Dr. Stephen C. Joseph and Dr. Kenneth W. Kizer

DoD and VA Joint Efforts -- Of Mutual Benefit

On June 29th, a significant event in the history of the Departments of Defense (DoD) and Veterans Affairs (VA) joint efforts took place. Not with a lot of fanfare but with a sense of common purpose, the Assistant Secretary of Defense (Health Affairs) and the Under Secretary for Health, Department of Veterans Affairs signed a memorandum of understanding. Under this agreement and for the first time, the DoD is making VA Medical Centers eligible to be reimbursed for care under Defense's new TRICARE program.

This newest effort, operating through Defense's TRICARE program, has the potential of giving DoD's CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) beneficiaries another choice, in addition to military and private sector providers serving them today. While beneficiaries can continue to use military treatment facilities and private sector providers, many may have one more option -- a VA Medical Center. Beneficiaries who prefer care from a VA Medical Center can choose to use one, as long as it meets the requirements of TRICARE and its managed care support contractors. Costs to beneficiaries will be the same as when they use a private sector provider.

With this new agreement, VA Medical Centers wishing to participate in TRICARE would apply to DoD's regional managed care support contractors and must meet the cost, access and quality criteria used by the contractors. Those VA Medical Centers striking agreements with TRICARE contractors would then be available to DoD's beneficiaries in the same way that private sector providers will be available. While this agreement does not automatically treat VA Medical Centers as TRICARE providers, for the first time it makes them eligible to apply through managed care support contractors to become TRICARE providers. This new effort with the VA will be phased in over the next two years.

This VA and DoD agreement, in the form of a memorandum of understanding, and the mechanisms it creates become the primary vehicle for VA Medical Centers wanting to provide care to DoD's CHAMPUS beneficiaries.

Why is this agreement so important? Very simply, it exemplifies the way that DoD and VA are approaching joint efforts now and into the future. The key is that VA and DoD joint efforts be of mutual benefit.

In this case, VA Medical Centers will benefit because they have the opportunity to attract not only more paying patients, but more paying patients who have much in common with the veterans already being served, yet present a more diverse set of medical conditions. At the same time DoD and its beneficiaries will benefit as beneficiaries have another option for receiving health care, in addition to Military Treatment Facilities and private sector health care providers. The more attractive, in terms of cost, access and quality, that VA Medical Centers become for DoD beneficiaries, the more DoD beneficiaries will choose VA Medical Centers.

DoD and VA are working cooperatively at all levels. The above agreement is just one example of cooperation at the highest level between the Under Secretary for Health in Veterans Affairs and the Assistant Secretary of Defense (Health Affairs). Many joint efforts have been operational for some time and many of those efforts reflect cooperation at all levels of both agencies. More joint efforts, as are described below, will come in the future.

Dr. Custis, in his June 1995 column in U.S. Medicine, points out that many joint efforts are already in place. For years, VA and DoD at all levels have engaged in a wide range of sharing arrangements built on the principle of joint efforts for mutual benefit. For example, VA and DoD have collaborated in research projects, such as traumatic brain injury, post-traumatic stress disorder, alcoholism, AIDS, spinal cord injury and sensory impairments and, most recently, illnesses that may be related to service in the Persian Gulf War.

In the area of sharing health care resources, Public Law 97-174, "The Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act," was specifically enacted in 1982, to promote cost-effective use of federal health care resources by minimizing duplication and underuse of health care resources while benefiting both VA and DoD beneficiaries. As a result of this legislation, the Economy Act (Title 31 USC) and administrative action, the two Departments have shared health care resources.

Since the 1982 legislation, facility-level resources sharing agreements, ranging from major medical and surgical services, laundry, blood, and laboratory services, to unusual specialty care services, have shown continued annual growth. In 1984, there were a combined total of 102 VA and DoD facilities with sharing agreements. By 1995, that number had more than doubled to 284. In two years between FY1992 and FY1994 shared services increased from slightly over 3,000 to more than 4000.

In addition to the hospital-to-hospital agreements, many education and training agreements exist between VA Medical Centers and military medical reserve component units. Under a typical agreement, a VA Medical Center provides space for weekend training drills. In return, reserve personnel serve as supplemental staff. For example, the VA Medical Center in Tampa, Florida, has training agreements with Army, Navy, and Air Force Reserve units. An average of 25 reservists train at Tampa on weekends while simultaneously supplementing VA staff. Reservists training at Tampa include physicians, nurses, and medical technicians. Training occurs in medical services, shock trauma, aeromedical evacuation, disaster preparedness, surgery, psychiatry, pathology and administrative services.

Also, for several years, the two Departments have pursued a program of joint venture construction and operation of hospitals. The first of these was the facility at Kirtland AFB in Albuquerque, New Mexico. In this joint undertaking, the Air Force is operating a wing in the Albuquerque VA Medical Center. The Air Force also operates a comprehensive health care clinic and dental clinic adjacent to the hospital. Through this sharing effort, the Air Force avoided approximately $10 million in construction costs and is producing additional savings through multiple sharing agreements within the facility.

Another joint effort is the new 129-bed hospital at Nellis AFB. The $75 million FY 1990 Federal Medical Facility which replaced the old Nellis Air Force Base Hospital opened in July 1994. The Air Force is operating the facility, but VA is staffing its 52 beds. The Air Force and the VA estimate annual savings of almost $24 million and approximately $7 million respectively.

At the same time, VA and DoD are working together on other potential joint ventures at sites such as Travis AFB (California), Elmendorf AFB (Alaska), East Central Florida, Fort Sill (Oklahoma), Fort Bliss (Texas) and Tripler Army Medical Center (Hawaii).

How are we approaching future joint efforts? DoD and VA have decided the best strategy is to link our two networks wherever their is substantial mutual benefit. We are aggressively fielding that strategy and will continue to do so for the foreseeable future.

While this may appear obvious, not everyone seems to agree that the criteria should be mutual benefit. However, to do otherwise causes problems. There are problems if VA and DoD were to pursue joint efforts when one of the agencies and its beneficiaries may see no benefit. There are greater problems with pursuing joint efforts when both agencies and their beneficiaries may see no benefit. Neither of these latter two criteria is in the best interest of our beneficiaries or taxpayers. Instead, since there are more than enough opportunities offering mutual benefit to DoD, VA and their beneficiaries, we apply the mutual benefit criteria and focus on those opportunities meeting that criteria.

To provide a better idea of what that portends for the future, it is helpful to cite another recent agreement reached between DoD and VA. Under this informal agreement, the two agencies laid out those areas which offer the best possibility for mutual benefit. As can be seen from the following list, future joint VA and DoD efforts cover significant territory.

PRIORITIES FOR JOINT DOD/VA EFFORTS

Health systems development

- DoD and VA will develop and operate shared facilities and joint venture sites.
- DoD and VA will carry out joint planning on medical facility construction that impacts both DoD and VA beneficiaries.

Readiness

- DoD and VA will carry out joint planning for and the development of:
  - The flow of patients (injured active duty troops) within the continental U.S.
  - Specialized care for specific types of conflict-related injuries, e.g. spinal cord injury, traumatic brain injury.

Provision of Care

- DoD and VA will sign the appropriate agreements and take the necessary steps which enable the provision of medical care to DoD beneficiaries by VA Medical Centers under the CHAMPUS managed care support contracts. (Signed June 29, 1995)
- DoD and VA will work together to develop arrangements whereby DoD beneficiaries can receive appropriate specialized care (e.g. head trauma, rehabilitative care) from VA Medical Centers.

Post-deployment epidemiology, research, evaluation and care

- DoD and VA will continue their close cooperation on post-deployment (including Persian Gulf Illness) research, epidemiology, and clinical care.

Technology/Information Systems

- DoD and VA will develop joint and coordinated efforts with regard to a) developing telemedicine as a means to improve readiness and patient care, b) improving interoperability and interconnectivity between VA and DoD services, and c) providing information management support for joint ventures.

With this as our joint strategy for the future, let us return to the issue of how our two networks should be linked. In this, we share the caution put forward by Dr. Custis. As he stated, "this is not to propose a single monolithic Federal Medical Service." On that point we concur. So what are we not only proposing, but actually implementing?

Paralleling what the DoD is doing within its own Military Health Services System, the VA and DoD are moving forward jointly on the development of their respective health care systems. Each agency is heavily involved in reinventing their health care systems.

For VA, that means the activation of the Veterans Integrated Service Networks (VISNs) along with a sweeping reorganization of the VA headquarters. Beginning in October of this year, the structure of both the field and headquarters of the Veterans Health Administration (VHA) will be significantly changed, In the field, the former four-region structure will give way to 22 smaller, more cohesive VISNs. These networks were chosen according to existing patient referral patterns, and groupings of facilities and patients sufficient to provide comprehensive services. The facility directors will collaborate with the VISN director to provide cost-effective care and improved patient services, and to pool resources to expand access of care to veterans. Each VISN will be headed by a director, who will have operational control, strategic planning and budgetary responsibility over all the patient care facilities and service providers in the network.

Commensurate with this decentralization of day-to-day decision making authority will be a re-engineering of VA headquarters, which will shift its focus to systemwide issues and the important function of governance of the system. This reorganization of VHA will improve efficiency, boost accountability and enhance customer service.

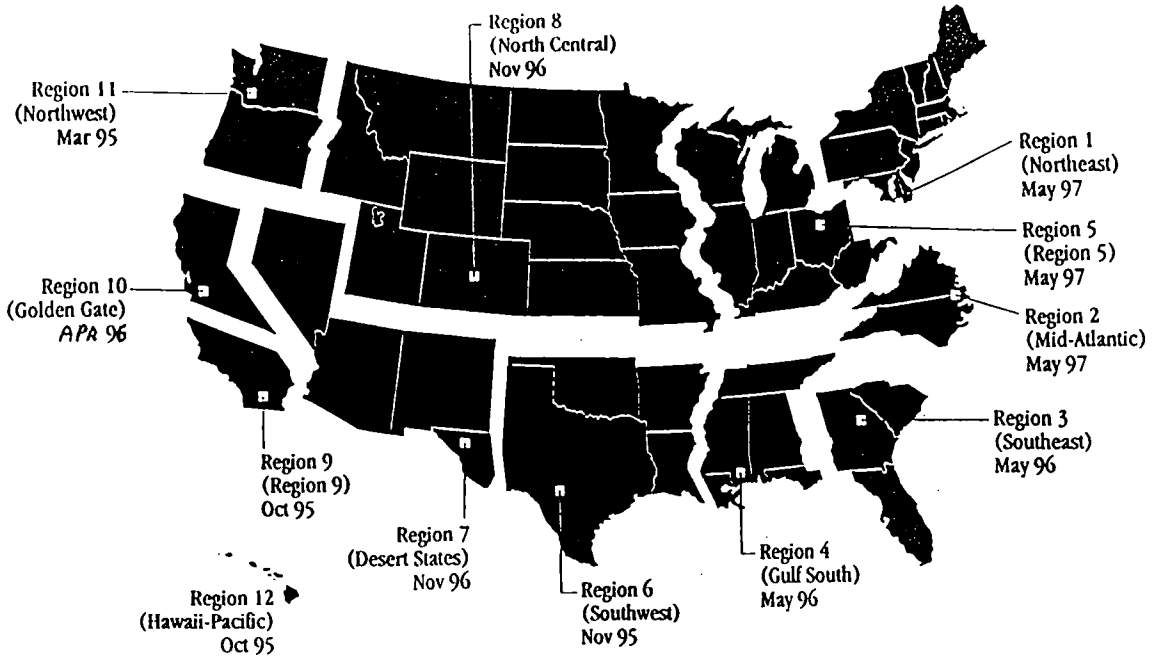
For DoD, reinvention, in part, means the development of TRICARE. TRICARE is DoD's regionalized managed care system, serving active duty troops and their families and retirees and their families. Moving away from the traditional workload based system, TRICARE moves toward capitation. Under capitation, the system will focus on funding Military Treatment Facilities and managed care support contractors per enrolled beneficiary rather than on the number of visits or bed days. With that change, the incentives change for military providers and the private sector, as managed through the managed care support contractors. Providers will need to be concerned about the total care of a beneficiary, not just for this current episode and not just for current year, but potentially for year after year. Preventing illness and injury becomes very important. Beneficiary satisfaction with access, cost and quality become more important. More cost-effective management of the Military Health Services System and its Military Treatment Facilities becomes more important.

DoD made a fundamental decision as to how to bring about this change. This change was to result from a joint effort of the Army, Navy, Air Force and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)). "Joint" is the key term. After all, that is how DoD carries out its military missions. That is how DoD is carrying out its health mission. Under the joint approach, the Military Services and the OASD(HA) retain their respective missions, identities, cultures, and strengths. Whenever it is to their mutual benefit, as is the case with the new TRICARE program, they join forces and work side-by-side.

So it is with the VA and DoD. They have joined forces and are working side-by-side. Both retain their identity and culture. Both play to their strengths. Both carry out their assigned mission. Both must be responsive to the American taxpayer. Both ensure that their respective beneficiaries are cared for.

Again, joint efforts are best built on the principle of maximizing mutual benefit. For DoD, VA and their beneficiaries, joint efforts have been and will continue to be of mutual benefit.

TRICARE will be coming to your Region in the near future. Beneficiaries in the States of Washington and Oregon now have the opportunity to participate in TRICARE. If you live in another state, check the map at right for the start-up date in your Region.



TRICARE

Quality Care for the Uniformed Services

Welcome to TRICARE!

TRICARE is the new Department of Defense health care pro-gram. We have combined the best features of the Army, Navy, Air Force and CHAMPUS health care programs to create the TRICARE triple option - health care plan.

This brochure is designed to give you a general overview of the three TRICARE options from which you can choose— Prime, Extra and Standard. However, it is not intended as a complete description of coverage.

OPTION I

TRICARE Prime–*beneficiaries may enroll in TRICARE Prime which features:*

- ★ Lower Costs—*no annual deductible and reduced copayments.*
- ★ Improved Access—*enrollees have timely access to health care services. This includes a twenty-four hour Health Care Finder who can assist you in quickly obtaining health care services.*
- ★ Enhanced Benefits—*preventive health care benefits to keep you and your family healthy.*
- ★ Less Paperwork—*usually there are no claim forms to file.*
- ★ A Primary Care Manager—*you select a Primary Care Manager (PCM) who will provide and/or coordinate all your health care needs.*
- ★ Point of Service—*the TRICARE Prime benefit also includes a new point of service option which allows enrollees to retain freedom of choice to use providers without an authorization from the PCM, but at significantly higher cost sharing than TRICARE Standard.*
- ★ A Quality Provider Network—*access to a network of quality doctors, hospitals and other health care providers usually near your home or work.*
- ★ No Balance Billing—*TRICARE network providers accept the negotiated rates and your copayment as payment in full.*

How can you enroll in TRICARE Prime.

Active duty personnel are automatically enrolled in TRICARE Prime and will continue to receive most of their care in military treatment facilities. Active duty family members, retirees and their family members and survivors can easily enroll in TRICARE Prime, for a minimum of one year, by filling out an application and agreeing to receive their health care services coordinated through their TRICARE Primary Care Manager.

MEDICARE-ELIGIBLE BENEFICIARIES

At this time, Medicare-eligible beneficiaries will not be able to enroll in TRICARE Prime. If the Department of Defense is permitted by Congress to obtain reimbursement from the Medicare system for providing health care services to Medicare patients, we will then offer Prime enrollment. Until then, Medicare beneficiaries will be able to use military treatment facilities on a space-available basis. In addition, Medicare beneficiaries will be able to use the Health Care Finders who can provide them a list of health care providers in their area who accept Medicare payments.

Do you have to pay any enrollment fees or copayments in TRICARE Prime.

Active duty personnel and their family members pay no enrollment fees. Retirees, their family members and survivors will be required to pay an enrollment fee (see costs chart). If a non-active duty patient receives care from the civil-ian network they will pay a small copayment (see costs chart).

OPTION 2

TRICARE Extra - if you choose not to enroll in TRICARE Prime, you may still take advantage of cost savings by using the TRICARE Extra option. The TRICARE Extra option offers the following features when you use our TRICARE Network Providers:

- ★ Lower Costs—*once the deductible has been met, your cost share will be 5% less than TRICARE Standard rates. You will also be able to take advantage of lower negotiated network provider rates.*
- ★ No Enrollment Fees—*unlike TRICARE Prime you do not have to enroll, but you can still use the network health care providers on a case-by-case basis.*
- ★ Less Paperwork—*usually there are no claim forms to file.*
- ★ Choice—*you have the choice of selecting your own health care provider.*
- ★ No Balance Billing—*network providers accept the negotiated rates and your cost share, after the appropriate deductible is met, as payment in full.*

OPTION 3

TRICARE Standard has been traditionally known as Standard CHAMPUS. This option offers our beneficiaries maximum choice in choosing their health care provider, but at the highest out-of-pocket cost to the beneficiary.

- ★ Flexibility—*you can use Standard or take advantage of cost-saving benefits under TRICARE Extra.*
- ★ Continuity of Care—*no need to change providers if you have established a relationship with a TRICARE Standard provider.*
- ★ No Enrollment—*with your military I.D. card, you can easily enjoy the benefits of TRICARE Standard or Extra.*

TRICARE Triple Option Costs

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductibles:			
• *Families of E-4 and Below*	*$0*	*$50/$100*	*$50/$100*
• *Other Active Duty Families*	*$0*	*$150/$300*	*$150/$300*
• *Retirees and Others*	*$0*	*$150/$300*	*$150/$300*
Annual Enrollment Fees:			
• *Families of E-4 and Below*	*$0*	*$0*	*$0*
• *Other Active Duty Families*	*$0*	*$0*	*$0*
• *Retirees and Others*	*$230/$460*	*$0*	*$0*
Civilian Provider Copays:			
• *Families of E-4 and Below*	*$6*	*15% of negotiated fees*	*20% of allowed charges*
• *Other Active Duty Families*	*$12*	*15% of negotiated fees*	*20% of allowed charges*
• *Retirees and Others*	*$12*	*20% of negotiated fees*	*25% of allowed charges*
Civilian Inpatient Cost Shares:			
• *Families of E-4 and Below*	*$11 per day*	*$9.50 per day*	*$9.50 per day*
• *Other Active Duty Families*	*$11 per day*	*$9.50 per day*	*$9.50 per day*
• *Retirees and Others*	*$11 per day*	*$250 per day plus 20% of negotiated prof fees*	*$323 per day plus 25% of allowed charges*

Note: This chart does not display all cost-sharing amounts.

MEDICAL CARE FOR BENEFICIARIES IN BASE REALIGNMENT AND CLOSURE (BRAC) AREAS

BACKGROUND: The approved base realignment and closure (BRAC) lists (1988, 1991, 1993 & 1995) will result in the closure of 31 military treatment facilities (MTFs) and an additional number of health clinics in the continental United States. In the past, when an MTF closed, residual beneficiaries used either the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or Medicare for their health care needs. That no longer is the situation. With strong Congressional support for the Department of Defense (DoD) to do more for beneficiary populations affected by base closures, we have enhanced our planning and programs to specifically address their needs. DoD eligible beneficiaries remaining in areas affected by BRAC actions will be provided with alternative health care delivery options after their local MTF closes. The Department's actions to lessen the medical impact include transitional health care programs, managed care initiatives, retail pharmacy networks, a mail service pharmacy demonstration, and meetings with beneficiaries at affected BRAC sites.

CURRENT STATUS: The Military Services are charged to develop transition medical plans for their MTFs scheduled for closure. These in turn are reviewed by a joint working group at the DoD level to ensure a consistent and integrated approach to the identification of resource requirements, allocation, and access at closure sites.

Our goal is to have TRICARE, the Department's managed care program, implemented throughout the United States by 1997. This initiative provides a uniform, triple option set of benefits for eligible beneficiaries and will offer stable, comprehensive, health care coverage, improved beneficiary access and choice while containing overall DoD health care costs. Once TRICARE is implemented, the managed care support contractor will be able to develop networks of providers for those locations having a sufficient density of eligible beneficiaries. In the interim, we are including in our fiscal intermediary CHAMPUS claims processor contracts the requirement for development of preferred provider networks in BRAC areas. This will provide our beneficiaries an optional network of health care providers, reduce cost, and eliminate claims paperwork.

A retail pharmacy benefit is also included in each location where a provider network is developed. This program for CHAMPUS-eligible personnel will also be available to military Medicare-eligible beneficiaries residing within former BRAC catchment areas or those who relied upon a now closed facility for pharmacy services within twelve months of its closure.

In addition, the Department is conducting a two year mail order pharmacy demonstration project which began service on November 1, 1994. This project involves two multi-state regions that include Florida, Georgia, South Carolina, Pennsylvania, Delaware, and New Jersey. At the end of two years, a Report to the Congress is required which will evaluate the project and recommend future deployment of the program. Additionally, on September 1, 1995, mail service was extended to 12 BRAC sites. As with the retail pharmacy benefit program, the mail service pharmacy benefit is also available to Medicare-eligible beneficiaries residing within former BRAC catchment areas or those who relied upon a former facility for pharmacy services within twelve months of closure. Additional BRAC sites may be added to the mail order service contract as future closures progress.

Our BRAC Health Care Beneficiary Working Group is composed of representatives of each Military Service, Health Affairs, and an independent member appointed from among private citizens qualified to represent all personnel entitled to military health care. Since May 1993, selected members of the Working Group have visited many of the installations scheduled for closure. They have met with beneficiary organizations, local officials, Congressional representatives and their staff, base personnel, and retired personnel at each of the closure sites. Town meetings were held at each site and attendance has averaged approximately 200 - 600 people.

The group has gained valuable insight into specific health care issues and concerns affecting beneficiaries who remain after a base medical facility has closed. Information gathered during these visits will be the basis for future recommendations to the ASD (Health Affairs) and the Congress concerning health care delivery systems within affected BRAC sites.

Military Hospitals Due to Close as a result of BRAC

Installations with Inpatient Hospital Facilities

Army

Presidio of San Francisco, CA
Fort Ord, CA
Fort Devens, MA
Fort B. Harrison, IN
Fort McClellan, AL
Fitzsimons Army Medical Center, CO
Fort Lee, VA
Fort Meade, MD

Navy

NH Long Beach, CA
NH Orlando, FL
NH Philadelphia, PA
NH Oakland, CA

Air Force

Pease AFB, NH
Homestead AFB, FL
Eaker, AFB, AR
England AFB, LA
George AFB, CA
Myrtle Beach AFB, SC
Wurtsmith AFB, MI
Williams AFB, AZ
Bergstrom AFB, TX
Carswell AFB, TX
Chanute AFB, IL
Loring AFB, ME
Castle AFB, CA
Griffiss AFB, NY
K.I. Sawyer, AFB, MI
Plattsburgh AFB, NY
March AFB, CA
Reese Air Force Base, TX
McClellan AFB, CA

BY MARILYN MOON

Your Health Coverage

Q. *Can a person who is over 65 but who hasn't worked in this country buy Medicare coverage—both parts A and B?*

A. A person who is over the age of 65, a resident of this country, and either a citizen or a lawfully admitted alien who has resided here continuously for at least the past five years, may buy Medicare coverage. For Part A, the person may be required to pay the full actuarial costs of the benefits—$261 a month in 1995. People who have some credits toward Social Security eligibility (of at least 30 quarters), but who are not fully eligible can enroll at a reduced rate of $183 a month. Part B coverage is also available at the standard premium, which is $46.10 in 1995.

Q. *My wife entered a nursing home July 11 suffering from Alzheimer's disease. I arranged to pay for her stay there privately, because I was informed that neither our HMO nor Medicare would pay. The next day, however, she fell in the nursing home, was taken to a hospital for a CAT-scan and other tests. She was found to have an inoperable brain tumor. She was in the hospital three days and then returned to the nursing home July 14. She was given Risperdal and Xanax, but (on our orders) no attempt was made to deal with the tumor. Nurses and aides from the Hospice organization took over comfort care and pain management from July 29 until her death Aug. 4. I hoped Medicare would pay the nursing home bills from July 15 to July 28, but the nursing home administrator told me that would be impossible since my wife was never moved from her original general-care bed to the high-level-care section of the nursing home. Is there any way to get Medicare to pay for that two-week period?*

A. You are correct that the nursing home stay after your wife's discharge from the hospital *might* qualify as a Medicare-covered service. If it does, then it is the HMO that would need to pay the nursing home for the stay. Skilled nursing facility services are covered by Medicare if there has been a three-day prior hospitalization (not counting the discharge day). Further, a person must need daily skilled care for a problem related to the hospitalization. From your description, it is not clear whether your wife's stay fits all the requirements. If you believe her stay would meet these requirements, you should appeal to the HMO for payment. It may take considerable time for this appeal to take place. If you are denied, you have further appeal rights and about one out of three appeals are granted at the next level.

The nursing home should have given you a notice explaining whether Medicare would cover your wife's care upon her admission to the nursing home both before and after her hospitalization. This is a requirement intended to avoid confusion in cases like yours.

Q. *Can you give us information about the new military health care program called Tricare? How does it affect people who are eligible for Medicare? We were guaranteed health care through the military, but that seems to be changing.*

A. TRICARE is the term given to the Department of Defense's new nationwide managed care program intended to improve military families' access to high-quality and lower-cost care. Traditionally, the military health care system has tried to meet the needs of active duty personnel, dependents and retirees through a combination of direct access to military facilities and the CHAMPUS program—the program that uses private hospitals and doctors to serve dependents and retirees. The first priority of military facilities is to care for active duty personnel. And often that means that access to care for other qualifying beneficiaries, such as retirees, is lacking since they are treated only on a space-available basis. After a number of years of testing this new system, TRICARE was adopted as a means for reorganizing the delivery of care, and it is expected to be implemented nationwide by 1997. Implementation is beginning gradually.

This program offers a choice among three types of plans. The first is the fee-for-service CHAMPUS program, which will require the insured person to pay a considerable part of his or her health care expenses. The second option will offer discounts to insured persons if they choose from a list of participating doctors and hospitals. The third option will be an HMO-like alternative that provides comprehensive care through a network of military and civilian providers who contract to offer care. Those who enroll in this third option must do so for a year and agree to see only the network providers. Out-of-pocket costs will be the lowest in this option.

The military health system is changing in ways much like the private sector. Individuals will be encouraged to use managed care options, and they will face substantially higher deductibles and co-payments if they choose fee-for-service options. ■

Do you have questions about health care coverage? Changes are occurring in the medical marketplace, the debate over costs, quality and access to care continues, and many questions remain. The Washington Post free telephone information service can take your questions. Call POSTHASTE at 202-334-9000 on a touch-tone phone and enter category code 8500 (in Prince William County 703-690-4110).

Tricare / Mil. HCSyst

Statement By

Stephen C. Joseph, M.D., M.P.H.

Assistant Secretary of Defense for Health Affairs

Before the

Subcommittee on Civil Service

Committee on Government Reform and Oversight

United States House of Representatives

September 12, 1995

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United States House of Representatives

The Honorable Stephen C. Joseph, M.D., M.P.H.
Assistant Secretary of Defense (Health Affairs)

Stephen C. Joseph, M.D., M.P.H., was nominated by President Clinton to be Assistant Secretary of Defense for Health Affairs on November 20, 1993, and confirmed by the Senate on March 22, 1994.

As Assistant Secretary of Defense for Health Affairs (ASD(HA)), Dr. Joseph is responsible for overall supervision of the health and medical affairs of the Department of Defense (DoD). He serves as the principal staff assistant and advisor to the Secretary of Defense for all DoD health policies, programs, and activities and, subject to the direction of the Secretary of Defense, exercises oversight of all DoD health resources.

The primary mission of the ASD(HA) is to ensure the nation has available at all times a healthy fighting force supported by a combat ready health care system. The ASD(HA) is responsible for providing a cost effective, quality health benefit to active duty members, retirees, survivors, and their families. The ASD(HA) carries out the medical readiness and health care delivery responsibilities to over 8.5 million DoD beneficiaries through a 15.2 billion dollar health care system consisting of a worldwide network of 130 hospitals, over 500 medical and dental clinics, and the Department's civilian sector health benefits cost sharing program.

Dr. Joseph was born in New York City, New York on November 23, 1937. A graduate of Harvard College (1959), Dr. Joseph received his M.D. from Yale University School of Medicine (1963) and his M.P.H. from Johns Hopkins School of Hygiene and Public Health (1968). He served his internship and residency in Pediatrics at the Boston Children's Medical Center.

Prior to his appointment, Dr. Joseph served as Dean of the School of Public Health, and Professor of Public Health and Pediatrics at the University of Minnesota. He previously served as the Commissioner of Health of New York City.

Before joining the New York City Department of Health, he served as Special Coordinator for Child Health and Survival for the United Nations Children's Fund. In addition, Dr. Joseph was Chief of Pediatrics at Grenfell Regional Health Services in Newfoundland. He has also worked as a physician at Children's Hospital in Boston, at the Children's Hospital Center of the District of Columbia, and with the Agency for International Development in Central Africa and in Washington. He was a Peace Corps Physician in Nepal for two years during his five year term as a Commissioned Officer with the United States Public Health Service.

Dr. Joseph was also Director of the Neighborhood Health Centers Program at the Office of Economic Opportunity, Director of the Office of International Health Programs at the Harvard School of Public Health, and Special Assistant to the Assistant Secretary for Health and Scientific Affairs at the United States Department of Health, Education and Welfare. He has held faculty positions at Harvard University, the University of Health Sciences in Cameroon, and the Memorial University of Newfoundland.

Among his numerous awards and honors, Dr. Joseph holds the Outstanding U.S. Alumnus Award for Public Health Leadership from Johns Hopkins School of Public Health, the Harmann Biggs Award of the New York State Public Health Association, and the Public Service for Medicine Award, American College of Physicians (NY).

Dr. Joseph's professional affiliations include being an elected member of the National Academy of Sciences Institute of Medicine, and the Johns Hopkins University Society of Scholars. He is also a Fellow of the American Academy of Pediatrics and the American Public Health Association, of which latter organization he is a former Chairman of the Executive Board. He is a frequent writer and speaker on public health issues. His book, "Dragon Within the Gates: The Once and Future AIDS Epidemic," was published by Carroll and Graf in September of 1992.

He is married to Elizabeth Preble, an international health specialist, and is the father of two daughters, Denise Ellen, a computer software buyer for a Cambridge based company, and Tara Anne, a London based journalist. Dr. Joseph and Beth Preble reside in Arlington, VA.

Stephen C. Joseph House Civil Service

Mr. Chairman, Distinguished Members of the Committee, it is a privilege and my honor to appear before you today. I welcome this opportunity to present the Military Health Services System and our initiatives to cost-effectively ensure the health of our troops, our retirees and their families. Our task is unique in that we are the only U. S. health care system that goes to war. And, that is the foremost responsibility entrusted to military medicine.

I want to respond in some detail to the questions you posed, Mr. Chairman, but first I will briefly summarize my view of military medicine and the FEHBP issue at hand.

- Military medicine's primary responsibility is readiness and today it "ain't broke!"
- TRICARE is essential to readiness, a fact clearly misunderstood!
- TRICARE enhances cost-effectiveness, high quality care, and patient satisfaction.
- FEHBP is undergoing our review as an option with results due in March 1996.

Wholesale conversion of military health care to FEHBP is not a good idea. It would be disastrous to readiness and unacceptably expensive for our beneficiaries. Very important to us, and I am sure to you, it would increase the risk to the health of our troops who we send into harm's way. Furthermore, to continue the patient benefit at the same level we provide within the Military Health Services System, which we believe to be an obligation, the recent CBO report states it will cost the government an additional $3.1 billion.

Now, let me turn to details of military medicine and answer the questions posed in your letter, Mr. Chairman.

There is a single mission for the Military Health Services System. It is that:

> **We are ready to provide top quality health services, whenever and wherever needed in support of military operations, and to members of the Armed Forces, their families, and others entitled to DoD health care.**

This mission weaves together the care provided to our active duty personnel with the care provided to all other beneficiaries. These responsibilities are not separable. Separability is a misconception of some who analyze and report on the military medical system of health care delivery. To provide top quality health services we must have the means to practice professional skills, not only our physicians, but also our nurses, technicians, physician assistants, nurse clinicians, hospital corpsmen, and others who may be faced with saving the life of a wounded or seriously ill soldier, sailor, marine or airman.

To maintain professional skills means taking care of patients, sick and injured patients who need extensive evaluation and detailed lab work, patients who need bones set, patients who need delicate or restorative surgery. Uniquely critical to military medicine is the professional medical training for enlisted medics, hospital corpsmen, and independent duty corpsmen. These individuals must be able to recognize critical signs and symptoms, to administer correct life-saving

techniques, and to stabilize patients sufficiently well to await a physician. On the front lines and in ships at sea, our medics and our independent duty corpsmen are the initial, and sometimes the only, medical professionals our military men and women have to advise, counsel, treat, and indeed save them. These medics cannot gain their training anywhere, I repeat: anywhere, except in military medical facilities.

Sustaining professional skills also requires training on how to lead a convoy, command a hospital or run a hospital ship, how to set up in a field environment, how to evacuate patients and to where, what the echelons of care are and where you and your unit or ship are located, how to gain supplies and resupply, how to communicate with the next echelon, where to contact a specialist, and so much more. These are the professional military skills our medical personnel – physician and medic alike – must know in order to provide top quality health services to deployed forces. These deployments may be for any of a continuum of military operations: humanitarian support, disaster assistance, quelling civil unrest, peacekeeping operations, as well as conflict and war. Military medical personnel must be prepared today and everyday.

Military Medical System & Readiness (Includes CHAMPUS Operations and Financing)

The Military Health Services System is an extensive system with tremendous capabilities. In the President's FY 96 Budget, the military medical system seeks $15.5 billion. This includes just over $10 billion in the Defense Health Program (DHP) appropriation and $5 billion in the three military departments' military personnel appropriations.

The $10 billion DHP amount includes a little more than $6 billion for the direct care system, that is, our own military hospitals and clinics, where over 70 percent of our beneficiaries care is provided.

For the CHAMPUS program, which is also included in the $10 billion DHP, we requested almost $4 billion which includes funding for the TRICARE Managed Care Support Contracts as well as the standard fee-for-service CHAMPUS program.

The quality of care provided in military medical facilities is better than that provided in non-military medical facilities. Measures supporting this statement include higher accreditation scores from the Joint Commission on Accreditation of Healthcare Organizations, maximum licensure of physicians and dentists, and board certification of the majority of physicians.

The FY 96 Budget request includes funding for 104,500 military and 45,200 civilian health care personnel. The Military Health Services System operates 124 medical centers and hospitals and 504 ambulatory care clinics worldwide. The 8.2 million beneficiaries eligible for care in these facilities include:

* 1.7 million active duty,
* 2.4 million active duty family members,
* 1.1 million retirees under age 65,
* 1.8 million retiree family members under age 65, and

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* 1.2 million Medicare-eligible military beneficiaries.

Military medical personnel must be prepared to deploy in support of our Armed Forces with little notice to any location in the world. Their skills, both medical and military, must be sharp and well-practiced. We can be certain of that only if they are doing military medical activities on a regular and routine basis. Active duty personnel are usually healthy and fit; they too must be prepared to deploy at a moment's notice. The question then is who will military medical personnel provide everyday care to in order to retain their professional medical skills. It is the population which is eligible for care in military medical facilities, our family members and retirees. If the Military Health Services System did not exist, the United States Armed Forces would not have well-trained, experienced military medical professionals to support them in their everyday activities, their exercises, in operational deployments, or in war. Bluntly, significant numbers of our soldiers, sailors, airmen and marines would die unnecessarily. That, in my view and I believe in their families' views, is totally unacceptable.

With the unprecedented changes in world politics, the national security strategy and objectives have been rewritten. The size of the Armed Forces has been reduced; the roles and missions of the military services have been evaluated and re-evaluated in light of the new strategy and objectives. In this whirlwind of change for the U. S. Armed Forces, military medicine also must change -- and it is.

The Military Health Services System, by the year 1997, will have closed 58 hospitals or 35 percent since fiscal year 1988, due to management initiatives, including the Base Realignment and Closure Act decisions. Military and civilian medical manpower has been reduced, deployable medical systems for field operations have been cut back, and the military medical budget has not kept pace with inflation, despite annual increases. Additionally, medicine in this country is grappling with significant change driven, in large measure, by the spiraling increases in health care expenditures. This change has impacts on the delivery of health care to military medical beneficiaries and on the Military Health Services System itself.

Military medicine, while declining in size, structure and manpower, has deployed medical units in support of our national interests to Haiti, Somalia, Rwanda, Kuwait, Croatia and Macedonia. Plus, military medicine continues to provide everyday health care...and everyday professional skills maintenance...for as many of its eligible population as is possible. And, that health care is of the highest quality: the military hospitals surveyed by the Joint Commission on Accreditation of Healthcare Organizations last year outscored non-military hospitals in all 17 patient care categories and four of our hospitals received accreditation with commendation.

TRICARE Program

Faced with the challenge of maintaining a top quality medical system to deploy at any time and to provide care to more people than possible within the military medical infrastructure, we found smarter ways to organize, to plan, to budget, and to deliver health care. In a word, our challenges are met in TRICARE.

Organizationally, TRICARE brings together the three military systems of health care in a joint and collaborative way to better support military operations and to better care for the whole beneficiary population. The United States has been divided by geographic regions, each administered by a military medical center commander who is known as the Lead Agent. All military hospital commanders within a region joined their Lead Agent in developing a comprehensive health care delivery plan for the entire region based on military support missions and on beneficiary profiles.

Analyses of our system of health care delivery have led to a significant modification in how we fund our health care operations. We changed from a workload driven system of budgeting to one of capitation. This initiative has the ability to alter provider incentives so that our patients receive the timely care they need in the most appropriate setting.

We brought the CHAMPUS program into the organizational structure of TRICARE, building on its authorities to purchase care from civilian sources for most categories of our beneficiaries. Seeking and awarding competitive managed care contracts for the TRICARE regions brings in supplemental support to round out health care capabilities to meet the needs of our beneficiaries in the event of a major deployment as well as in the everyday delivery of patient care.

TRICARE is a joint and collaborative effort which relies on Lead Agents, capitation funding and competitive managed care support contracts.

Let me turn to a brief description of TRICARE as a health care delivery plan. First, it is centered in the military medical facilities so that wherever there is a military hospital, a triple option benefit will be available to beneficiaries. Included in the triple option are a Health Maintenance Organization (HMO) called TRICARE Prime, a Preferred Provider Organization (PPO) called TRICARE Extra, and a fee-for-service option called TRICARE Standard.

The uniformity and stability of benefit is built into TRICARE. Both the scope of coverage and the cost of coverage is the same for the three options anywhere those options are available. Access to care has been standardized across the entire system in terms of wait times and availability of some preventive examinations and their results. And, with the supplemental capability of the managed care support contractor, the majority of patients will be able to receive all the care they need in the vicinity of their residence.

The organization and budgeting initiatives inherent in TRICARE will result in a more effective health care delivery system. Unnecessary duplication of programs is being eliminated, consolidations of training programs, logistics, and support services are being accomplished. Each of these measures furthers our efforts to work jointly and to bring about an environment of interservice cooperation that will enhance the medical support capability in joint military operational deployments.

Of the TRICARE benefit options, only Prime is an enrollment option. As the option centered in the military medical facilities, Prime assists in identifying the majority of patients to

receive care within that facility or group of facilities. Further, each Prime enrollee will have a primary care manager to be the source for most of the enrollee's health care needs. Primary care managers offer beneficiaries continuity of care as well as familiarity and comfort with the system. Having non-enrollment options extends the ability of military medicine to offer coverage to beneficiaries not within an easy commute of a Prime plan and satisfies the issue of choice which is important to some of our beneficiaries.

TRICARE is a transformation of the Military Health Services System, a transformation in its implementation stages. Many of the management initiatives, organizational arrangements, and design elements have been accomplished, but the operational activities involving beneficiaries are just beginning. TRICARE is in the early stages of full implementation in our first region, Region 11, which includes the states of Washington and Oregon. Using the enrollment figures in that region as one measure beneficiary knowledge of TRICARE, we have over 100,000 beneficiaries enrolled after only six months and our projected enrollment for the first year was less than a third of that number.

As the full implementation of TRICARE draws near within a Region, the tempo of educational activities for both beneficiaries and providers increases dramatically. In the interim, we continue to speak with beneficiary groups, advocacy organizations and representatives of the media to let military medical beneficiaries know that TRICARE is a major change to military health care delivery and it will be implemented across the United States by fiscal year 1997. Any health care plan is detailed and can be rather complex. It is our intent to continue to pursue all opportunities to talk about TRICARE and what it means to the military, to individual service members, to health care providers, to corporate health care, and especially to our beneficiaries.

TRICARE supports our readiness requirements, it sustains the skills of our medical personnel, it realigns our organizational structures, it introduces appropriate incentives, it has appeal to the majority of our beneficiaries, it is a partnership between public and private health care systems, and it affords military medicine flexibility to meet its range of responsibilities.

* TRICARE today does not include our Medicare eligible beneficiaries. These patients may continue to seek care in military medical facilities on a space-available basis, but they may not enroll in TRICARE Prime. This is not the Department's preferred position. We would like to do more, but statutory requirements and budget constraints make this situation today's reality. Nevertheless, we are actively pursuing other options.

At present we estimate that military medical facilities provide care to the equivalent of 320,000 Medicare-eligible military beneficiaries at a cost of about $1.4 billion annually. The cost of caring for all military Medicare-eligible beneficiaries who might want to participate in TRICARE Prime is more than the Department can afford. In an effort to fix this problem, we have begun working with the Health Care Financing Administration (HCFA) to setup a large-scale demonstration project where the TRICARE Prime option would be treated by HCFA as a Medicare HMO and would receive a discounted reimbursement from the Medicare trust fund once the Department exceeds its current level of effort. This is the solution most strongly advocated by our beneficiaries and the one DoD supports.

Costs/Savings

Mr. Chairman, you asked what savings could be realized from downsizing the military health care system to its wartime mission only. As I have indicated, to have a fully prepared, skilled and trained military medical capability to support the Armed Forces in all of its mission responsibilities, there must be a functioning health care delivery system. Consequently, it is unclear what savings, if any, would be realized by downsizing the Military Health Services System to wartime requirements.

The total wartime and operational support requirements are currently being refined, updated, and quantified by the Department. This analysis will be used to update the results of the April 1994, Section 733 Study of the Military Medical Care System, which was directed by section 733 of the National Defense Authorization Act for Fiscal Years 1992 and 1993.

Once the total wartime and operational support requirements of active duty military medical personnel are determined, we must ensure that they are properly trained and continue to maintain their medical proficiency and required wartime skills. The best and most cost effective way, and for some the only way, to achieve this objective is by having our personnel deliver health care services to our eligible beneficiary population in our direct care system of military medical facilities. An important point to note is that the 733 Study found that care provided in military medical facilities is the most cost-effective care provided.

If our medical personnel do not practice their professional medical skills in our medical facilities, the only other alternative is to send them to civilian hospitals. This has been advocated by some; however, it is an option that has not been proven to be more cost effective, it omits entirely military professional training, and it is filled with many unresolved obstacles and potentially serious problems.

The 733 study recommended several steps to eliminate potential military medical cost increases due to military medicine having a more attractive health plan. We are implementing these recommendations.

The recent Report by the Commission on the Roles and Missions (CORM) of the Armed Forces, dated May 24, 1995, also contained recommendations related to the DoD medical program which we are pursuing. Unlike early drafts of this report, the final document contained no recommendation to downsize the direct care system and move that care to the FEHBP. The cost effectiveness of such a recommendation could not be demonstrated.

The recent CBO paper "Restructuring Military Medical Care" (July 1995) suggested downsizing the direct care system from 120 to 11 military hospitals and shifting all but 33% of active duty care to the civilian sector. CBO developed three options for downsizing the direct care system, eliminating CHAMPUS, obtaining 67% of active duty health care from civilian sources, and providing all non-active duty beneficiary health care through the Federal Employees Health Benefits Program (FEHBP). My concerns with this paper include the following:

First, CBO did not include the closure cost to downsize the direct care system, but stated it would take 5 to 10 years before the Department could realize projected savings from downsizing the direct care system.

Next, only the first of CBO's three options produced a savings for the Department and that is achieved by shifting a significant amount of the Department's costs to its beneficiaries. And, the beneficiary costs would further increase if the proposed legislation is passed to increase the employee share of FEHBP premium contributions.

Finally, no where in the CBO paper is the necessity of professional skills maintenance, both medical and military, addressed for all military medical personnel. It is unclear how the military would be supported medically during extended cruises, operational commitments around the globe, field training exercises, and periods where military requirements are centered on the installations in the United States.

It remains unclear to me that there would be a savings generated by downsizing the Military Health Services System to its wartime requirements. In the first instance, wartime requirements must be clearly defined, then mechanisms must be in place to ensure continuous military and medical professional training, the process for identifying operational medical support requirements must be established, and saving should not be accrued at the expense of either medical readiness or beneficiaries.

I think it is very important that the Committee know something about the trend of DoD's health care expenditures. Prior to the Defense Health Program appropriation, from 1985 through 1990, DoD health care per capita rates, in constant FY 94 dollars, reflected the national annual increase. With the establishment of the Defense Health Program appropriation, from 1991 through the present time, that per capita rate has remained constant and is projected to decline through our program years. Additionally, the DoD rate of inflation for health care is half that of the nation and one-third that of HMOs. Clearly, the Military Health Services System is operating more cost-effectively than most health care systems in the country today.

Mandatory enrollment in FEHBP will not satisfy our medical readiness requirements, nor will it be willingly accepted by a significant number of our beneficiaries, nor will it produce savings. The FEHBP does offer two advantages that military medicine does not offer. First, it continues to cover retirees beyond the age of 65, which our military medical facilities also do, but CHAMPUS does not. And, second, it is available in a number of locations where only standard CHAMPUS is (and standard TRICARE will be) available.

Some military Medicare-eligible beneficiaries may be interested in the FEHBP. However, those who reside near a military medical facility would choose the military facility as long as they could gain access. The FEHBP is significantly more expensive than TRICARE, and the strongest statements from our military retirees regarding their health care are about costs. Let me be clear on this point. By our estimates and without a significant infusion of new Federal funds, military retirees face significantly increased out-of-pocket costs under FEHBP. From the majority of

beneficiary associations we hear their preference for an arrangement with HCFA for TRICARE Prime to be recognized as a Medicare HMO with reimbursement to DoD from the Medicare trust fund.

In our efforts to consider all possible alternatives, we have in progress an analysis to determine the advantages and disadvantages of including the FEHBP as a fourth option of TRICARE. This analysis is in its formative stages with a projected completion date of March 1996.

In closing, Mr. Chairman, it is my belief that TRICARE is the most cost-effective delivery system, and is the only system which can ensure that the men and women of the Armed Forces have top quality health care wherever and whenever they, and their families, may need it. It is the system that ensures we are ready, no matter what the military mission, to support that mission and to protect the health of our troops. In good conscience, I cannot support a Military Health Services System that does not fulfill our obligation to our troops...those who serve today and those who have served so well in years past.

Thank you. I would be happy to respond to your questions at your convenience.