TRICARE Reform
Written Statement of John Whitley, February 2016

Mr. Chairman and Members of the Committee: It is a privilege to participate in this panel. The views I express are my own, and should not be interpreted as reflecting any position of the Institute for Defense Analyses. The military medical community is a dedicated force trying to provide beneficiaries a quality benefit and maintain their readiness to provide lifesaving care on the battlefield. But this community works within a Military Health System (MHS) that often fails to encourage these outcomes and, at times, actually hinders their ability to succeed. I commend Congress for addressing these challenges and would like to make three primary points in my testimony:

1. TRICARE reform is an opportunity to improve choice and access for beneficiaries while controlling costs in DoD—it is not simply increasing cost-shares or tweaking contracts.
   - For much of the last 10 years, TRICARE reform has been defined as increasing cost-shares for beneficiaries to reduce utilization and raise revenue—saving DoD money.
   - TRICARE is a flawed program that is out of step with healthcare trends.
     - It is focused on purchasing procedures, with few tools to promote health outcomes, manage utilization, coordinate care, or control costs.
     - Pass through (government bears risk) contracting fails to incentivize contractors to manage care and improve health outcomes.
     - Five-year, winner-take-all contracts are cumbersome, uncompetitive, and hinder the infusion of new ideas from the private sector.
     - Result is poor beneficiary experience (e.g., poor choice/networks) at high cost.
     - Raising cost shares or tweaking the TRICARE contracts cannot fix this problem.
   - TRICARE should be based on purchasing a benefit (not procedures) for an individual with a risk-bearing contract.
     - The healthcare sector knows how to administer a health benefit to maximize outcomes while controlling cost—DoD should use this expertise, not shun it.
     - Annual (evergreen) contracts should be used to ensure timely adaption of new innovations as they are introduced in the rapidly evolving healthcare sector.
     - Contracts should shift financial risks and provide flexibility to incentivize contractors to use state of the art business practices in delivering the benefit.
   - Cost shares are only a part of this discussion; they are a tool, but only one of many.
2. TRICARE reform can be used to improve medical readiness, breaking the historic cycle of letting medical readiness atrophy when DoD returns to a peacetime focus following war.
   - A tremendous deployed medical capability was built during the wars, but the MHS does not have the needed case mix and volume of workload in military hospitals to sustain it.
   - Congress can leverage TRICARE reform to help prevent the loss of this capability.
3. TRICARE reform is an opportunity to reform the MHS—improving efficiency and incentives.
   - MHS is a complex interweaving set of missions, delivery systems, benefits, and funding.
   - It involves duplicative management layers and fails to incentivize unity of effort on the key system-wide outcomes of readiness, high-quality benefit delivery, and cost control.
   - TRICARE reform, with a readiness focus, could begin the process of transitioning the MHS into a more streamlined system incentivized to focus on outcomes.

TRICARE reform is not simply increasing beneficiary cost-shares

For much of the last 10 years, TRICARE reform has largely been defined by the Department of Defense (DoD) as increasing cost-shares for beneficiaries; this would reduce utilization of healthcare services and raise revenue, reducing the cost to DoD of providing the healthcare benefit. As the Military Compensation and Retirement Modernization Commission (MCRMC) report pointed out, this narrative is, at best, incomplete. The TRICARE program is structurally flawed, and the result is poor performance at high cost. Its poor performance can be observed for many attributes other than cost-shares (e.g., choice and access). These limitations in the TRICARE benefit are largely driven by structural flaws in the design of the program. TRICARE reform is not simply raising beneficiary cost-shares; it is an opportunity to address these structural flaws to improve choice and access while controlling costs.

This framing of the debate is important. When TRICARE reform is defined as raising cost-shares, it creates a clear winner (DoD) and loser (beneficiaries who are paying more for the same quality of benefit). When TRICARE reform is understood to be modernizing a poorly performing program, it focuses discussion on solutions that leave many beneficiaries better off while simultaneously saving DoD money. The debate is no longer about whether to harm beneficiaries to help DoD, it is about how best to modernize the purchase and administration of healthcare to benefit everyone. Cost-shares can be an element of reform, but they are not the only element, and beneficiaries can be rewarded with better choice and access in return for higher cost-shares.

Structural Flaws in the Design of the TRICARE Program

In the late 1980s, as the Cold War was ending, DoD's limited method of purchasing healthcare was the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), used primarily for recruiters and others located far from military hospitals. By the 1990s, as large-scale post-Cold War rationalization of DoD infrastructure began, it had become clear that DoD healthcare was going to have to shift to a more integrated system with greater reliance on private sector care. The dominant method for purchasing care in the private sector was fee-for-service (FFS), in which doctors and other healthcare providers are paid for each service or procedure performed. FFS purchasing was also a simple approach for a system focused on purchasing wraparound or overflow care to augment its in-house facilities in select markets and situations in which it could not deliver all care itself. In this environment, the limited CHAMPUS system was transformed into the much larger TRICARE system, which today comprises three geographic regions that purchase community care through pass-through (i.e., no substantive risk transfer) five-year FFS contracts, one per region. The initial contracts (called T1) were built on pass-through FFS purchasing of care, but did allow some limited use of alternative methods for purchasing care, risk sharing between the government and the regional contractor, and contractor provision of ancillary services such as augmenting staff in military hospitals.

DoD is now on a third round of contracts (T3) and is currently in the process of contracting for T4. Two particular trends that have occurred since TRICARE's inception are important to highlight for understanding the structural flaws in the TRICARE program. The first is the movement away from FFS purchasing of healthcare in both the private and public sectors. The primary alternative to FFS when TRICARE was established was the staff model health maintenance organization (HMO). The two methods formed opposing poles, with various private sector insurers and other market participants ranging along the continuum between these poles. Modern healthcare no longer fits into this framework. There are very few market participants at these poles and the continuum between them has been replaced by intense competition in a wide-ranging space of alternative value-based purchasing

(VBP) methods. The healthcare sector discovered that pass-through FFS contracting provided poor (and sometimes perverse) incentives for utilization management, care coordination, and promotion of health outcomes—in short, it was not a sustainable business model. FFS purchasing remains an element of an overall strategy for purchasing healthcare, but its use as the only method in a non-risk-bearing contract with a contractor has greatly diminished. FFS coupled with no risk transfer to the contractor is a poor program design. In the public sector, the traditional FFS Medicare (of which TRICARE is a variant) has already seen one-third of beneficiaries migrate to Medicare Advantage (risk-based plans) and the Administration has set targets to have 30 percent of individual Medicare payments made through alternative (non-FFS) methods by 2016 and 50 percent by 2018. The second important trend is that, although TRICARE started out with contracts that promoted a broader focus than just pass-through FFS purchasing of healthcare, over three generations of contracts TRICARE devolved to just that. While the healthcare sector has moved away from that model, TRICARE has narrowed to little else.

This history helps identify some of the key flaws in the design of the TRICARE program:

1. **TRICARE contracting is based on pass-through (non-risk bearing) contracting for procedures instead of purchasing a benefit for an individual with a risk-bearing contract:** TRICARE should not be built on the purchase of individual procedures or visits; it should be built on the purchase of a benefit for the individual or family. This is essential for ensuring that care is coordinated, utilization is managed, and health outcomes are promoted—the key outcomes of interest. In addition, the purchase of this benefit must transfer risk to the contractor. The healthcare sector is rapidly evolving, and a focus of a reformed TRICARE should be on the incentives being provided to the contractors to adopt and further innovate in their use of these VBP tools to promote the key outcomes of interest. Insurance carriers focus on these problems every day and are professional managers of healthcare. DoD should leverage their expertise and put it to work on behalf of military beneficiaries.
2. **TRICARE cost control strategies are based on costs per procedures instead of the total cost for the value received**: One unfortunate impact of pass-through FFS contracting is that it focuses attention on per-procedure costs while distracting attention from, and providing few tools to manage, utilization and total cost. DoD's system is anchored in its use of Medicare reimbursement rates for procedures, and TRICARE often contracts for procedures at 20 percent or more below commercial rates. This has become an overriding focus in DoD and a primary measure by which reform alternatives are evaluated (i.e., a key evaluation criterion is often whether it raises per-procedure rates). FFS models, however, incentivize increased utilization that may not be clinically necessary, and in DoD, utilization rates are 30–40 percent higher than demographically similar comparison groups. Despite paying less per procedure, DoD pays more in total per beneficiary.

   The healthcare sector is focused on total cost and the value received for the amount paid. To take a common example (taken specifically from interviews conducted in Alexandria, Louisiana), a particular market may have several orthopedic surgeons performing total knee replacements. The best surgeons may charge higher rates for the surgery (there is higher demand for their services) but may also have lower costs for the entire episode of care (driven by lower failure rates, quicker healing rates, shorter physical therapy requirements, etc.). Private insurers will observe this difference and be willing to pay the higher surgical rate, incentivizing their patients to use the more expensive surgeons. This cannot be done in the TRICARE system; regardless of health outcomes and total cost, the surgeons with the lowest per-procedure cost will be the

only ones allowed. The focus on procedure rates drives other perverse results as well, e.g., narrow networks and poor access.

3. **TRICARE contracts are long-lived and winner-take-all instead of competitive evergreen contracts**: TRICARE uses winner-take-all (one successful contractor per region) five-year (often extended) contracts. The process by which TRICARE's contracts are awarded is complicated, prolonged, and characterized by protests and delays, increasing TRICARE's costs. More importantly, the lack of competition and multi-year duration of contracts limits TRICARE's ability to innovate and keep pace with healthcare trends and advances. Most other public sector healthcare programs use competitive, annual (sometimes known as evergreen) contracts, e.g., Medicare Part C, Medicare Part D, and Federal Employees Health Benefits Program (FEHBP). Large, multi-year, winner-take-all contracts can appear simple at first and may be attractive for this reason, but TRICARE experience demonstrates otherwise.

These challenges are fundamental to the design of the current TRICARE program. Minor tweaks of the program such as retaining the five-year, winner-take-all pass through structure but directing VBP instead of FFS purchasing will not substantively change the result. Each of the structural flaws should be addressed as part of TRICARE reform and the flaws are interconnected—fixing one element without the others can leave the program performing just as poorly as it currently does.

Implications of TRICARE Program Flaws

The structural flaws of the TRICARE program design cause poor performance in many areas. From the perspective of healthcare experience to the beneficiary, the flaws cause limitations on choice and access. From the perspective of DoD and the taxpayer, the flaws cause unnecessary overutilization and high costs.

The most important attribute to beneficiaries in benefit design is choice. Families and individuals in different stages of life (e.g., child-bearing years versus retirement years) and with different situations (e.g., higher income versus lower income, married versus single, and healthy versus infirm) have different healthcare wants and needs. Providing choice among a variety of plan options allows beneficiaries to select the plan that best suits their needs, trade off added benefits against the associated premium increases, and take ownership of their healthcare experience. In a study on employer-sponsored insurance, it was found that the value placed on choice by beneficiaries equated to 16 percent of their employer-provided healthcare subsidies.[1] Choice is the most important attribute because it is the one that empowers beneficiaries to correct deficiencies in other attributes—with choice, the beneficiary can simply walk away from the plan (or provider) that isn't meeting their expectations and choose another.

Providing choice among plans also has significant value in program design and management. It corrects the winner-take-all structural flaw identified above. Under a centrally directed program design (a uniform benefit), the central authority (DoD, in accordance with statutory direction, in the case of TRICARE) designs the healthcare plan and dictates its terms to beneficiaries. Under a program designed

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[1] Leemore Dafny, Kate Ho, and Mauricio Varela, "Let Them Have Choice: Gains from Shifting Away from Employer-Sponsored Health Insurance and Toward an Individual Exchange," *American Economic Journal: Economic Policy* 5, no. 1 (2013): 33, 56.

around beneficiary choice among multiple plans, competition between the plans is created. To survive in the marketplace, contractors/carriers have to attract beneficiaries to their plan (and away from competing plans). This means that the plans have to focus carefully on designing options that are attractive to beneficiaries and provide the services beneficiaries want. It also means that they have to be price competitive, so they have to offer those desired services as cheaply as possible. Instead of having a central authority dictate to beneficiaries regardless of their preferences, a program design based on choice harnesses beneficiary preferences to improve program performance. The Office of Personnel Management (OPM) stated to the MCRMC that this competition among plans drove a one percent reduction in premium growth in the FEHBP compared to similar employer sponsor premium growth in recent years. TRICARE has experienced average cost growth several percentage points above civilian healthcare.

For most DoD beneficiaries, there are two health plan options: TRICARE Prime and the combined TRICARE Extra (network) and Standard (non-network) plan. To understand choices available to other beneficiary groups, one simple comparison group is federal civilians. Table 1 compares the plan choices available to military beneficiaries in three markets compared to the choices available to the federal civilian workforce in those markets.

Table 1. Plan Choices for Military Beneficiaries Compared to Federal Civilians

Market Area	Military Beneficiaries	Federal Civilians
Las Vegas, NV	2	19
Pensacola, FL	2	18
Leesville, LA	2	16

Another key attribute is the size of the provider network available to the beneficiary. A regular concern raised by military beneficiaries is that TRICARE has limited networks. Table 2 provides a comparison between the civilian providers available to military beneficiaries in three geographic markets compared to the networks available to federal civilians in those markets for two FEHBP plans, the Government Employees Health Association (GEHA) plan and the Blue Cross and Blue Shield (BCBS) plans. Two of these markets (Fayetteville and San Diego) have military treatment facilities (MTFs) in them that expand the pool of available providers for the subset of military beneficiaries enrolled in Prime to the MTF, but even for this subset of beneficiaries, the list of available providers is dwarfed by the plans available to federal civilians.

Table 2. Provider Networks for Military Beneficiaries Compared to Federal Civilians

Market Area	Specialty	TRICARE	GEHA	BCBS
Fayetteville, NC 28310 (Fort Bragg)	Family Practice	64	123	148
	OB/GYN	28	86	111
	Orthopedic Surgery	19	43	163
Phoenix, AZ 85004	Family Practice	94	158	124
	OB/GYN	114	126	138
	Orthopedic Surgery	84	111	108
San Diego, CA 92136	Family Practice	111	149	149
	OB/GYN	53	93	78
	Orthopedic Surgery	90	142	130

Source: Sarah K. Burns, “Network Analysis Methodology,” Power Point presentation, March 3, 2015.

It is important to note that the "narrow networks" of the TRICARE program are different from the trend in civilian healthcare being used to control costs. The narrow network options in civilian healthcare are focused on the best value providers. The Aetna Aexcel Specialist Performance Network provides a good example. Aetna considers this its "Tier 1" network, and it is narrower than their traditional network. Beneficiaries get reduced cost shares for using providers in this network. The network is developed in accordance with Aetna's Aexcel Performance Network Designation Measurement Methodology.[2] The designation process is conducted every two years for a provider and is based on four criteria: volume, clinical performance, efficiency, and network adequacy. Table 3 illustrates selected clinical performance measures used by Aetna.

Table 3. Aetna Aexcel Clinical Selected Performance Measures

Measure	Description	Specialty Attribution
30 Day Readmission Rate – Management Physician	This measure calculates the percentage of acute care inpatient hospitalizations followed by a subsequent acute care inpatient hospitalization within 30 days of the discharge date of the first hospitalization. This measure excludes readmissions that would have been expected based on the clinical nature of the case.	All specialties included in Aexcel.
Adverse Event Rate/Acute Inpatient Hospitalization – Managing Physician	This measure calculates the percentage of acute care inpatient hospitalizations that include an identified undesirable (adverse) event during the hospitalization.	All specialties included in Aexcel.
Adverse Event Rate – Outpatient Procedure	This measure calculates, for members having selected outpatient procedures, the frequency of an adverse event within the 30 days after the procedure.	Gastroenterology, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Plastic Surgery, Surgery, Urology
Asthma: Use of Appropriate Medication	This measure calculates the percentage of members age 5 to 64 who were identified as having persistent asthma and receiving appropriately prescribed medication.	Otolaryngology

In contrast, the TRICARE network is based almost exclusively on per-procedure cost. TRICARE is a strictly FFS program design that bases its procedure rates on Medicare procedure pricing. A major determinant of network designation for TRICARE is the willingness of the provider to accept a procedure rate below Medicare rates. In other words, the TRICARE network is limited to those providers in a market willing to take the lowest rates for their services. Although basic standards of licensure and credentialing are maintained, there is little room for consideration of health outcomes similar to that described in Table 3 for Aetna's Aexcel program.

This creates a contrast between Aetna's definition of a narrow network option and TRICARE's narrow networks. Aetna's narrow network is built upon the providers offering the best value, whereas

[2] Aetna *Performance Network Designation Measurement Methodology*, 2016.

TRICARE's narrow network is based on the providers that accept the lowest rate. This difference in perspective is driven by the fact that the healthcare sector is focused on total cost and the value received for the amount paid. An example of this was provided above about an orthopedic surgeon in Alexandria, Louisiana. That market has several orthopedic surgeons performing total knee replacements. The surgeon widely-regarded as the best surgeon in the area can charge higher rates for the surgery (there is higher demand for their services), but generally experiences lower costs for the entire episode of care (because of lower failure rates, quicker healing rates, shorter physical therapy requirements, etc.). Private insurers observe this difference and are willing to pay the higher surgical rate, incentivizing their patients to use the more expensive surgeon. But this cannot be done in the TRICARE system; regardless of health outcomes and total cost, the surgeons with the lowest per procedure cost will be the only ones allowed in the TRICARE network. The surgeon discussed in Alexandria was not a TRICARE network orthopedic surgeon.

It is also important to note that this is not a criticism of the TRICARE contractors. They are presumably doing the best job they can, given the contracts awarded to them and the constraints of the system within which they operate. In fact, the incumbent contractors have experience outside of TRICARE, where they are making great strides in raising quality while controlling costs—but they are prohibited from applying those innovations to TRICARE.

From the perspective of DoD and the taxpayer, the problems created by the flawed design of the TRICARE program include high utilization and cost. Healthcare utilization necessary for good health outcomes is a good thing, but the TRICARE program design encourages utilization for which the benefits do not exceed the costs. One simple comparison is to use DoD's data on utilization rates for inpatient care for military beneficiaries compared to the utilization for a demographically similar group of people in civilian healthcare plans. This comparison can be made for beneficiaries in TRICARE Prime with a comparison group in civilian HMO plans and, separately, beneficiaries in TRICARE Standard and Extra with a comparison group in civilian Preferred Provider Organization (PPO) plans. Figure 1 provides these comparisons for 2014, showing that, for Prime enrollees, utilization is 68 percent higher than the comparison group and, for Standard and Extra users, utilization is 133 percent higher than the comparison group. [3]

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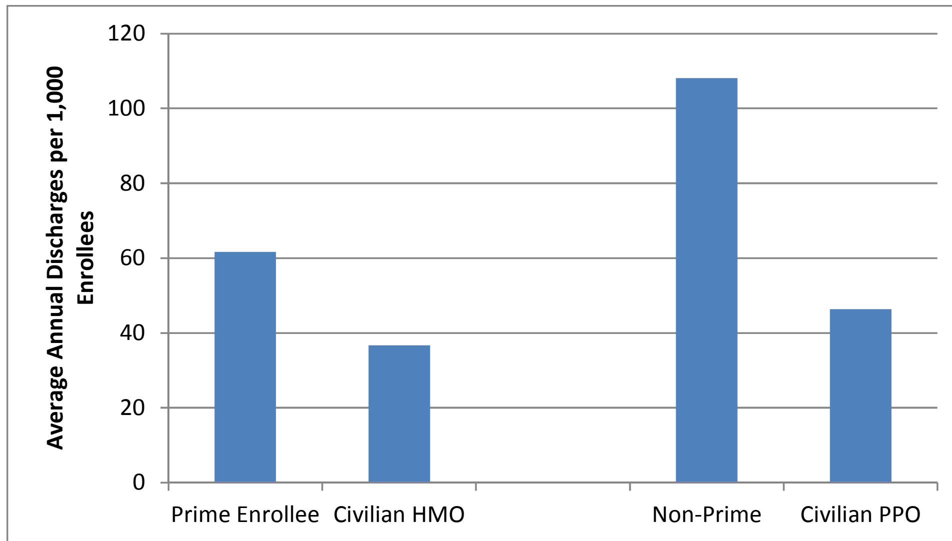
[3] For outpatient utilization, Prime enrollees had more encounters than their demographic equivalents in HMO plans, while Standard and Extra users had fewer encounters than their demographic equivalents in PPO plans.

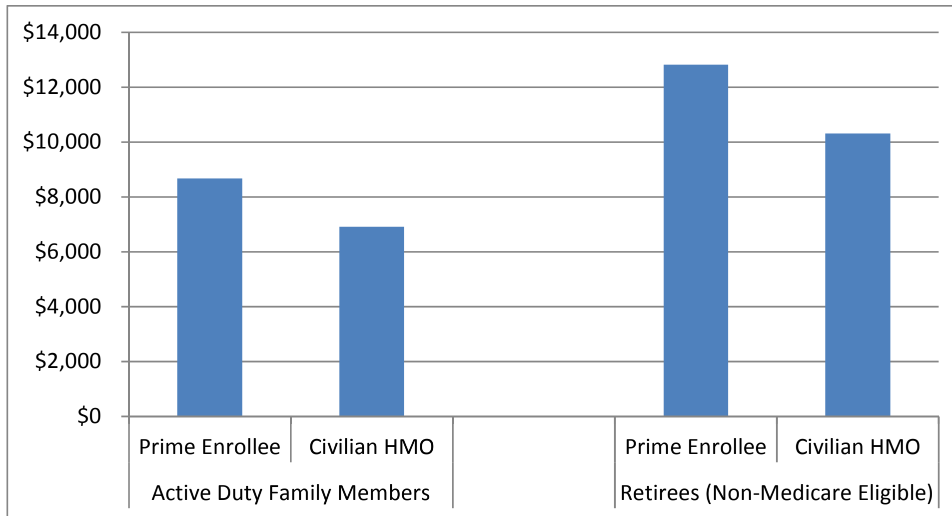


Source: 2015 TRICARE Evaluation Report, pp. 78 and 79.

Figure 1. 2014 Utilization Comparison for Inpatient Care

For cost, one simple exercise is to compare DoD's data on the cost of healthcare utilization for TRICARE beneficiaries to the utilization for a demographically similar group of people in civilian health care plans. Figure 2 provides this comparison for active duty family members and, separately, for non-Medicare eligible retirees. The comparison is for Prime enrollees compared to a demographically similar group enrolled in a civilian HMO plan. [4]

[4] Results are similar for active duty family members who are Standard and Extra users. Retirees who are Standard and Extra users show a smaller difference in cost.



Source: 2015 TRICARE Evaluation Report, p. 95.

Figure 2. 2014 Cost per Family Comparison

The lower cost shares of the TRICARE program (primarily in TRICARE Prime) are only one factor driving these differences in utilization and cost. The nature of the TRICARE contracts incentivizes increased utilization—the lack of risk transfer along with the lack of flexibility provided to the contractors means that they have little incentive or ability to manage utilization for cost control. In testimony to the MCRMC, Dr. Gail Wilensky provided cost estimates of the potential savings from TRICARE reform, and only about half of the estimated savings was from changes to cost shares; the rest was from non-cost-share improvements to program design.[5]

Some Basic Principles for TRICARE Reform

The healthcare sector is adopting VBP methods to promote health outcomes, improve utilization management, better coordinate care, and control cost. TRICARE reform should be informed by these trends but, as stated above, simply directing VBP within the existing TRICARE program structure is not modernization of the program.

Every transaction is different and a clean and definitive taxonomy of VBP methods has not yet emerged. Some of the more common examples include:

1. **Capitation**: Imposing risk (partial or full) on delivery system to incentivize improved management of the provider and greater coordination of care.
2. **Bundling**: A set of providers agreeing to collectively accept a pre-determined payment equal to the expected cost for a given set of healthcare services.
3. **Accountable Care Organizations (ACOs)**: Integration of providers to achieve joint accountability for achieving quality improvements and reductions in the rate of spending growth.
4. **Pay-for-Performance**: Linking payment to measures of quality and care.

My fellow panelists are experts in these trends and will likely speak in much more detail about them.

[5] Gail Wilensky, "Alternative Strategies to Influence Cost and Utilization," PowerPoint presentation, April 9, 2014.

These VBP purchasing trends are primarily focused on the market between the contractor and the delivery system. DoD's direct influence is on the transactions between the employer (DoD) and the contractor. This is where DoD has the opportunity to incentivize efficient purchasing practices. Figure 3 illustrates the structure of the market within which the TRICARE contracts operate. As stated above, the market between DoD and the contractor is currently composed of five-year, winner-take-all contracts with little substantive risk-bearing by the contractor, and largely restricts the contractor to FFS purchasing methods in the downstream market between the contractor and the delivery system.

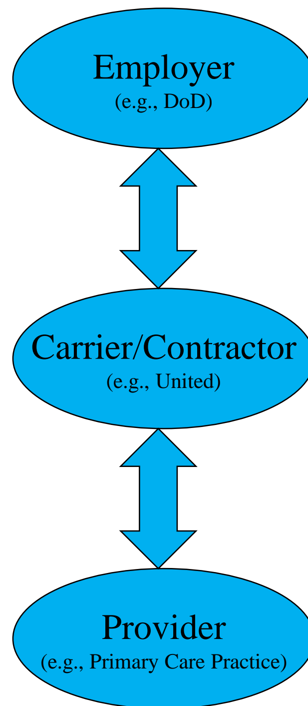


Figure 3. Healthcare Markets and Contracting Environment

Three basic principles for the design of the TRICARE program in the relationship between DoD and the contractor that will determine how well the program will ultimately perform are:

- **Competitiveness:** This is a key to incentivizing carriers/contractors to focus on the preferences of beneficiaries.
- **Risk-bearing:** This is a key to incentivizing the carriers/contractors to aggressively manage cost and improve outcomes.
- **Flexibility:** This allows the risk-bearing carrier/contractor to compete and evolve their suite of tools as the market changes and conditions vary across markets.

As discussed above, choice is the key attribute of benefit design because it empowers the beneficiary to correct other problems with the benefit, and it creates a simpler program design that is self-correcting and monitoring—a plan that fails to offer what the beneficiaries want is driven from the market, with no DoD intervention required. The ultimate objective of TRICARE reform should be to ensure that beneficiaries have multiple options in each market from which they can choose. Most large federal healthcare programs are based on this principle (e.g., Medicare Part C, Medicare Part D, and FEHBP). These existing government programs provide examples of how TRICARE reform could accomplish this.

Per the MCRMC recommendation, TRICARE reform could provide a cafeteria-style menu of plan options in each market (similar to FEHBP). The MCRMC recommended moving at once to this alternative to avoid paying overhead for two distinct program designs and for improved incentives, but an alternative would be to make FEHBP enrollment an option for beneficiaries in select markets to begin a process of transitioning to a competitive framework. Alternatively, the Medicare Part C approach could be used and, in fact, is already used in six areas of the country with the United States Family Health Plan (USFHP), although this is the only allowed alternative in these markets, which does not allow for full competition. In this framework, TRICARE reform could include the expansion of additional fully capitated (i.e., risk-bearing) plans in individual markets. These additional plans could be delivery system-based like USFHP or could be expanded to allow traditional insurance carriers to provide options within markets. Like Medicare Part C and USFHP, specific plan attributes could be regulated (e.g., covered services and cost-share structures).

Risk-bearing contracting incentivizes the contractor to focus on cost. In traditional contracting, forcing the contractor to bear risk raises cost, and self-insuring (DoD bearing the risk) lowers average cost. That logic applies when all else is held constant. But in healthcare contracting, the biggest factors in determining the contractor's costs are the incentives placed on them to manage care and control cost. In other words, exposing the contractor to risk can actually lower the cost of delivering the benefit.

With competitive, risk-bearing contracts, the contractor can then be given the flexibility (in both VBP methods and, within established bounds, in benefit design) to deliver the benefit. In the current TRICARE design, DoD's strategy for ensuring contractor performance is to micromanage the contractor (e.g., directing them to use FFS contracting only). With competitive, risk-bearing contracts, the choice behavior of beneficiaries ensures contract performance, and the contractors can be left free to innovate and adapt to market conditions as they vary geographically and evolve over time.

Different reform options (e.g., making FEHBP available or adding capitated plans in each market) can be evaluated based on the degree to which they advance these principles. The more the three principles are advanced, the higher the quality of the benefit will be and the greater the savings to DoD. Figure 4 illustrates how these different reform options can be evaluated.

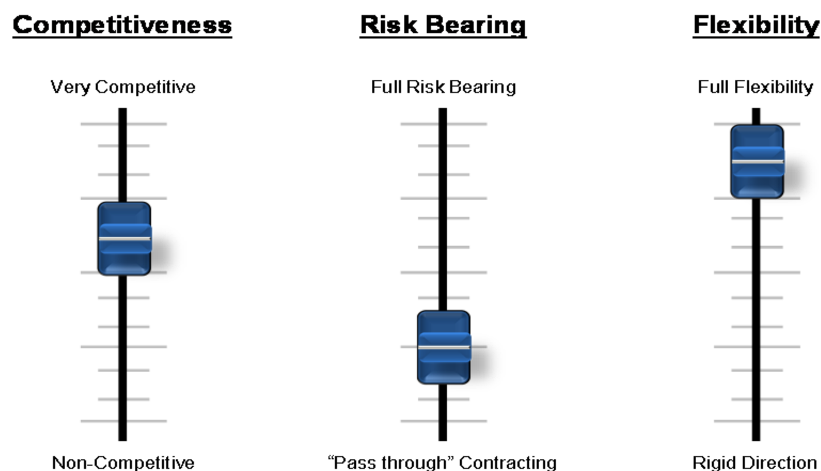


Figure 4. Three Elements of TRICARE Reform

Although they are not the primary focus of this testimony, it is also important to briefly mention two additional populations of TRICARE beneficiaries: Reserve Component members and Medicare-eligible retirees. Members of the Guard and Reserve eligible for TRICARE benefits experience many of the same challenges with choice and access as active duty family members and retirees, but the impact of TRICARE's design flaws can be even more severe. Many Guard and Reserve members live further from military bases than the active and retiree populations, where TRICARE networks can be even less developed, driving even more significant choice and access problems. TRICARE reform is an opportunity to improve the health benefit provided to Guard and Reserve members.

Medicare-eligible retirees using the TRICARE for Life (TFL) program present a unique opportunity for TRICARE reform if Congress decides to include that population. TFL beneficiaries' healthcare costs are paid both by Medicare and DoD. Their costs tend to be very high and, for similar reasons to the discussion above, there is little coordination of their care for promotion of health outcomes and cost control. This is even more important for this older population because of the higher complexity of their care as they age. But neither DoD nor Medicare are fully in control of this situation or incentivized to deal with the problem because of the division of the costs. Significant opportunities are likely available to improve care while reducing costs by introducing capitated (e.g., Medicare Advantage-like) plans for Medicare-eligible retirees.

TRICARE reform can be used to improve medical readiness

The readiness of the military medical force to conduct its deployed mission should be a primary consideration in TRICARE reform. The military medical community built an incredible level of capability and readiness during the wars in Iraq and Afghanistan. But the MHS in its current form cannot maintain that capability, and it will atrophy as attention returns to peacetime beneficiary care delivery. The MCRMC found that "[r]esearch reveals a long history of the military medical community needing to refocus its capabilities at the start of wars, after concentrating during peacetime on beneficiary health care."[6] TRICARE reform should be leveraged to break this historic cycle and help ensure we start the next war with the most ready medical force possible.

<u>*Medical readiness challenges*</u>

The military medical mission of DoD is to provide a medical force ready to deploy for the provision of medical care. The MHS combines this operational mission with the delivery of beneficiary healthcare by using the military medical force during peacetime to deliver a portion of beneficiary healthcare in house in military hospitals. Although there have been long standing challenges with this model,[7] it arose in a period of time when medicine was less specialized than today and theater medical care included significantly longer-term care than is currently practiced.

The challenges with the model have grown over time as there have been changes to warfighting and the practice of medicine. Examples of these changes include:[8]

- Moving to a more decentralized, mobile battlefield—which drives a smaller medical footprint in operational theaters;
- Evacuating casualties early—which is better for the casualties and reduces risk to forces in theater;
- Greater specialization in the profession of medicine; and
- Shifts in medical workload on the modern battlefield, e.g., more immediate and less definitive care, different wound and injury patterns as body armor and weapons evolve, and earlier transportation of patients than would have occurred in earlier conflicts.

These changes in warfighting have implications for medical force requirements and readiness. The shift to more mobile operational forces with a lighter theater footprint produced a shift in the required operational medical capabilities—medical forces may be often forward-deployed with operational units and provide more immediate complex medical care. There is also less definitive care, as the historic model of extensive in-theater care, practiced in World War II and Korea, has been replaced with rapid evacuation to hospitals outside the operational theater. Lower in-theater holding times decrease the

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6 MCRMC report, citing Bernard Rostker, *Providing for the Casualties of War: The American Experience Through World War II* (Santa Monica, CA: RAND, 2013) and General Accounting Office, *Medical Readiness: Efforts Are Underway for DOD Training in Civilian Trauma Centers*, GAO/NSIAD-98-75 (Washington, DC: GAO, April 1998), 12.

7 Rostker, *Providing for the Casualties of War.*

8 This material is drawn from John E. Whitley, Brandon Gould, Nancy Huff, and Linda Wu, "Medical Total Force Management," IDA Paper P-5047 (Alexandria, VA: Institute for Defense Analyses, May 2014). See that paper for a more detailed discussion.

deployable medical requirement. However, a lower theater medical requirement that is deployed further forward and provides more immediate care limits the opportunities for substitution across specialties, increasing demand for highly specialized medical personnel. A hospital with a requirement for ten surgeons can more readily substitute two obstetricians alongside eight surgeons than a forward-deployed surgical team with a requirement for two surgeons; there is not enough overlap in staff for the requirement to be met with one surgeon and one obstetrician. In summary, the degree of overlap between the operational mission and the beneficiary care mission has eroded over time, causing the readiness requirement to become increasingly focused on more complex immediate life-saving care that is seldom seen in peacetime military hospitals.

As the MCRMC report identified, “[r]elying on existing MTF medical cases as a training platform for combat care can result in a misalignment of military medical personnel compared to the medical requirements necessary to support the operational missions.”[9] Table 4 illustrates this misalignment in the early years of Operation Iraqi Freedom and Operation Enduring Freedom. The Service-identified medical force requirements were for operationally required specialties such as surgeons and anesthesiologists, but the actual executed force was composed of specialties more in demand for beneficiary healthcare.

Table 4. Misalignment of Medical Force

Specialty	FY 2004 Military Requirement	FY 2004 Executed End-Strength	End-Strength Minus Requirement
Pediatrics	286	645	359
Obstetrics	208	387	179
Anesthesiology	318	259	-59
General Surgery	685	443	-242

Source: “DoD Force Health Protection and Readiness—A Summary of the Medical Readiness Review, 2004–2007,” June 2008.

Although this misalignment improved during the wars,[10] more recent research has still found misalignment:

> Today the U.S. Army has less than a dozen prehospital physician specialists and about the same number of trauma surgeons on active duty. By comparison, the Army has roughly the same number of radiation oncologists and nearly three times the number of pediatric psychiatrists and orthodontists. This is largely because medical specialty allocations are based on traditional peacetime beneficiary care needs. Refocusing on the wartime needs could populate key institutional and operational billets with a critical

9 *MCRMC Final Report*, 64–65.

10 John E. Whitley et al., “Medical Total Force Management.”

> mass of trained prehospital and trauma specialists and drive further advances in battlefield care during peacetime.[11]

These alignment issues are a significant readiness challenge. During the wars, the medical force experienced uneven deployment rates, with the operationally required specialties having relatively high deployment rates and experiencing potential force stress while other specialties hardly deployed.[12] Interviews conducted with Combatant Command (COCOM) staffs by the MCRMC found challenges in sourcing operational medical requirements.

The reason for this misalignment is that the military hospital system does not have sufficient workload to support the operationally required specialties—so the military medical force migrates to beneficiary care specialties. The challenge is compounded by the fact that even when the right specialties are employed, the workload is still not ideal for preparing the medical personnel for their deployed mission. As the MCRMC report identified,

> [s]urgeons overwhelmingly cited vascular surgeries as the most difficult cases [they faced in combat], followed by neurosurgical procedures, burns, and thoracic cases. Surgeons reported they had difficulty with these procedures because they had not performed them in nondeployed clinical settings, and because there had been a substantial time lapse since they had last treated these types of injuries.[13]

GAO found "[s]ince most military treatment facilities provide health care to active-duty personnel and their beneficiaries and do not receive trauma patients, military medical personnel cannot maintain combat trauma skills during peacetime by working in these facilities."[14]

To illustrate this challenge, Table 5 provides the top ten inpatient diagnoses in the military hospital system in 2015 and Table 6 provides the top ten inpatient diagnoses in Iraq in 2007.

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[11] R. L. Mabry and R. DeLorenzo, "Challenges to Improving Combat Casualty Survival on the Battlefield," *Military Medicine* 179, No. 5 (May 2014): 477–82.

[12] Whitley et al., "Medical Total Force Management."

[13] *MCRMC Final Report*, 63–64, citing Joshua A. Tyler et al., "Combat Readiness for the Modern Military Surgeon: Data from a Decade of Combat Operations," *Journal of Trauma and Acute Care Surgery* 73, No. 2 (2012): S64–S70, http://www.ncbi.nlm.nih.gov/pubmed/22847097.

[14] General Accounting Office, "*Medical Readiness: Efforts Are Underway*," 12.

Table 5. Top Ten Inpatient Diagnoses in Military Hospitals, 2015

Clinical Classification Software (CCS) Grouping	Dispositions
Newborn Care	48,490
Normal Pregnancy and Delivery	46,947
Complications of Pregnancy	45,427
Unclassified Care	44,281
High Blood Pressure	43,701
Perinatal Conditions	37,695
Screening/History of Mental Health and Substance Abuse	36,403
Complications of Pregnancy - Care of Mother	32,708
Disorders of Lipid Metabolism	31,305
Nutritional, Endocrine, and Metabolic Disorders	27,887

Table 6. Top Ten Inpatient Diagnoses in Iraq, 2007

Clinical Classification Software (CCS) Grouping	Dispositions
Open wounds of head, neck, and trunk	3,488
Open wounds of extremities	2,650
Other injuries and conditions due to external causes	2,274
Fracture of lower limb	992
Nonspecific chest pain	986
Abdominal pain	683
Crushing injury or internal injury	589
Other specified and classifiable external causes of injury	571
Fracture of upper limb	563
Skin and subcutaneous tissue infections	543

These tables understate the challenge because, in addition to having different preponderances of diagnoses, even when the diagnoses overlap, they differ in their severity. For example, open wounds of the head, neck, and trunk are seen in military hospitals, but the cases seen in Iraq were over twice as severe (as measured by probability of death) as those seen in military hospitals. For open wounds of extremities, the Iraq cases were almost four times as severe as the military hospital cases.

Leveraging TRICARE reform to improve medical readiness

The MCRMC recommended a comprehensive solution to deal with these challenges that included:

- Providing new tools and access to new beneficiary populations to attract a medical workload of the required case mix and complexity to maintain medical readiness;
- Developing a new concept of "Essential Medical Capabilities" (EMCs) and integrating EMCs into readiness reporting tools and processes to increase measurement, transparency, and accountability for medical readiness;
- Realigning funding to improve incentives for maintaining medical readiness; and

- Establishment of new command structures and changes to Joint Staff structures to focus leadership attention on medical readiness and provide authority to ensure it is a priority.

The third element of the recommendation (realigning funding) will be discussed in the final section of this testimony under MHS reform. The fourth element of the recommendation (new command structures) is beyond the scope of this testimony on TRICARE reform (although streamlining management structures is mentioned in the final section on MHS reform). But the first two tie integrally into TRICARE reform.

The first element (new tools and populations) is directly relevant to TRICARE reform. In its simplest form, there are only two solutions to the readiness problem—patients providing the right case mix have to be brought to the military medical personnel for training or the military medical personnel have to be taken to the right patients. Our allies have wrestled with this problem already. The United Kingdom closed its military hospitals and moved its military personnel to civilian hospitals with more volume and better case mix. Germany still has military hospitals but has opened them to civilian patients. We are big enough to follow an "all of the above" approach. TRICARE reform provides an opportunity to begin this transformation.

DoD currently has few tools for attracting care into MTFs. Compounding this problem is that the few tools available, e.g., cancelling civilian primary care managers, brings the wrong care into MTFs—it brings routine and primary care into MTFs when what is needed is a case mix that includes complex surgery and trauma. Redesigned TRICARE contracts can include provisions to channel certain types of care into MTFs. The most rigorous example of this is provided by the MCRMC recommendation that the MTFs be reimbursed for the care they deliver and allowed to differ the prices of procedures to attract the right case mix. Although using price is the most powerful way to channel care, there are also more limited options that can be used. One straightforward method would be to include performance measures in the redesigned TRICARE contracts that include channeling of care and are tied to payments. Another would be to make the MTFs available to the contractors for free or reduced-price care for the required case mix.

TRICARE reform also provides opportunities for getting military medical personnel out to civilian settings that provide a better case mix. One direct approach would be if delivery systems become TRICARE contractors. This would increase DoD's ties to these healthcare providers and expand opportunities for placement of military personnel into civilian facilities.

The EMC recommendation of the MCRMC is focused on improving transparency and accountability for readiness. An important reason for directing DoD to implement the EMC framework as part of TRICARE reform is that it will give Congress information on readiness that can be used to evaluate readiness trends, providing Congress an opportunity to provide oversight and further direction if DoD begins to let readiness lapse during peacetime.

TRICARE reform is an opportunity for MHS reform

The MHS is a complex interweaving of missions (beneficiary care and readiness), delivery systems (MTFs and purchased care), benefits, and funding sources. It involves duplicative management layers and fails to incentivize unity of effort on the key outcomes of maintaining readiness, providing a high-quality benefit, and controlling cost. TRICARE reform provides Congress an opportunity to reform the entire MHS to create a more streamlined system that incentivizes a focus on these outcomes.

As stated in the previous section, the MHS combines two primary missions. The operational or readiness mission—inherently military and performed with military personnel—is to provide medical care during wartime or other deployed contingencies. The MHS also supports the beneficiary care mission, which does not have to be performed with military personnel or hospitals; about two-thirds of this mission is delivered by purchasing private sector care. The reason that some of the beneficiary care mission is performed in house is because it has historically been used as the training venue for the military medical personnel supporting the operational mission. These personnel have had dual assignments; they are assigned to a military hospital to provide beneficiary healthcare in-house and are also assigned (directly in their assignment orders or indirectly by forming a pool of available personnel) to an operational platform such as a theater hospital or a surgical company. Figure 5 illustrates this dual-mission framework.

Figure 5. Dual-Mission Framework of MHS

The dual mission framework dominates the organization of the MHS. Military personnel are required for the operational mission, but used for the beneficiary care mission. MTFs are justified as readiness training platforms for the operational mission, but used for the beneficiary care mission. A large portion of the funding for both missions is provided in a consolidated appropriation (the Defense Health Program (DHP)). Leadership are responsible for both missions, but may have their evaluations dominated by beneficiary care considerations.

Specific challenges created by the structure of the MHS include:

- Conflicting missions for the military hospital system: The "direct care" system of MTFs exists to support the readiness of the military medical force, but is generally used for beneficiary healthcare with little readiness focus in its day-to-day operations.
- Lack of transparency in funding: The line Service leadership, Office of Secretary of Defense (OSD), and Congress cannot identify how much is spent on beneficiary care and how much is spent on readiness, reducing effectiveness of resource allocation decision making and accountability.
- Lack of focus on readiness (discussed in the previous section).

Conflicting Missions for the Military Hospital System

The MHS direct care system includes over 50 inpatient military hospitals and over 300 outpatient clinics. The purpose of having a DoD-run MTF system is for it to serve as the clinical skill maintenance platform for the operationally required military medical force. But its day-to-day workload and operations are almost exclusively focused on beneficiary healthcare. This puts military hospital commanders in an almost impossible situation and creates a climate of confusion within the MHS that affects everything from staffing decisions to major investment decision making. Some simple examples of the confusion include:

- Emergency Medicine: Emergency medicine physicians were one of the specialties with the highest deployment rates to Iraq and Afghanistan.[15] But touring a typical MTF reveals that the Emergency Department is often staffed with contracted civilian physicians while pediatrics and obstetrics are mostly military.
- Outsourcing Surgical Workload: Surgical workload is generally more relevant for maintaining the clinical skills of the military medical force, but MTFs generally outsource this workload to private sector care while retaining in house more care in areas like obstetrics. Table 7 illustrates this for three DoD markets, and it can be seen that obstetric workload is generally kept in house at over twice the rate of surgical workload.

Table 7. Surgical versus Obstetric Workload Mix

	Surgical Workload			Obstetric Workload		
Market	**Military Hospital**	**Purchased Care**	**% Military**	**Military Hospital**	**Purchased Care**	**% Military**
Las Vegas, NV	1,315	4,749	22%	582	651	47%
Pensacola, FL	657	5,403	11%	368	888	29%
Ft. Polk, LA	192	203	49%	409	24	94%

[15] Whitley et al., "Medical Total Force Management." See Figure 2, p. 32.

- Graduate Medical Education (GME) Programs: The direct care system supports DoD-run GME or residency programs, but there is little attempt to focus these on operationally required specialty areas like trauma, surgery, emergency medicine, etc.

This confusion is an important driver of excessive costs in the MHS. The direct care system is expensive to operate, with the average military hospital costing about 50 percent more to deliver inpatient care than it would cost to purchase that care in the local markets at current payment rates.[16] Table 8 illustrates this cost difference for three markets in which DoD operates.[17]

Table 8. Military Hospital Inpatient Costs versus Private Sector Care

Market	Inpatient Military Hospital Cost	Cost of Purchasing Care in Local Market
Nellis Air Force Base, NV	$34,624,144	$29,909,465
Naval Air Station Pensacola, FL	$31,180,755	$13,747,915
Ft. Polk, LA	$14,727,029	$6,604,439

Source: Lurie, "Comparing the Costs of Military Treatment Facilities with Private Sector Care."

When the direct care system is successfully delivering its readiness mission, i.e., providing readiness training for the military medical force, this excess cost may be justified—a necessary cost for ensuring our warfighting capability. But in cases in which the direct care system is not succeeding in its mission, this excess cost is a source of inefficiency in the MHS—wasting taxpayer resources that could be used to increase compensation or reallocated elsewhere in the defense budget for mission delivery.

DoD recently conducted an extensive internal study of the direct care system, finding that many military hospitals did not have economically viable inpatient capacity and should be right-sized to the workload they can effectively support. This study, the *MHS Modernization Study*, was not able to directly assess the degree to which military hospitals were meeting the readiness mission and instead focused on workload in major specialty areas. Although imperfect, this workload analysis provided a valuable "lower bound" measure for the readiness question—a hospital that does not have enough workload in a particular specialty area to maintain an economically viable capacity does not have enough workload to maintain the readiness of military providers in that area.

The *MHS Modernization Study* also ended up providing important evidence on why the direct care system is so costly. It found very low levels of productivity across specialties and across facilities in the direct care system. The study began by obtaining civilian provider workload by specialty. It then compared DoD providers in the direct care system to these civilian distributions, finding that providers in the DoD direct care system were generally below the tenth percentile of civilian providers in workload produced per year. Table 9 provides data DoD shared with the MCRMC from the *MHS Modernization Study*. For four specialties, it provides the average workload—as measured by relative value units (RVUs), which provide a measure of intensity-adjusted workload—of providers within MTFs as a

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[16] See Philip Lurie, "Comparing the Costs of Military Treatment Facilities with Private Sector Care," IDA P-5262 (Alexandria, VA: Institute for Defense Analyses, 2016) (forthcoming). See Table 6, p. 27.

[17] Inpatient care is used for illustrative purposes. Comparisons of outpatient care yield similar results.

percentage of the civilian median. Since percentage of median is not a commonly used statistical measure of a distribution, Table 10 converts it to a percentile of civilian providers under the assumption that the civilian distribution is approximated by a gamma distribution. As can be seen, the average providers in MTFs operate at significantly lower workload levels than civilian providers.

Table 9. Average Workload in Ten Largest DoD Markets as Percentage of Civilian Median

Market	Emergency Medicine	Family Medicine	General Surgery	Orthopedic Surgery
National Capital Area	31%	43%	18%	26%
Tidewater, VA	49%	36%	22%	41%
San Diego, CA	60%	48%	34%	35%
Puget Sound, WA	33%	27%	36%	43%
San Antonio, TX	28%	54%	39%	41%
Bragg/Pope, NC	21%	30%	36%	39%
Ft. Hood, TX	47%	15%	37%	37%
Colorado Springs, CO	35%	39%	28%	36%
Hawaii	34%	22%	39%	41%
Jacksonville, FL	59%	55%	41%	29%

Table 10. Average Workload in Ten Largest DoD Markets as a Percentile of Civilian Providers

Market	Emergency Medicine	Family Medicine	General Surgery	Orthopedic Surgery
National Capital Area	1%	2%	0%	0%
Tidewater, VA	8%	1%	0%	3%
San Diego, CA	15%	3%	2%	2%
Puget Sound, WA	1%	0%	2%	4%
San Antonio, TX	1%	6%	3%	3%
Bragg/Pope, NC	0%	0%	2%	2%
Ft. Hood, TX	6%	0%	2%	2%
Colorado Springs, CO	2%	1%	1%	2%
Hawaii	2%	0%	3%	3%
Jacksonville, FL	15%	7%	3%	1%

Very low productivity is an important proximate cause of the high cost of the direct care system, but to understand how to reform the system, it is necessary to identify root causes for the inefficiency. Likely root causes include the following factors:

- **Direct care system run as military units**: Military hospitals are led and administered as military units and justified by their readiness mission. But in actual practice they are almost exclusively focused on beneficiary healthcare delivery. This misalignment of leadership and administrative structure with actual operations and functions means that the wealth of experience in civilian healthcare at running effective and efficient hospitals is not applied to military hospitals. Professional business management of these large complex businesses is not used.

- **Military hospitals don't have to directly compete for business**: Private hospitals that cannot manage themselves effectively lose business and either get better or go bankrupt. Military hospitals are protected from this disciplining force of markets by simply being given bigger budgets to account for their inefficiency and attempts are made to coerce beneficiaries that choose to go elsewhere to return to the system.[18]
- **Military hospitals given a budget for inputs instead of paid for outputs**: Funding large DoD support missions that approximate commercial activities with direct appropriation for their inputs instead of on a reimbursable basis for outputs produced is a funding mechanism long ago abandoned in most other large support mission areas, e.g., logistics, financial services, and information services. But military hospitals still receive their funding according to the inputs they consume instead of the outputs they produce.
- **Military hospitals overuse military personnel for non-operational specialties**: As discussed in the readiness section above, the military medical force is overstaffed in beneficiary care areas like pediatrics and obstetrics. Military personnel are generally more costly than civilian personnel, so the use of military personnel not required to be in uniform for delivery of beneficiary care is inefficient and drives higher costs.

Lack of Transparency in Funding

The root causes listed above all relate, at least in part, to a lack of transparency in the funding structure of the MHS. The DHP appropriation provides almost all of the funding for beneficiary healthcare and a large portion of the funding for the readiness of the medical force in a single, undifferentiated amount. The impact of this on resource allocation decision making includes:

- Healthcare benefits and medical readiness are put into a direct tradespace with each other, competing for resources against each other. Decision makers are forced to make tradeoffs between increasing medical readiness at the expense of the health benefit or vice versa, with no direct considerations of readiness more broadly or compensation more broadly.
- Medical readiness is removed from the tradespace of other readiness functions within each Service so that the Services cannot easily create a balanced readiness plan across medical and non-medical functions.
- Healthcare benefits are removed from the tradespace of compensation instruments (e.g., base pay, special and incentive pays, retirement, and quality of life programs) so that compensation cannot be easily understood and balanced across the range of compensation instruments.

This distortion of decision making trade-off spaces is compounded by the lack of visibility and transparency available to the Service line leadership, OSD, and Congress. This reduces incentives to manage healthcare. For example, a Service Chief has little incentive to actively manage the healthcare portfolio because doing so incurs the political cost of managing a three star officer within the Service, but fails to yield a benefit because the savings are within an OSD account and unlikely to be given to the Service.

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[18] See, for example, Amy Bushatz, "Families Forced to Give Up Civilian Health Care," June 27, 2014. http://www.military.com/daily-news/2014/06/27/some-families-forced-to-give-up-civilian-health-care.html

Some Basic Principles for MHS Reform

The overarching principle that should guide MHS reform is increasing transparency between and separation of the operational mission and beneficiary healthcare. Complete separation may not be obtainable (at least in the short-run), but an increased degree of separation will improve focus on readiness and allow for more rational management of the direct care system and benefit. Incremental steps in which this further separation can be achieved include reforms to funding, MTF management, and benefit administration.

One of the biggest challenges mentioned above is the commingling of funding for readiness and beneficiary healthcare. TRICARE reform provides an opportunity to advance the principle of clearly identifying the costs of the health benefit and separately budget for them in the appropriate way, i.e., in the military personnel budget account. Purchasing a benefit in a risk-bearing contract provides a clear measurement of benefit cost. In addition, the budgets for many of the overhead functions are spread across DHP accounts, and TRICARE reform would centralize them in the contracts. Placing this funding into the MILPERS appropriation account would then separate it from readiness and provide it in the appropriate location for its function, increasing transparency of the defense budget and improving incentives for compensation management within DoD.

With the health benefit costs separately identified and accounted for in the military personnel accounts, the remaining funding in the unified medical program is readiness-related (or inefficiency) and can then be placed in Service readiness accounts. In addition to increasing transparency, this removes the artificial tradespace created between medical readiness and benefits. It puts medical readiness into a tradespace with other readiness investments so that efficient decision making can occur. Basic principles of funding and budgetary account structure include:

- Costs of personnel benefits should reside in MILPERS budget accounts.
- Costs of readiness should appear in Service readiness-related budget accounts.
- MTFs and other activities replicating commercial activities should be funded according to outputs produced, not inputs consumed.
- Costs should be recognized in the budget when the obligation is incurred.

The high costs of the MTF system are a major driver of costs in delivering the healthcare benefit. Ultimately, DoD will likely have to rationalize a large number of its current facilities and focus its direct care investments on the core MTFs that can become readiness training platforms, creating truly world class capabilities in the things DoD should be focused on, such as trauma, burns, and brain injuries. TRICARE reform provides an opportunity to begin reform of the MHS in ways that will improve incentives for more effective and efficient MTF management. Three basic principles that should be applied include:

- **MTFs should be professionally managed**: Organizing and operating MTFs like military units when the majority of the daily operations are the provision of beneficiary healthcare with little difference from civilian hospitals is inefficient. It fails to take advantage of the expertise resident in the healthcare sector at running medical facilities. A simple incremental step that could be taken as part of TRICARE reform is directing that a group of MTFs be placed under civilian management (e.g., as government owned, contractor operated (GOCO) facilities) on a trial basis. One limited example of professional management being used in the management of the direct care system already is two outpatient clinics in the national capital region and by most accounts

this is considered very successful. If military hospitals are to be maintained, they should be led and operated by business professionals.

- **MTF management layers should be reduced**: The direct care system is actually four separate systems, three systems separately managed by each Military Department and one additional system (the National Capital Region) managed by the Defense Health Agency (DHA). This duplication of overhead functions is another driver of high costs. Consolidating oversight of the MTFs in conjunction with the introduction of professional management per the item above would likely reduce cost. If MTFs were managed separately from the readiness function (e.g., the MTFs are consolidated within the DHA), this would also help improve the focus on medical readiness within the Services by removing the conflicting priority they face.
- **MTFs should be funded according to outputs instead of inputs**: The MTFs are the last large support function in DoD that are still funded with a budget for inputs instead of for the outputs they produce. One way to achieve this is by placing them in a revolving fund. Another, overlapping, option would be to GOCO the MTFs with the contractor's payments based on healthcare delivered.
- **MTFs should face competition**: Competition is the ultimate disciplining force in markets, and lack of competition is a primary driver of inefficiency. Ensuring that the MTFs face competition for beneficiaries and care delivery is the most important structural reform for focusing them on improvement. It should also be noted that this does not threaten readiness. The care the MTFs are primarily delivering and that would be at risk of moving to the private sector if the MTFs failed to effectively compete is obstetrics and other areas of beneficiary care that are not readiness related. In areas where DoD has invested in developing world-class readiness capabilities (e.g., burns and orthopedic rehabilitation in San Antonio), DoD should have no trouble competing for patients.
- **MTFs that cannot succeed in their mission should be downsized or closed**: Many MTFs today are not providing sufficient workload of the required case mix to support their readiness mission. For many of these, there is no reasonable or practical way to get the right workload into the facility and, thus, the facility will not be able to succeed in its mission. These facilities should be transitioned to clinics or closed.

Finally, TRICARE reform offers an opportunity to improve benefit administration. Purchasing a benefit for an individual or family in a risk-bearing contract implies transferring many of the benefit administration functions currently conducted in-house by DoD to professionals from the private sector that perform these functions for a living. This will have the likely effect of streamlining MHS bureaucracy and lowering the costs of these administrative functions. TRICARE reform could go further and affirmatively transfer responsibility for benefit administration to the personnel management and compensation community. Providing a healthcare benefit is not an inherently military function, and evidence shows that it becomes a competitor for medical readiness when combined in the MHS. Clearly defining healthcare benefits as a compensation issue to organize and manage them as such within the DoD would be an important MHS reform.