

“Department of Defense Healthcare Proposals”

Statement

of

The Honorable Robert F. Hale
Under Secretary of Defense (Comptroller)

before the

Senate Armed Services Committee
Subcommittee on Personnel

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Senator Webb, Senator Graham, members of the Committee, thank you for the opportunity to speak about the budget of the Department of Defense and our efficiency proposals, especially our proposed health care initiatives.

I will address these military health care issues with a focus on their financial aspects. I appreciate the leadership of the Under Secretary of Defense (Personnel and Readiness), and from his staff, on broader issues related to personnel in the Department.

I would like to begin with a brief overview of the President's Budget for the entire Department including our overall efficiency initiative. I will then focus on our health care proposals.

Base Budget Request

Mr. Chairman, the Department's Budget for FY 2012 includes \$553.1 billion in discretionary budget authority and continues and reinforces three priorities laid down by Secretary Gates for the Department:

- First, it reaffirms our commitment to take care of the all-volunteer force, America's greatest strategic asset. We propose a 1.6 percent military pay raise, \$8.3 billion for family support programs, and \$52.5 billion for military health care.
- Second, the FY 2012 base Budget continues the rebalancing of the Department's capabilities in order to improve our ability to prevail in current conflicts, such as the unconventional war in Afghanistan. For example, we plan to invest \$4.8 billion to purchase unmanned aerial vehicles and \$2.3 billion for cyber activities.
- Third, the President's Budget for FY 2012 maintains and enhances capabilities for the conflicts we may face in the future. Included are a restructured but substantial Joint Strike Fighter program, a new tanker program, an aggressive shipbuilding program, a new ground combat vehicle, and many other initiatives.

In addition to these three broad priorities, the Budget for FY 2012 furthers the reform agenda that Secretary Gates launched in FY 2010 and which continues in this budget. In FY 2010 and 2011 that agenda included steps to curtail or eliminate programs that have fully satisfied procurement needs, as well as those that are seriously troubled or provided capabilities too narrow to justify their expense. More than 20 programs were restructured or eliminated, among them further production of the F-22 and the C-17 aircraft, the program for the new VH-71 Presidential helicopter, the Navy's DDG-1000 ship program, and the Army's Future Combat System (FCS). These difficult decisions resulted in substantial savings.

For FY 2012, we propose to continue our cost-cutting with emphasis on business operations. Our plans save \$178 billion in FY 2012 to FY 2016 through efficiencies and streamlining of programs. The Armed Services identified about \$100 billion of savings, which they are reinvesting to improve combat capability. The remaining \$78 billion in Defense-wide savings was used to accommodate reductions in the defense topline and to support the Administration's efforts to reduce the Federal deficit.

These savings will be achieved through reform of DoD's organizational structure, weapons programs, infrastructure, and business processes. We propose to terminate or consolidate organizations in all the military departments. We will terminate the Marine Corps' Expeditionary Fighting Vehicle, end procurement of the Army's SLAMRAAM surface-to-air missile, and make other changes in weapons programs. Changes in business processes include consolidation of data centers, improvements in weapons sustainment, reductions in acquisition costs, and elimination or streamlining of lower-priority support tasks in order to accommodate a civilian personnel freeze and reductions in funding for contractors. Included in this package of efficiencies are proposed changes to the Military Health System (MHS).

Health Care Efficiencies

The FY 2012 Budget includes \$52.5 billion to support the MHS and its 9.6 million eligible beneficiaries, including Active Duty Service Members and their families, military retirees and their families, dependent survivors, and certain eligible Reserve Component members and their families. Starting this year, the MHS is adding the TRICARE Young Adult Program, which extends benefits for certain dependents in accord with the National Defense Authorization Act for FY 2011.

We take pride in providing MHS beneficiaries with the best medical care, and we will do nothing to reduce the quality of that care. But the costs of the Military Health System have nearly tripled in little more than a decade, from \$19 billion in 2001 to the present request of more than \$52 billion. The challenge we face: find ways to maintain quality health care while slowing the growth in costs.

Efforts to achieve this are by no means new. To date, more than \$1.65 billion in annual savings have been implemented. The 2007 National Defense Authorization Act prohibited employers from offering incentives to employees to drop employer-based health insurance in favor of TRICARE. Savings of \$500 million were achieved thanks to rebates from pharmaceutical manufacturers for retail prescriptions. Matching payments to Medicare rates for outpatient care in hospitals and ambulatory centers will save another \$900 million. Enhanced fraud, waste, and abuse detection and prosecution are expected to net another \$137 million. And by standardizing medical supplies and equipment, we are producing another \$30 million in annual savings.

These achievements are noteworthy, but we must do more. As a result, the Department has proposed additional headquarters reforms, changes in the TRICARE system that will better balance responsibilities for health between DoD and the people

we serve, shifts in pharmacy co-pays designed to encourage efficiency, and changes to ensure that costs to individuals and payments to hospitals are consistent throughout the military medical care system.

Headquarters Efficiencies

Greater efficiencies begin with streamlined operations at headquarters. Health Affairs is reducing headquarters staff by more than 700 contractor positions, as well as promoting greater sharing of services and capabilities between the Armed Services. We are currently devising specific plans to accommodate these reductions, plans that include approaches such as contract consolidation and the efficiencies in Information Technology (IT) support. Other efficiencies are anticipated with the conclusion of the BRAC process and consolidation of medical headquarters for Health Affairs, the TRICARE Management Agency, and the Service Surgeons General.

TRICARE Enrollment Fees

Additional reforms will involve beneficiaries. We are proposing a modest increase in TRICARE enrollment fees for working age retirees. Congress introduced fees for TRICARE in the mid 1990s, when the program was created. Since then, annual fees have not been changed in dollar terms. Had they been indexed to Medicare, fees of \$460 for families would have grown to more than \$1,000 by FY 2010. Instead, retiree out-of-pocket expenses actually fell from 27 percent of total health care costs in 1995 to 11 percent in FY 2010.

The Administration's proposal will increase fees for working-age retirees by a modest \$5 per month for families and \$2.50 per month for individuals, which will raise the annual fee from \$460 to \$520 for families and from \$230 to \$260 for individuals. Beginning in 2013, future enrollment fees will also be increased based on growth in per capita National Health Expenditures. Note that the increases will only affect the 1.6 million retirees in TRICARE Prime who are younger than 65 years of age. Disabled retirees and survivors will be exempted.

These modest, limited, first-ever increases will save an estimated \$434 million in the FY 2012-2016 period and \$1.5 billion through FY 2021, money that will help to maintain a strong, well-trained military.

Pharmacy Co-Pays

We plan to change co-pays for pharmaceuticals to provide incentives for beneficiaries to choose the most cost-effective options for prescriptions, namely use of generic drugs and delivery of prescriptions by mail. Co-pays are eliminated altogether for generic drugs ordered through the mail order program, which will mean a savings to beneficiaries of \$3 per prescription. Most non-generic drugs are available via mail order with no increase in co-pays. For retail pharmacies, co-pays are increased by \$2 to \$3

per prescription. We estimate that these reforms will save over \$2.5 billion between FY 2012 and 2016 and, again, help to maintain a strong military even in lean times.

In addition, changes in co-pays are expected to improve patient care. It has been noted that patients with chronic conditions requiring regular medications are actually more likely to comply with their medical regimen when the prescriptions are delivered to their homes.

Sole Community Hospitals

DoD proposes a TRICARE regulatory change that will eliminate special subsidies for Sole Community Hospitals (SCHs) that serve military beneficiaries. Current rates for the SCHs are more than twice as high as what is paid to other acute TRICARE network and non-network hospitals covered under this proposal and 29 percent higher than commercial insurers are paying for the same services. Federal law requires that we adopt Medicare rates to the extent practicable. By implementing this regulatory change at SCHs, we can save the Military Health System \$395 million between FY 2012 and 2016.

We realize that this proposal will have an impact on the revenue streams of certain hospitals, but that impact should be modest for all but a handful of hospitals. TRICARE accounts for less than one percent of inpatient admissions at the vast majority (81 percent) of SCHs and less than 5 percent of inpatient admissions at 95 percent of these hospitals. We propose phasing this change in over the next four years for all affected hospitals, and we will work with those who are most affected to minimize disruptions.

USFHP Enrollees

Lastly, we propose to provide equitable treatment for all Medicare-eligible retirees by offering a single program design across the country. Under current law, Medicare-eligible enrollees are allowed to remain in the US Family Health Plan (USFHP), whether they enroll in Medicare Part B or not. They are the only military retirees using military health benefits who do not have to enroll in Medicare when they become eligible. We seek legislative authority that will require those who are part of the US Family Health Plan to join Medicare upon reaching age 65. Under current law, the six USFHPs receive claims payments that exceed Medicare rates. We seek legislation that would permit us to reimburse these plans in the same manner as we do for all other Medicare-eligible retirees. Our plan will fully grandfather all of those who are already in USFHP, but would require future USFHP enrollees to transition to Medicare and TRICARE for Life once they become Medicare-eligible. Future retirees covered by the proposal would still be able to obtain services from providers associated with USFHP as long as the providers accept Medicare.

We believe that it is not appropriate to treat individuals differently just because they join a particular plan. Nor is it appropriate to provide a few hospitals with special

subsidies. This proposal is estimated to reduce Federal outlays by \$34 million over the FY 2012-2016 period and \$279 million over the next decade. And because DoD budgets for this program on an accrual basis, the Department's savings from this proposal would be substantial. Under our proposed changes, DoD accrual contributions are reduced by \$3.2 billion over the five-year period, FY 2012-2016.

Conclusion

I want to emphasize that none of our proposals would affect costs to Active Duty Service Members. Also, there will be no change in enrollment fees for medically retired Service Members or survivors of Service Members.

These proposals represent a package of incentives and changes in payments and benefits that we believe are reasonable and fair to all. Most importantly, they lay the groundwork for a strong and sustainable future for the military health care system. And the proposals generate savings that will help to pay for needed training and equipping of the Armed Forces.

Mr. Chairman, that concludes my statement. My colleagues and I welcome the Committee's questions.

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