost to that of when the health care benefit was put into place in 1996. It says that the cost share borne by the retiree has fallen from 11% to 4%, and that this inequity is “unfair to U.S. taxpayers.” The report says that health care benefits available to retirees should be generous but not free, and listed some recommendations:

- ◆ Implement a phased-in increase in cost sharing for <65 retirees (approximately 7.5% per year)
- ◆ Create a modest enrollment fee for >65 retirees
- ◆ Index selected retiree costs to inflation to prevent “tier creep”
- ◆ Improve coordination of insurance among <65 retirees
- ◆ Raise the catastrophic cap to \$2,500
- ◆ Establish an open season to switch from Prime to Standard or vice versa
- ◆ Automatically enroll retirees in TRICARE Standard upon retirement unless another choice is made at that time

**Twelve Recommendations of the Task Force:**

1. Develop a Strategy for Integrating Direct and Purchased Care
  - ◆ Develop a strategy for integrating the direct and purchased care systems
  - ◆ Provide incentives to optimize the best practices of direct care and private sector care
  - ◆ Fiscally empower the individuals managing the provision of integrated health care and hold them accountable
  - ◆ Draft legislative language to create a fiscal policy that facilitates integrated health care
  - ◆ Develop metrics to measure whether the planning and management strategy produces desired outcomes
2. Collaborate with Other Payers on Best Practices
  - ◆ Align with government and private sector organizations to make health care quality and costs more transparent and accessible to beneficiaries
  - ◆ Use performance-based clinical reporting
  - ◆ Strengthen incentives to achieve high-quality and high-value performance
  - ◆ Implement a systematic strategy of pilot/demonstration programs and identify successes for widespread implementation

3. Conduct an Audit of Financial Controls
  - ◆ Charge the auditor with assessing the most efficacious and cost-effective approach
  - ◆ Ensure audit recommendations are implemented and followed up
  - ◆ Establish a common cost accounting system while ensuring TRICARE is a second payer when other health insurance exists
4. Implement Wellness and Prevention Guidelines
  - ◆ Continue to prioritize prevention programs
  - ◆ Implement and resource standardized case management and care coordination beyond the Wounded Warrior and across the spectrum of care
  - ◆ Ensure timely and accessible performance feedback to providers, managers, and the chain of command
  - ◆ Maintain high-level visibility of business/clinical performance for the entire enterprise
5. Prioritize Acquisition in the TRICARE Management Activity
  - ◆ Elevate the level of the Head of the Contracting Activity
  - ◆ Ensure acquisition personnel are certified according to the Defense Acquisition Workforce Improvement Act
  - ◆ Ensure management of programs is consistent with the Defense Acquisition System process
  - ◆ Place acquisition functions under a Chief Acquisition Officer
  - ◆ Study possibility of collocating TRICARE Deputy Chief TRICARE Acquisitions organization with acquisition counterparts
6. Implement Best Practices in Procurement
  - ◆ Examine and implement strategies compliant with Executive Order 13410
7. Examine Requirements in Existing Contracts
  - ◆ Examine benefits/risks of waiving cost accounting standards
  - ◆ Examine referral and enrollment processes
  - ◆ Test and evaluate through pilot or demonstration projects the effectiveness of carved out chronic disease management programs
  - ◆ Examine overarching contracting strategy for purchased care
8. Improve Medical Readiness of the Reserve Component
  - ◆ Assess the impact of TRICARE Reserve Select in three to five years
  - ◆ Improve education/information flow about the health care benefit
  - ◆ Harmonize/leverage work of other review groups to improve DOD/VA coordination of beneficiary services and reduce administrative “seams” in the Military Health System
  - ◆ Expand efforts in nonprime service areas to improve access
9. Change Incentives in the Pharmacy Benefit
  - ◆ Revise the pharmacy medication tier structure
  - ◆ Conduct a pilot program on the impact of total spend and outcomes
  - ◆ Grant DOD authority to selectively include clinically and cost-effective over-the-counter medications in the formulary when recommended by the Pharmacoeconomics Center
  - ◆ Grant DOD authority to mandate the point of service for Special Category Medications, based on established criteria
10. Revise Enrollment Fees and Deductibles for Retirees
  - ◆ Increase enrollment fees for non-Active Duty TRICARE Prime Beneficiaries
  - ◆ Establish enrollment fees for all other non-Active Duty beneficiary categories
  - ◆ Establish indexing for all non-Active Duty beneficiary categories for enrollment fees, copayments, deductibles, and catastrophic caps
  - ◆ Tier enrollment fees based on retiree pay
  - ◆ Examine feasibility of establishing other TRICARE options so all retirees can have comparable choices

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

- ◆ Study and possibly pilot a program to better coordinate insurance practices for those retirees who are eligible for private health care insurance as well as TRICARE

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

- ◆ Develop metrics of success for any planned transformation of command and control of the Military Health System

**On the Net.** The final report (204 pages in PDF format) of the Task Force can be found at:  
[http://www.dodfuturehealthcare.net/images/103-06-2-Home-Task\\_Force\\_FINAL\\_REPORT\\_122007.pdf](http://www.dodfuturehealthcare.net/images/103-06-2-Home-Task_Force_FINAL_REPORT_122007.pdf).

Task Force Web Site is at: <http://www.dodfuturehealthcare.net/>.