THE MILITARY OFFICERS ASSOCIATION OF AMERICA (MOAA)

STATEMENT FOR THE RECORD

BEFORE THE

SENATE ARMED SERVICES COMMITTEE

PERSONNEL SUBCOMMITTEE

ON

MILITARY HEALTH BENEFIT MODERNIZATION

February 25, 2015

Chairman Graham and Ranking Member Gillibrand, members of the committee, on behalf of the 390,000 members of the Military Officers Association of America (MOAA), we welcome this opportunity to submit testimony for the record, regarding our views concerning the Military Compensation and Retirement Modernization Commission's (MCRMC) report and recommendations regarding military health benefits.

MOAA sincerely appreciates the hard work and detailed analysis that went into the Military Compensation and Retirement Modernization Commission's report. The commissioners and professional staff should be commended for their extensive effort. Their product provides the country with an instrument that we can use as a catalyst to begin important thoughtful discussions, analyses, and debates on vital issues that directly affect our service men and women, retirees, their families, and their ability to insure our national security. We look forward to working closely with the Congress and in particular this committee, your staff, the Pentagon and the Administration on these critical concerns and recommendations regarding military compensation, benefits and the retirement system.

The Commission and MOAA both seek the same objective. However, we urge caution concerning any major changes to the military's health care system (MHS) that could potentially have a negative impact on the military medical readiness of our medical personnel, as well as on the entire all-volunteer force and their families. Several of the health care proposed recommendations represent nothing short of a seismic change, and have not been modeled and studied within the complex and dynamic realities of the military health care system.

Some defense leaders and others have stated, and continue to state, that the military's health care costs absorb a disproportionate 10 percent, non-war share of the Department of Defense (DoD) budget, and that this spending trajectory must change. These assertions should be viewed in proper context in that healthcare costs comprise 23 percent of the nation's budget; 22 percent of the average state budget; 16 percent of household discretionary spending; and are 16 percent of the U.S. gross domestic product – so a 10 percent share of DoD's budget is not too bad a deal. Additionally, not usually highlighted are the improvements to the benefit and the extended benefit coverages for reserve and guard components which Congress rightfully mandated during the past decade. The facts also show that DoD healthcare costs have been relatively flat over the past three years because of changes Congress already has put in place.

The current and future national security situation will require that we maintain a balance of investment in equipment, training, operational capabilities, as well as personnel requirements which have been the cornerstone of the success of our all-volunteer force. There are finite resources for these competing demands and we strongly agree that the military's health care system needs to evolve beyond what it is today, into a modern high performing integrated

system, delivering quality, accessible care, safely and effectively to its beneficiaries – while simultaneously meeting international health crises and national disasters, while at the same time honing its readiness capabilities. No other health care entity in the country is charged with these dual, yet mutually inter-dependent, mandates.

Our nation's health care industry is undergoing rapid change, and it is within this context that the military health care system finds itself at a major inflection point. It must sustain the advances and skills learned from the past 14 years of combat experience and it cannot compromise on its readiness platforms. Thus, any reforms must support the goal of sustaining an operationally ready force with a ready medical force. How to most effectively accomplish this without negatively impacting retention and readiness is the crux of the issue.

Military Health Care and the Importance of the TRICARE Program

The MCRMC recommends the TRICARE program be eliminated and replaced with a Federal Employee Health Benefits Program (FEHBP)-like substitute health plan. It is worthwhile to understand the importance of the current program that it is purported to replace.

There have been, and continue to be, many studies on the organization, coordination, and the increasing costs of the military health system, as well as its effectiveness addressing particular health challenges. Despite the stress that has been placed on the military's health system and the TRICARE program, because of war – its performance has withstood the test of time and in some ways, is stronger and more resilient now than it has ever been.

The TRICARE program was established in 1995 having evolved from the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Today, it provides care to over 9 million service members and families, retirees, and survivors, through a range of benefits from TRICARE Young Adult to TRICARE for Life.

TRICARE, by its very nature, was designed to support military medical readiness as well as to ensure the delivery of a defined benefit. It accomplishes this by sustaining the operational capability for military treatment facilities through an augmented network of health care services provided by three managed care support contractors, who ensure the continuous delivery of the benefit.

The heart of military medical readiness is found in the direct care system, of which military treatment facilities provide the core platform for training. The provision of care in these facilities is vital to the ongoing training of physicians, nurses, corpsmen, medics, and other ancillary and administrative personnel. Managed care support contracts allow for nationwide flexibility in support of a ready deployable force. This model has proven successful but expensive, as evidenced by large budget increases for civilian purchased care.

Managing and maintaining a health care budget in excess of $50 billion a year is complicated and intricate. It is precisely because of the challenges presented in managing such a large program that the system has become somewhat, over time, both self-defeating and sub-optimal. For instance, reducing the Prime Service Areas (PSA's) around the MTFs saves money in the budget, but reduces the number of beneficiaries utilizing the MTF which creates even more excess capacity. The overall result of this sub-optimization of the direct care system has directly resulted in both the increased use of purchased care in civilian networks, and a shrinking patient base.

Despite its current challenges and short-comings, MOAA believes TRICARE is not currently in a "death spiral" as some have said, and it is not broken – but there are areas that definitely need urgent focused attention and reform. The recent 2014 MHS Review identified key shortcomings and areas for improvement in the domains of access, quality, and patient safety – with some steps already underway. This past summer, MOAA's own survey on MHS access, quality and safety corroborated much of the same, especially regarding access to care issues. In short, we will not accept the status quo and we must all must continue to hold the Department accountable for aggressively correcting these areas.

TRICARE has come to a unique moment in its history, and is presented with an opportunity for a thoughtful re-design of the program. This should be done with the goals of ensuring that the TRICARE benefit remains robust and medical readiness is strengthened while keeping beneficiary care and access in the forefront.

The MCRMC Proposals

The MCRMC has advanced four over-arching proposals that represent significant changes to the MHS. We are generally in support of two of them but have significant concerns regarding the other two.

We applaud the Commission for addressing issues experienced by military families with special needs. We generally agree with the recommendations and the intent to improve support for these beneficiaries by aligning services offered under the Extended Care Health Option (ECHO program) to those of state Medicare waiver programs. We believe that Guard and Reserve families are particularly vulnerable during transitional periods and should have an extension of support. It is imperative that the benefit must include members of all seven of the uniformed services.

We also support dramatically improving collaboration between the DoD and VA and there exist some excellent examples, such as the joint DoD/VA health care facility in North Chicago. For

years MOAA has advocated for legislative authority to grant the existing Joint Executive Committee additional authority and responsibility to enforce collaboration. Many of the issues impeding progress range from a common electronic medical record to joint facility and acquisition planning can be accomplished in a transparent manner. Similarly, the issue of a transitional formulary for service members leaving the DoD and enrolling into the VA system should be immediately corrected.

We have significant concerns regarding the Commission's proposals to create a new Joint Readiness Command (J-10), tasked with overseeing new standards for essential medical capabilities and establishing military treatment facilities as preferred network providers within civilian communities. MOAA for years has supported the concept of a unified medical command that has a single budget authority over the three military systems. The time is right for this to come to fruition **now**, starting with the large multi-service market areas (MSM's). A single budget authority to include human resources and infrastructure oversight and control, will yield huge cost savings and efficiencies that we can only now dream about. Throughout the years, numerous studies have recommended the consolidation of medical budget oversight and execution and this can be done while maintaining the readiness responsibilities of the Surgeons General under Title 10. However, the MCRMC proposal does not include this MOAA-supported recommendation.

Associated with that recommendation, is the proposal to increase beneficiary health care choice by dis-mantling the current TRICARE three-option program and moving active-duty family members, retirees under age 65 and Reserve component members into a commercial premium-based insurance model, similar to the Federal Employee Health Benefit Program (FEHBP).

Proposal to Eliminate the TRICARE Program and Replace it with a Federal Employees Health Benefits Program (FEHBP)-like System

Offering military families and retirees under age 65 choices in a FEHBP – like program is one of the centerpieces of the MCRMC's health care proposals. It is in response to reported access, referral, contracting, and bureaucratic problems that beneficiaries experience under TRICARE Prime. Observations made by the commission regarding many of these issues are right on the mark.

TRICARE Prime is by design an HMO model of care, costing beneficiaries less and inherently providing less choice. TRICARE Standard provides a wider range of choice and is more popular. The commission's main concerns involve issues with the TRICARE Prime; a fair question to ask is whether it takes such a radical change to address those problems.

The new FEHBP-like program, called TRICARE Choice, would offer beneficiaries an array of plan options to choose from based upon their location. MTFs would be offered as one of the providers in the plan. It is envisioned that DoD would have the authority to adjust MTF billing for civilian reimbursements and co-payments for insurers as needed to meet the MTF's readiness requirements.

Concerns:

This proposal is a dramatic change in the entire philosophy of delivering military health care coverage and if it is seriously entertained, should be subject to much more scrutiny to ensure it meets beneficiary needs without changing the fundamental benefit value or leading to un-intended consequences.

TRICARE is designed to support military readiness – to include military family readiness. FEHBP serves a very different purpose and does not factor in readiness. For example, how would DoD's new investment in an electronic medical record be used in a FEHBP-like benefit design?

Instead of fixing existing issues and investment in fixing these, the Commission's answer is to eliminate the entire program and have beneficiaries, particularly retirees not on Medicare, pay substantially more under the premise of receiving more "bang for their buck."

The unintended consequences to military medical readiness could be great. Using MTFs as network providers, competing for business in the civilian market was not thoroughly examined in the Commission's report - this represents an unacceptable level of risk. Especially since the MTFs exist for readiness or a unique mission. The use of TRICARE as a back-up to absorb care during periods of readiness has largely been a success – for example, during large scale deployments of medical staff on the hospital ships in both war-time and humanitarian scenarios.

The Commission also presumes the Defense Department, in working with FEHBP insurers, would be afforded the right to set provider payments and beneficiary copayments for MTFs versus other providers, and adjust those as necessary to direct patient flow to MTFs. MOAA remains dubious that a broad range of insurers would be comfortable with extending such authority to one provider, however preferred.

Military families would have to receive extensive education when selecting health plans. Overwhelming choice may be just that – overwhelming and confusing, especially in the face of the existing stressors military families face. Educating beneficiaries on their TRICARE benefits has been a challenge since the program's inception. Under the MCRMC concept, we are skeptical that DoD could effectively educate beneficiaries on an even greater array of plans.

Under FEHBP, an open season for plan changes occurs once a year. If a military family member experienced a new diagnosis or health status change, he or she may want to change plan coverages. This would be especially problematic with mental health issues. There are already shortages of mental health providers in many states with our largest military bases, regardless of network.

Premiums, copays, unique plan features, and the determination of medical necessity would vary by location and plan design. This would be a dramatic and unwelcome departure from what has been a program with a **uniform benefit.** Military families today can only plan as far as their next set of orders. **They have come to rely on the uniform nature of the health benefit administered by TRICARE, no matter where they are stationed in the world.**

For example, Applied Behavior Analysis (ABA) is a therapy increasingly sought by military families for autistic dependents on the autism spectrum. Within the FEHBP, the therapy is not a covered benefit and it is offered by only 20 plans in a handful of states.

Another area not fully addressed by the Commission is pharmacy coverage. The Commission proposes that the TRICARE pharmacy program remain unchanged. But virtually all of the FEHBP plans include different levels of pharmacy coverage, and practical experience is that the TRICARE pharmacy program is virtually unusable if other coverage exists. MOAA believes this would entrap military families between significantly higher costs for civilian coverage or extraordinary bureaucratic problems if they seek to use TRICARE pharmacy programs.

The needs of a military family today can be dramatically changed by the demands of service. Unlike the TRICARE managed care support contractors, it is not clear that commercial plans under an FEHBP-like scenario would be sensitive to or responsive to a military family's unique needs. *"Ready to Serve"* the title of MOAA and United Healthcare Foundation's recent survey on civilian providers, conducted by RAND and released in December 2014, shows that civilian mental health providers are not equipped with the necessary knowledge or cultural sensitivity required in the care of military and veterans populations.

Putting this major military health benefit under the administration of the Office of Personnel Management (OPM) appears to be a significant step toward treating military beneficiaries like federal civilians for health care purposes. Military beneficiaries incur unique and extraordinary sacrifices unlike the service conditions of any civilian, and their health benefits have been intended to be significantly better than civilian programs.

MOAA's recent survey of over 7,000 respondents revealed that **four out of five prefer TRICARE** over an FEHBP-like system for retirees and families, and **nine out of ten do not feel confident** that OPM would be able to understand and accommodate the unique needs of military

families. The respondents include active duty, active duty family members, retirees, military spouses, and survivors of all the uniformed services.

An additional concern of MOAA centers on the potential premium working-age retirees will pay. It is not clear how the commission determined premium cost shares for beneficiaries. A 20 percent premium cost share for retirees is substantially too high, regardless of any phase-in period. A cost structure this high devalues the in-kind premiums service members contributed through decades of arduous service and sacrifice acknowledged in previous cost-share settings.

The fundamental issue is that recognition of decades of service and sacrifice in uniform should be formally recognized in any cost determination. A 20 percent cost share is not far off from the 28 percent cost share for federal civilians using FEHBP. Comparison with civilian or corporate cash fees is inappropriate. Military retirement and medical benefits are the primary offset for enduring decades of arduous service conditions. Career retirees pre-pay huge "up front" health care premiums through 20 to 30 years or more of service and sacrifice.

Proposal to Establish a Joint Readiness Command

MOAA has long been on record in support of a joint or unified medical command to ensure inter-service consistency of policy, consolidated budget authority, appropriate determinations for medical staffing, training, procurement efficiencies, and more.

Unfortunately, the creation of another layer of bureaucracy does not address the root of the MHS's problems. **The largest barrier to a truly efficient and highly reliable healthcare organization is the current three service system organization.** This arrangement is directly responsible for extensive costs through the duplication of technology services, medical equipment, lack of common procedures and processes, especially in the much touted multi-service market areas. Literally millions are wasted each year due to the inefficiencies of this type of structure.

An example is the military's integrated referral and management center which serves the multiple clinics and hospitals in the National Capital Area. It is charged with making specialty referrals and appointments for the geographical market area. However, they only end up making approximately 20 percent of the total appointments, due to the fact that there is no unified policy and process in appointing beneficiaries into all of the military clinics and hospitals. The hospitals and clinics still report to three different service commands under three or more different sets of orders and varying budgets. This wastes millions in missed referrals going into the private sector.

There have been measures made at integration. The creation of the Defense Health Agency is a step in the right direction and has proven it can get things done - but its budgetary successes

have mainly been borne on the backs of the beneficiaries by higher pharmacy fees, mandatory mail order and rising premiums and co-payments. **The MCRMC health care proposals represent a "shot across the bow" and should serve as a catalyst for the DoD to quickly push through with these long needed structural reforms under the direction of Congress.**

Concerns:

This new command structure does not provide a unified budget authority, but rather, participation in the budget process with the service and others. One of the key's to an efficient joint organization is budget accountability and direct oversight.

The proposed rate setting authority charged to coerce beneficiaries into using MTFs and to induce private insurers to use the facility is risky and managerially cumbersome. Even if potential insurers would allow one provider system to exert such powers. It is unclear if this could increase the potential to put MTF needs in more direct opposition to dependent/retiree/survivor beneficiary desires.

Historically, MTFs have wanted older beneficiaries for trauma, surgical procedures and other needs, but has not had the capacity to enroll beneficiaries for routine and specialty care.

Placing a new bureaucratic structure over the existing one seems redundant, especially if it fails to address the principle problems of diffuse budget and oversight authority for DoD-wide medical programs. The functions overseeing readiness already exist in the service Surgeons General and Joint Staff Surgeon. Service consolidation can and should take place without introducing another costly layer.

TRICARE Has Its Faults But Can Be Improved with Congressional Leadership

Problems in TRICARE like rising costs, barriers to access, and lack of customer service in certain areas, can be addressed in a systematic manner without resorting to its elimination. The elimination of TRICARE would be akin to "throwing out the baby with the bath water" and does not get to the root of the problems. The recent MHS Review produced a baseline starting point.

The time is ripe to institute change. The development of a new set of TRICARE contracts, set to start in 2017, is about to commence bidding. The Request for Proposal (RFP) seeks industry bidders and additional input has gone out. Now would be an opportune time to institute innovative ideas from industry.

The Department of Health and Human Services' Centers for Medicare and Medicaid (CMS) have instituted reforms calling for more payments to providers that place the value of health care over volume. There needs to be more focus on value based reforms which reward innovation

and quality outcomes. DoD and TRICARE should maintain alignment with Health and Human Services and set goals to institute these same types of payment reforms into the new contracts. For example, a program to bench-mark that is already under TRICARE, the U.S. Family Health Plan, uses capitated financing to effectively manage its defined beneficiary population.

A great deal of the cost increases have come from the current fee-for-service payment structure that TRICARE uses to pay its providers as this facilitates increased use of services. DoD must recognize that it is simply not possible to maintain a traditional fee-for-service discount purchasing strategy to keep costs down and improve access for beneficiaries.

The discounted fee-for-service strategies from the past have also not been effective in creating provider networks that meet the needs of TRICARE beneficiaries in an economical and customer satisfying way. The Commission acknowledged this feedback from beneficiaries in their report.

A value-based model will require new ways of thinking and risk-sharing. Under new contracts, managed support contractors and MTFs should be incentivized to align and integrate, with risk shared by each for the success of the whole.

These payment innovations can and should be tried in a pilot program, using one or more of the enhanced multi-service markets as a testing ground. Experimenting with innovative public /private partnerships, including the VA, should be done to increase training case-mix and critical skills maintenance. This can be done now, without change to the whole system.

One area where the Commission proposal to use an FEHBP-like program could be productive is for Guard and Reserve members and their families. We have long sought to bridge the health care continuity gap between and during periods of activation. As Guard and Reserve family members are not usually subject to frequent relocations and typically prefer to keep their employer coverage, the FEHBP-like concept would be more fitting for this population, including providing these families an option for an allowance to cover their civilian employer coverage during periods of deployment.

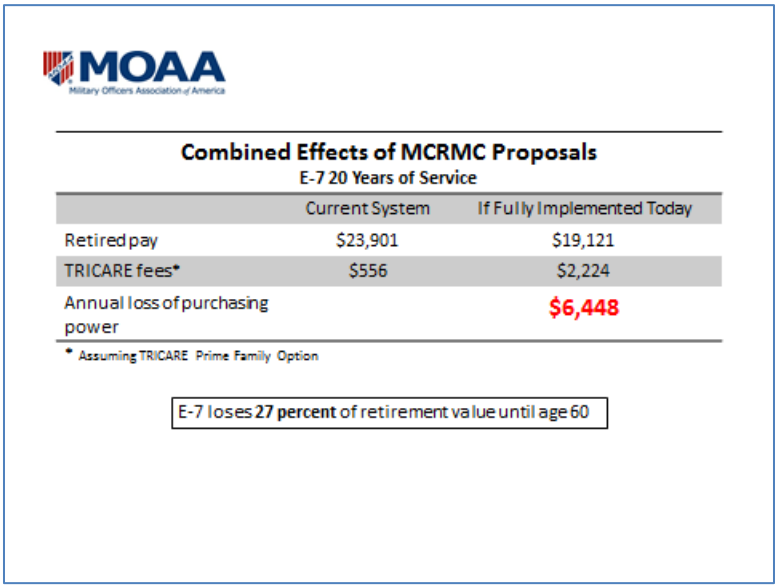
By effective rationalization of the current military health care infrastructure, great savings can be gained with resulting better quality of care for beneficiaries. It simply does not make sense to keep open facilities with minimal inpatient occupancy.

For the continuous development of the future MHS and TRICARE, DoD would benefit from frequent dialog with leaders in the health care industry. A regularly scheduled forum could be modeled after the existing Defense Health Board (DHB), focused on industry best-practices from all sectors. A forum like this could also leverage ideas from the Commission and beneficiary engagement.

Lastly, targeted investment should be made in technologies and people to support established joint processes and procedures that will generate real return on investment.

Summary

The MCRMC has made 15 recommendations – 2 of which propose dramatic changes to both military retirement and health care programs that could, in MOAA's opinion, seriously impact on career retention required in the all-volunteer force. Both recommendations produce a negative effect on the pocket book of those whom the government needs to serve for a career of 20 years or greater. For example, the combined effects of the MCRMC's health care and retirement change, if fully implemented today, on a retired E-7's annual retirement value is over $6,400 or a loss of 27 percent until they can draw from their Thrift Savings Plan at age 59 and a half.



Therefore, a complete overhaul of a health plan and the system serving 9.6 million military retiree and family beneficiaries deserves thoughtful and careful consideration, with Congress ensuring that legislation and implementation reflects intent. Congress should take all needed time to make deliberate decisions about this proposed wholesale change, ensuring that both Congress and stakeholders understand the second and third order effects.

Some of the findings in the MCRMC report align with concerns raised by MOAA, and deserve to be addressed now, pending deeper consideration of the broader issues. The number one action the Congress should take immediately is to demand that DoD without delay, reform under a truly unified military health care system – and not just the service member's share of it. Without unified budget and oversight delivery of current multi-service, multi-contractor programs, TRICARE as we know it will remain parochially administered and sub-optimized.

Service members, whether in garrison, down range, or anywhere in the world, should not have to worry if they have selected the appropriate health care coverage for their families. Radical change of core retention programs always carries significant risk of unintended negative retention effects. And that risk is exponentially magnified when the changes include significantly higher costs for already-stressed beneficiaries.

The key is to ensure that program changes entail real improvements, both for readiness and the beneficiaries, and avoid the kinds of changes that merely create a new set of problems for both.