

**U.S. House Armed Services Committee
Military Personnel Subcommittee Hearing
“Military Health System Overview and Defense
Health Program Cost Efficiencies: A Beneficiary Perspective”
Wednesday, March 16, 2011, 8:00 a.m.**

Members Present

- Joe Wilson (R-SC-2nd) – *Chairman*
- Susan Davis (D-CA-53rd) – *Ranking Member*
- Joe Heck (R-NV-3rd)
- Niki Tsongas (D-MA-5th)
- Allen West (R-FL-22nd)
- Mike Coffman (R-CO-6th)

Witnesses

- Colonel Steve Strobidge USAF (retired) – Director, Government Relations, Military Officers Association of America (MOAA)
- Master Chief Petty Officer Joseph Barnes USN (retired) – National Executive Director, Fleet Reserve Association (FRA)
- Rick Jones – Director, Government Relations, National Association of Uniformed Services (NAUS)
- Deidre Parke Holleman Esq. – Executive Director, The Retired Enlisted Association (TREA)
- Kathy Moakler – Director, Government Relations, National Military Family Association (NMFA)
- Marshall Hanson – Director, Government Relations, Reserve Officers Association (ROA)
- Mary Cooke – Vice President, Johns Hopkins U.S. Family Health Plan (USFHP); Chair, U.S. Family Health Plan Alliance

Focus of the Hearing

This was the second in a series of hearing to analyze the Administration’s Fiscal Year 2012 for military health programs with the Department of Defense. The Subcommittee heard testimony on the Military Health System (MHS) and the Department of Defense’s (DOD) proposed cost saving initiative from the beneficiary perspective.

Chairman Joe Wilson Opening Statement

- We must seek reasonable solutions for ensuring the availability of world class military health care, not only to our returning wounded and injured and their families, but to future generations of brave young men and women who answer the call to serve our nation.
- DOD has proposed several measures aimed at reducing the cost of providing health care to our service members and their families and military retirees. The plan is a more comprehensive approach than previous cost cutting efforts. That being said, these proposals will affect not only

beneficiaries, they will also affect the people who support the military health care, such as pharmacists, hospital employees and contractors.

- I look forward to hearing your views on the DOD proposals; what do you support, what do you oppose and do you recommend alternatives to the proposals that we may consider.

Ranking Member Susan Davis Opening Statement

- Yesterday we heard from Under Secretary Stanley, Assistant Secretary Woodson and the Surgeons General on their views of the MHS and their efforts to improve the care.
- Today we'll hear first hand from the people who really make the most difference here – the beneficiaries of the MHS and the experience they're having with the MHS and their thoughts on the DOD's proposals.
- Our country is facing difficult economic times and we're faced with making difficult decisions that could impact the lives of those who are currently serving or who have previously served.

Witness Opening Statements

Steve Strobridge

- I'm here representing the Military Officers Association of America (MOAA). In our view, the bulk of what military people pay for their health care is paid up front in the form of service and sacrifice. We are encouraged that the new DOD proposal does a far better job of acknowledging that than did those of several years ago. Our principal objection is to DOD's plan to index future TRICARE Prime increases to some undetermined health care index that they project to rise at 6.2 percent per year.
- In our view, the main problem is that current law leaves much of the TRICARE fee-setting-and-adjustment process to DOD's discretion. For many years, no secretary proposed any increase in TRICARE fees, leading beneficiaries to believe there would be no increases. In 2007 and 2008, beneficiaries were shocked when a new secretary proposed tripling or quadrupling fees.
- To restore important career benefit stability and limit future adverse retention consequences, MOAA believes Congress should establish in law the following principles:
 - The military retirement and health care package is the primary offset for the many unique and extraordinary demands and sacrifices inherent in a military career.
 - Those decades of service and sacrifice constitute a very large, pre-paid premium for career military members' and families' health care coverage in retirement, over and above the fees they pay in cash. This large, up-front and in-kind premium must be acknowledged in statute to explicitly reject inappropriate, "apple-to-orange" comparisons focused on cash fees paid by military beneficiaries versus civilians.
 - The way to incorporate this inherently unquantifiable military-unique premium of service and sacrifice in the fee adjustment process is to limit the percentage increase in TRICARE fees in any year to the percentage increase in military retired pay.
- In the meantime, we pledge our support to work with DOD and the Subcommittee to find other ways to hold down military health cost growth. We believe much more can be done to encourage voluntary use of the mail-order pharmacy system; reduce costs of chronic conditions; reduce system duplication; and cut contracting and procurement costs, to name a few.

Joseph Barnes

- The Fleet Reserve Association's (FRA) reaction to drastic health care fee increase proposals from 2006 to 2008 includes support for legislation that would shift oversight from DOD to Congress,

and support for a Senate bill in the 110th Congress prohibiting fee adjustments from exceeding the annual Consumer Price Index (CPI), which determines military retired pay adjustments and other federal benefits pegged to inflation.

- DOD's 2012 TRICARE Prime fee adjustments plan is more acceptable than past proposals, however, initial adjustments are only part of the plan and we're concerned about the yet-to-be-determined annual adjustment index for TRICARE Prime fees in 2013 and beyond.
- FRA supports the elimination of co-pays for generic drugs via home-delivery, and notes that survivors and medically retired personnel are not impacted by the plan. There are also no active duty fee increases, no changes to TRICARE Standard, and no additional TRICARE for Life fees.
- FRA agrees with GAO that management efficiencies and cost saving initiatives can significantly offset higher health care costs, and our members ask that you find a permanent doc-fix to pending cuts in Medicare physician reimbursement rates, which is essential to insuring access to care for all beneficiaries including those under TRICARE for Life.

Rick Jones

- The National Association of Uniformed Services (NAUS) asks Congress to hold the line, and we're not alone in this request.
- At first look, the plan for TRICARE increases may seem modest, but it's clear that it's a "Trojan Horse" designed to divide Congress and divide military associations' voices and to start a rollout for substantial increases in TRICARE fees and co-pays.
- To achieve their plan, the Pentagon officials began with a public affairs attack that suggested that a pre-war cost for military health care was \$19 billion (in 2001) and will rise to \$52 billion by 2012, and they say that it is the fault of retirees. Gentlemen, we're at war – the cost of military health care will always increase during wartime. But the Pentagon blames the retirees.
- Our members tell us it's hard to imagine anything that can be so callously said as to hear of the stories in the media that depict the cost of retiree benefits as being responsible for threatening available funding for our national security. This is a benefit that has been earned by honorable military service.
- NAUS is not comfortable with defense leadership suggesting to the public that the price we pay for health care is more than the value that our nation receives from those who serve more than 20 years.
- Certainly, there are a number of lower priority programs that can be reduced. If cuts are needed to tighten the budget, there are things big and small that can be done. Our members understand this, but they are troubled with always being first in line for sacrifice when they witness resources continuing to go to lower priority programs such as they have seen in the past.
- As we see \$120 billion stolen by fraudsters in various medical and social programs, we wonder why they point to an earned benefit.
- We have faith in our leaders, but we are not blind. Before we begin whacking our military earned benefits, let us make certain that we use our best wisdom and select our most important programs over our lesser important ones and let us not forget that we are at war.
- Many of our military retirees are on fixed incomes; many can't afford the so called modest 13 percent increase in monthly expenses. And please consider that our members have not received a Cost of Living Allowance (COLA) increase over the last two years.

Deidre Parke Holleman

- I am testifying today on behalf of The Retired Enlisted Association (TREA).
- We all acknowledge that the primary mission of the military health system is to support readiness, and the cost of that mission must be paid by the entire nation; it shouldn't be the responsibility of those who have served a career in the military.

- Obviously, the present proposals are not as appalling as previous ideas and for that we're grateful. That doesn't mean, however, that we support all of the proposals.
- It's not clear to us or others which medical inflation index DOD is planning to use, but it's clear that DOD is using a compounding figure of 6.2 percent. In a short amount of time that figure will dramatically eat into a retiree's earned retirement package. It would completely destroy the purpose of the COLA for the retirement pay. We are completely opposed to this part of the proposal, and we feel no assurance that if this change is made, more costs will not be added or more groups would not be included after Baldacci finishes his study.
- As you can tell from my written testimony, TREA was planning to focus on the need to keep the US Family Health Plan running in its present structure. However, since you have invited a representative of that fine program, let me simply state that we know how hard it is to get up and running any effective program. USFHP does a wonderful job for its beneficiaries; we should be very careful not to dislodge its smooth functioning.
- While of course we're focused on the new budget proposals, I do not wish to miss the chance to mention the continuing need to focus on our goal of a seamless transition for our wounded warriors transferring from DOD health care to VA health care. In particular at this moment, both departments should be urged to coordinate their Wounded Warriors Caretakers programs. Currently, the ending of DOD's program and the starting of the VA's program do not mesh. This really needs to be corrected.

Kathy Moakler

- National Military Family Association (NMFA) agrees that DOD's proposed increase of prime enrollment fees for working age military retirees and their families is fair. We have concerns however with using a civilian based index in determining these fees after 2012. We have always supported the use of COLA as an index for increasing fees.
- While we agree that it can drive efficiencies through changing behavior, we do have some concerns with the proposed increase in co-pays for retail medications and the impact this will have on beneficiaries who have no choice but to rely on the retail pharmacy for urgent, non-maintenance medications. We shouldn't penalize a military family when their child needs an antibiotic and they have no other option than the retail pharmacy.
- Family readiness calls for access to quality health care and mental health services. Military families may be encountering access challenges and provider shortages as we look ahead to the prospect of decreasing Medicare reimbursement fees, new contract renegotiations with the TRICARE Third Generation (T3) contract, and the uncertainties faced by providers in regards to health care reform.
- We're pleased with the many resources that have been provided for families for non-medical counseling. We are concerned about a shortage of behavioral health providers in the Military Treatment Facilities (MTFs) and the network. While we know that the services are addressing this with new programs, we are troubled by increases in service-member and family suicides.

Marshall Hanson

- The Reserve Officers Association (ROA) finds DOD's proposal of a fee increase of \$60 per year for TRICARE Prime families and \$30 for individuals a modest rise. And doesn't find the proposed increases for pharmacy co-payments excessive. We hope that initial prescriptions at retail sites are exempted though, permitting the beneficiary follow-up time to take advantage of mail-order savings.
- Where we hesitate is that DOD's suggesting an index for increasing TRICARE Prime fees in future years. While ROA would accept an index based on COLA, we also feel there is a need to explore other indices should a COLA basis not be accepted.

- The most important point of this hearing is to establish a process to involve Congress, beneficiary associations and DOD in determining acceptable rates. The unilateral decisions by the Pentagon worry ROA members. While ROA was once open to a cards-on-the-table approach to health care discussions, we have grown hesitant by how the Pentagon implements programs. ROA is frustrated that DOD treats reserve component health care for drilling reservists as a health insurance program even though reserve component members have mobilized over 800,000 times. And we are quite disappointed with the market-level premiums levied upon gray area retirees.
- We hope that this Committee will agree to a GAO review on premiums for TRICARE Retired Reserve the same way the HAS prompted reductions in costs for Tricare Reserve Select.
- Also, ROA asks that you look into DOD allowing TRS beneficiaries who are discharged the option of being in the Continued Health Care Benefit Plan. Selected Reservists are the largest group in the U.S. not provided transitional COBRA protections.
- Lastly, we need to work with your staff to ensure that all guard and reserve members coming off of active duty are permitted a Transitional Assistance Management Program (TAMP) coverage. Some individuals are being told they are not covered.

Mary Cooke

- I'm here to provide testimony regarding the Uniformed Services Family Health Plan (USFHP) perspective.
- My testimony will focus on the successful partnership between USFHP and DOD, and our concern that a proposal in the President's budget request, if enacted, would prohibit us from caring for many of our nation's heroes and their families.
- Thirty years ago, Congress directed that our organizations continue the tradition of providing health care to uniformed services beneficiaries including those aged 65 and older. With the introduction of the TRICARE program, new legislation made us a permanent part of the military health system, establishing the USFHP as a fully at risk managed care model designed to provide comprehensive health care while maintaining cost neutrality.
- Today, the USFHP provides the TRICARE Prime benefit to nearly 115,000 military beneficiaries. Our objectives are aligned with DOD's stated goals, which include readiness, the patient's experience of care, population health and controlling per capita costs. We continue to be the highest rated health plan in the military health system. 91 percent of our members rated our program highly, as compared to 62 percent of members in commercial managed care plans.
- With regard to cost, by statute, total payments for health care services to enrollees of the USFHP can't exceed an amount equal to what the government otherwise would have incurred had our enrollees received care from alternative sources.
- Because we're reimbursed on a capitated basis, our financial incentives are aligned with our longitudinal approach to population health. Namely, to engage our members in living healthy lives and preventing chronic illnesses.
- Given our high level of beneficiary satisfaction and our success in adopting innovative strategies to improve health outcomes, we were disturbed that the President's budget proposes to require all new members to disenroll from our program at age 65, just when they need the benefits of our program the most. The proposal does not save the government any money; it would merely shift the cost of care for our older beneficiaries from the DOD to Medicare. In doing so, military beneficiaries and their families who choose our plan, in large part due to our integrated approach to population health, would lose access to our highly effective prevention and medical management programs.
- It appears then that the budget proposal and its destabilizing impact on the USFHP is in conflict with the stated goals of the military health system. Perhaps most concerning is the fact that over time, thousands of aging military beneficiaries who need our help in managing complicated medical conditions simply won't have access to it.

- We understand the challenges DOD and Congress face in needing to reduce costs. But the elimination of innovative programs like USFHP is counter to the goal of reducing government health care costs. Accordingly, we urge Congress to reject this proposal and protect military families' and retirees' access to the quality of care they like, need and deserve.

Question & Answer Session

Chairman Wilson – I'm frustrated that with the DOD's capabilities, the President has named a military health care czar, Governor Baldacci. I think those expenses are being diverted from the military health system to pay for the czar. I think that the first thing Governor Baldacci should do is step down. Tell me how you would provide for efficiencies.

- Strobridge – There are a lot of opportunities for efficiencies. We have engaged with the DOD to a significant degree on the mail-order pharmacy system. Despite what DOD has done so far, there has only been a modest shift and we have proposed that they have gotten most of what they're going to get from people who are motivated by the money savings. Our surveys indicate that people who aren't shifting are because they're worried about one aspect or another, and we've talked to DOD about giving people that information ahead of time, but they haven't done that yet. Once people try the mail-order system they're pretty satisfied with it, so we just need to answer their questions so that they try it.
- Barnes – I echo Strobridge's comments with regard to mail-order pharmacy. We also note that GAO has identified several opportunities for significant savings, including command structure reorganization which could save an estimated \$260 million to over \$400 million annually. There are also opportunities with regard to greater interaction and coordination with the VA with regard to electronic medical records. The Alta and Vista programs do not interact, which is baffling.
- Jones – I echo both of those thoughts, particularly the Alta issue. Alta comes in with rave reviews from defense contractors, but the doctors seem to say it's a burdensome system and it's incompatible with VA. DOD and VA have been working on finding a way to combine the electronic system for years. Also, there are other opportunities for this combination of joint working between DOD and VA. Procurement reform is necessary in DOD. And finally, need to incentivize the health care mail order system.
- Holleman – I agree with the suggestions that have already been made, and there also should be more of a major focus on treating chronic illnesses. It saves money and it accomplishes the purpose of the health care system. USFHP is a prime example of how that works and how it saves money and improves lives.
- Moakler – We agree with all of the previous efficiencies that have been introduced. Also want to reemphasize that establishing a unified joint medical command structure would introduce many efficiencies. We also encourage the inclusion of recommendations of the task force on the future of military health care in this year's NEAA; restructuring TMA to place greater emphasis on its acquisition role; examining and implementing strategies to insure compliance with the principles of value driven health care; reassessing requirements for purchase care contracts to determine whether more cost effective strategies can be implemented; and removing the systemic obstacles to the use of more efficient and cost effective contracting strategies.
- Hanson – Medical and dental readiness continues to be having a big impact on reserve component mobilization. As Dr. Heck pointed out during yesterday's hearing, if reserve dentists and doctors were permitted to treat fellow reservists, this would save health dollars and help our nation's readiness.
- Cooke – I echo Mrs. Holleman's statement. The best way to decrease health care costs is to eliminate the medical conditions that diminish quality of life and contribute disproportionately to

rising health care trends. So I would suggest an up-front investment in prevention and programs to minimize and eliminate chronic conditions as the long-term efficiency.

Ranking Member Davis – I want to focus on Cooke’s earlier comments because there is a difference in capitated care, so we’re trying to understand this. I know prevention saves money, but unfortunately it doesn’t score and that’s the great frustration. Can you explain exactly how your plan saves money, and how has that been documented over the years?

- Ms. Cooke – With regard to managing chronic conditions, the health care industry faces the problem of how do you quantify non-events. We have over 40 disease and care management programs.

Representative Heck – What we heard yesterday was them talking about the “working-age retirees” and how those people might go on to a second career and whether or not there should be some responsibility on that person’s part or their new employer’s part to provide some of their health care coverage. Can you address the counter argument and why that analogy doesn’t really hold water?

- Strobridge – That’s one of the problems we have with some of the DOD descriptions. When they talk about “working-age retirees” there’s an implication there that if you go out and get a job, you didn’t really earn your health care. That is what gets military retirees so upset. That’s why we think there should be a law that explicitly states that military health care is one of the crucial offsets to the adverse conditions of service.
- Hanson – One of the arguments we made for the existence of TRICARE Reserve Select was to improve the hire-ability for members of the reserve by having a health care plan that’s exportable. That would help small employers know that when they bring an individual in, they’re bringing a health care plan with them. This is one of the incentives that we have in place. This same argument can be taken over to TRICARE for the active duty workers, as well.
- Jones – Some may find it hard to understand that these men and women earned a retirement benefit and they look forward to using it. It’s a breach of moral contract to stunt that promise that’s been made to these people.
- Barnes – This issue goes to military service being unlike any other career occupation. Also with regard to the retired enlisted force, many of them do not have the high paying jobs or the resources that are assumed when these discussions are brought up.

Representative Tsongas – Yesterday I said that before Congress could increase TRICARE fees for working age retirees, any proposal would have to be proven to minimize impact. I also questioned the disparate impact of any increases on service members who accrue less annual retirement benefits than others. Retirement benefits vary greatly depending on a number of factors such as how long a person served and whether they were decorated for extraordinary heroism. The key metric is the rank they held. Yesterday, I asked Stanley and Woodson if DOD had seriously reviewed any proposals for a stepped increase of TRICARE Prime fees for working age retirees determined on the basis of rank at the time of retirement and retiree benefits earned. Woodson answered that DOD did not consider this proposal because it would be difficult to administer since DOD would want to take into consideration retirees’ other streams of revenue. More importantly though, he stated that it was unnecessary in this case because the fee increases that were proposed are modest; but, he said that if they were proposing large fee increases then he would strongly agree with me. Do you agree or disagree with Woodson’s assessment?

- Strobridge – DOD did in fact propose tiering fee increases previously; the military coalition has been unanimous in opposing means testing of military benefits. One of the concerns is creating a situation where the longer you serve and the more successful you are, the less your benefit is. The military benefit package is considered the offset for the adverse conditions of service. You earn the package mainly by your service. I would have to agree with what Woodson said yesterday that once you start trying to split it, basically what you’re saying is who can afford to

do what. To us we don't think that should be based on what kind of job you get as a civilian, what your spouse's income is, etc.

- Barnes – I agree with Strobridge's comments. The comparison issue between military benefits and federal civilian benefits is a compelling example with regard to that concept. There also are a number of variables and it sounds like DOD is referencing the complexities of administering that.
- Hanson – ROA doesn't support a tiered approach based on rank because it should be pointed out that reservists and guards members have an income in their retirement that is 25 to 30 percent of what an active duty member does because of the fact that they are part time warriors.

Representative West – This panel is important and personal to me. When I sit here I think about a George Washington quote that “The future generations of a nation will judge itself based upon how well we treat our veterans.” When I first retired I would spend my Fridays going down to the VFW post but found myself not being able to endure that because of the cigarette smoke. How do we develop initiatives that incentivize healthy living in our military retirees?

- Moakler – The military health system has already introduced some preventive care programs within the MTFs. As with any benefit offered to our military service members, it's an issue of communicating the availability of these programs and insuring that our service members can take advantage of these programs.
- Holleman – The military life is a fit life but not necessarily a healthy life due to the habits that they develop in large part because of the pressures of that lifestyle. I firmly agree that the MTF program and others should be a focus and should be widely publicized.
- Strobridge – One of the frustrating things is that there has been a lot of effort put to that, sometimes to no avail. We actually had to get this Subcommittee to pass legislation to get DOD to run a pilot program to try to get TRICARE pay for smoking cessation programs. So the budget rules actually inhibit us from doing things that will encourage healthy lifestyles. Also, need to eliminate the co-pays for those maintenance medications for people with chronic conditions. So there are lots of disincentives built into the system.

Representative Mike Coffman – Would you support the proposed increase – \$30 for individuals and \$60 for families annually – if it were tied to a retired pay COLA device in Medicare? For those who say no, what if the increase didn't impact current retirees; what if it were grandfathered in?

- Hanson – A combination of the modest increases this year with an index-based COLA is something that ROA could not object to. One concern that I have with how you phrase things is the setting up of generational differences in benefits to where one group is grandfathered and the next is charged more. It should be uniform across all people who serve.
- Moakler – I agree with Mr. Hanson. We have agreed to the increase in fees even when they were first introduced four years ago and we've always maintained that they should be tied to COLA. I also agree that creating a population of have and have-not's is never a good thing with the military benefit.
- Holleman – This question has been discussed in great detail in my organization recently. We have found that we could agree to a COLA increase if that was absolutely necessary. Our people are dedicated and see the problems that are happening but they also see their own problems.
- Jones – The 13 percent increase is modest in some people's eyes but there's concern in our group that it's too steep. We participate in retiree activity days across the nation and overseas, and what we have heard is the word “grandfather” and that's something that we might be attracted to. We would certainly give it our very serious consideration.
- Barnes – There is less opposition to what you're proposing than the current DOD proposal, but I have to state that the oversight responsibility on this issue is key. DOD currently has the authority to adjust these fees apart from the USFHP part of this, which requires legislative

change. That goes back to 1995 when TRICARE was established. So key to answering this question is consideration of those key aspects.

- Strobridge – We would have a hard time objecting to what you propose, but with the one caveat that we think it's important to put those principles in legislation to specify that the benefits is the offset to conditions of service and those constitute an up-front premium, and that is why the COLA adjustment is reasonable.

Chairman Wilson – Should pharmaceuticals be mail-order or by pharmacy? I know that I have found it very helpful to have one-on-one contact with the local pharmacist. Are there ways to reduce cost by using the local pharmacy?

- Cooke – There's a role for mail-order. For beneficiaries who are on several routine maintenance medications, it may be more convenient for them. But there are circumstances where having a relationship with a local pharmacist are critical. So I think there isn't a one-size-fits-all solution. Home delivery for maintenance medications really should be considered, but it couldn't necessarily offset peoples' right to receive urgent medications or exercise their options to receive it at the retail location.
- Hanson – We have worked hard with DOD health affairs to try to get beneficiaries to shift over to the mail-order system and they are finding immediate savings by accomplishing this. So the ROA supports this type of move. But having some type of way that people aren't penalized when they have to go to a retail side with higher co-payments is something that we have to explore and include in any type of program that we go to so that young families that have to do a late-night run don't have to pay higher prices.
- Moakler – I agree with the two previous statements. Also, one of the things we've discussed is education of the beneficiaries on how easy it is to use the mail-order pharmacy because people are reluctant to move over. It can be difficult to make that initial start. But we do believe that not penalizing those who need that urgent medication or need a narcotic that they couldn't get sent through mail-order shouldn't be penalized with increased fees.
- Holleman – I agree with everything, and I will also say that speaking to a pharmacist can be very helpful, particularly with an initial prescription. So I think it's obvious that we need both in the system, but for continuing maintenance drugs that you're taking for years, of course the home delivery is a very useful option.
- Jones – Home delivery is a useful option that saves money for the beneficiary and the DOD taxpayers. However, one thing that could save money for the DOD that we feel is a primary reason for the higher costs in the pharmaceutical program is a lack of aggressiveness in pursuit of the federal pricing schedule for drugs that they use in DOD. Some years ago we offered the opportunity for federal pricing; it was projected to return \$1.6 billion annually. The lack of aggressive nature of the DOD in securing federal pricing has resulted in 1/3 of that amount being received. So we need more aggressive action on the part of DOD and a little less blame on retirees.

Ranking Member Davis – Could you turn to some of the transition programs...when I speak to people I have the feeling that something's not quite connecting. Could you specify where do you see that gap? Is there something about the way the service could be improved that would enable that transition back to the community to be much smoother?

- Strobridge – One of the things we've talked about consistently that has been a chronic problem is mental/behavioral health. There's a lot of fear on this issue. The service member is afraid that if they identify themselves they will ruin their career. There are programs underway to do those in ways that aren't reported back to the DOD. Those get more participation but they don't identify the problem to DOD, so there's a chronic issue. The key will be the de-stigmatization effort.

- Barnes – The stigma issue is huge and it will take a long time to turn that around. Another aspect of this is family readiness and awareness of programs. We still hear stories about families that aren't aware of available programs. Going back to the seamless transition issue – the bureaucratic challenges associated with the DOD and the VA for these wounded warriors is still very challenging. The special oversight committee is faltering. There needs to be a lot more done to effect seamless transitioning.
- Hanson – One challenge that we have is the duration that people are placed in these transitional programs. Sometimes they're kept too long and sometimes not long enough. So they need to have oversight and review.
- Moakler – Also want to look at some bridge programs for our service members who are being medically retired or medically discharged. Our organization has promoted the idea of a three-year active duty benefit for those who are medically retired. We know they're still eligible for TRICARE as a retiree but it would be similar to the survivor benefit and help them in those transition years.

Representative West – I want to go back to my previous question. I believe that if we are serious about how we can lower the cost for military retiree health care, then we need to make sure they're healthy.

- Jones – Those who will be coming into service tomorrow do reflect on how our veterans are currently being treated. And to your question of how to encourage individuals to maintain their health, we need to do that by setting an example and showing appreciation. 20 percent of Americans today are not ready physically to become a service member. We need to incorporate physical education in our schools. We'll do it by example; not necessarily by government.
- Barnes – Our organization is working to communicate with three generations. The communications aspect of this is key. The starting point is understanding the demographics and the perceptions of these different groups and trying to communicate and educate them about the importance of healthy lifestyles.

Representative Coffman – Maybe you all can give me some examples of if we were to focus on the delivery process, what specific changes do you think we could make to contain the costs? Is there room to maneuver in terms of saying that there has to be some primary care gatekeeper? Are we doing enough in terms of cost containment at that level?

- Cooke – It's less about the gatekeeper and more about integration. The relationship eliminates duplication of service. Also there's value in understanding the complete picture of the beneficiary.
- Hanson – TRICARE Prime has primary care managers that try to control this. DOD says the real costs they're facing is because so many people who are beneficiaries go straight to Emergency Care.
- Moakler – TRICARE Prime is not the entry to the benefit. So many of our beneficiaries are actually enrolled in TRICARE Standard, so I think it would be interesting to compare those two.
- Strobridge – One of the big problems is that DOD spends a lot of time on TRICARE Prime but they don't have those chronic condition programs for TRICARE Standard. Yet we know who the diabetics are, who the high-cost people are, so to us there is a great reason to reach out to those people to urge them to participate in these kinds of programs.

Ranking Member Davis – I would invite all of you to submit anything else in writing or communicate with us in any way that you prefer. I feel as if I don't have as good of information from the DOD as we might like to better understand the real impacts of some of this.