

2002 Defense Economics Conference
Defense Agencies: Public Provision of Commercial Goods
and Services

Make vs. Buy: The Defense Health Program and
Tricare Management Activity

Chaired by Dr. Susan Hosek

Background Presentation by Dr. Carla Murray

Panel:

Dr. Edward Martin

Dr. Dennis Weaver

Mr. John Cuddy

Mrs. Patricia Lewis

Susan Hosek: This topic is one that I'm not sure I can remember a time in my life when it wasn't something that people were talking about. It may be one of the oldest of the current topics, and it's kind of interesting that the question of what to do with military health care goes back to the beginning of the modern Department of Defense.

To take a broader perspective, it's kind of interesting that the Hoover Commissions thought the federal health care system ought to be integrated and there shouldn't even be a military health care system. There is currently a task force looking at the DoD and VA systems and there are members of that task force who are intrigued from time to time about such ideas.

I don't think we want to go there today. What we want to talk about is what to do with the system that exists today. The particular topic is the question of making or buying not all of the healthcare, but the healthcare that is the capacity that goes beyond the amount that's needed for readiness.

Back in the 1970s and 1980s, of course, the requirement for readiness was so large that this was not an important question, but it emerged immediately when the Soviet Union went away and the requirement decreased. I would just like to throw out one comment. At some point, it would actually be nice to take a step back and ask how the system is organized to tackle the readiness part of the piece.

I don't mean looking at the readiness requirements again, because I know those of you who have been involved in that would not relish such an idea. Instead what I mean is to think about the entire approach that's used. However, today we are going to talk about the system pretty much as it exists now with the question of whether the capacity that exists today should be there. If it should be there, then should it be less, or perhaps should it be somewhat larger.

I think there are really two questions that are important. One is looking for ways to ensure that the resources that are in place are performing at a reasonable level of efficiency. Quality is, I think, generally thought to be quite high in the system. Many people believe that more work could be done with the resources that are in place. Perhaps that's not true. That may be one thing we want to think about.

Then given what's needed for readiness, the next question is, is the incremental capacity cost effective. Is it better to make or buy? I think we're going to get a background talk from Carla that will go over the main points so that everybody is on the same page. Then each of the three panel members will have their say.

Let me just take a minute to introduce them. Dr. Weaver is at KPMG and he's been heavily involved for some years. We run into each other in the Pentagon often advising the department, particularly on organizational and managerial issues. I'm sure you probably all know Dr. Martin. He was the acting assistant secretary for a number of years and I think most people would acknowledge, had a lot to do with the features of the system that you see today.

Patty Lewis was in health affairs for a number of years, but prior to that and now is up on the Hill on the Senate staff.

Mr. Cuddy and I met many, many years ago. He is the infamous money person in the Navy. I think we have four very different and interesting perspectives that we will bring to the topic. Carla?

Agenda

- ➔ ● Background: Size of the Defense Health Program
- The make versus buy decision--sizing in-house care
 - » Wartime mission and peacetime missions
 - » Relative cost of care
 - » Controlling beneficiary behavior
 - » New TRICARE for Life Benefit complicates incentives
 - » Conclusions
- Ongoing make versus buy decisions--How well does DoD Make or Buy?
 - » Beneficiaries pushed out onto more expensive TRICARE contracts
 - » Root causes of perverse incentives

Carla Murray: Today I've been asked to basically tee up the issues and give a common starting point. I have divided the issues sort of into two general areas. I'll give you a little background.

The first set of issues involve sizing in-house care. The make-or-buy decision itself. There's a host of issues associated with that that we can discuss. Once we've all reached a common understanding perhaps of those issues, one is naturally led then to the issue that has occupied most of our time recently, and that is how well do we either make or buy or both. So we'll work through that

Size of the Defense Health Program

- \$24.9B in FY 02 to run total system
- 130,000 personnel (military and civilian)

DoD Medical Treatment Facilities (MTFs)

- \$10.4B to run hospitals and clinics
- 76 hospitals and medical centers
- 513 clinics

Purchased Care

- \$10.0B in purchased care
- 14 TRICARE regions
- 7 TRICARE regional contracts
- Some non-TRICARE purchased care

Other programs: Education and Training (\$1.3B), Consolidated Health Activities (\$1.2B), IM/IT (\$.6B), RDT&E (\$.5B), Management (\$.3B), Procurement (\$.3B) and Milcon (\$.2B)

The size of the defense health program, of course is quite large. It involves \$25 billion in '02 of appropriated funds. A piece of that will be funded from an accrual fund for over-65 care starting in FY '03. It involves 130,000 military and civilian, about 90,000 of that are the military.

We generally divide it into the two broad categories of the in-house side there on the left, the military medical treatment facilities. It's about \$10.5 billion to run our in-house medical establishment, which comprises 76 hospital and med centers and 513 clinics.

On the other side, we have the stuff we buy, the purchased care that is predominantly the Tricare contracts. About \$7 to \$8 billion of that \$10 billion is Tricare contracts, our HMO. There is some non-Tricare purchased care. However, the focus is usually Tricare.

There are some other programs, of course. Education and training, central IMIT and other things that we probably won't get into today.

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Policy Guidance to the 733 Update Study for Sizing the Post-Cold War Medical Establishment

- All active duty care provided or arranged by military physicians
- Wartime casualties cared for in military facilities until return to duty or discharged to VA for any further care
 - » **Implication: MTFs must be at least large enough to care for wartime casualties**
- Beyond wartime requirements, provide care in MTFs to the extent it is cost effective
 - » Additional peacetime care to dependents and retirees provided through TRICARE by private sector providers

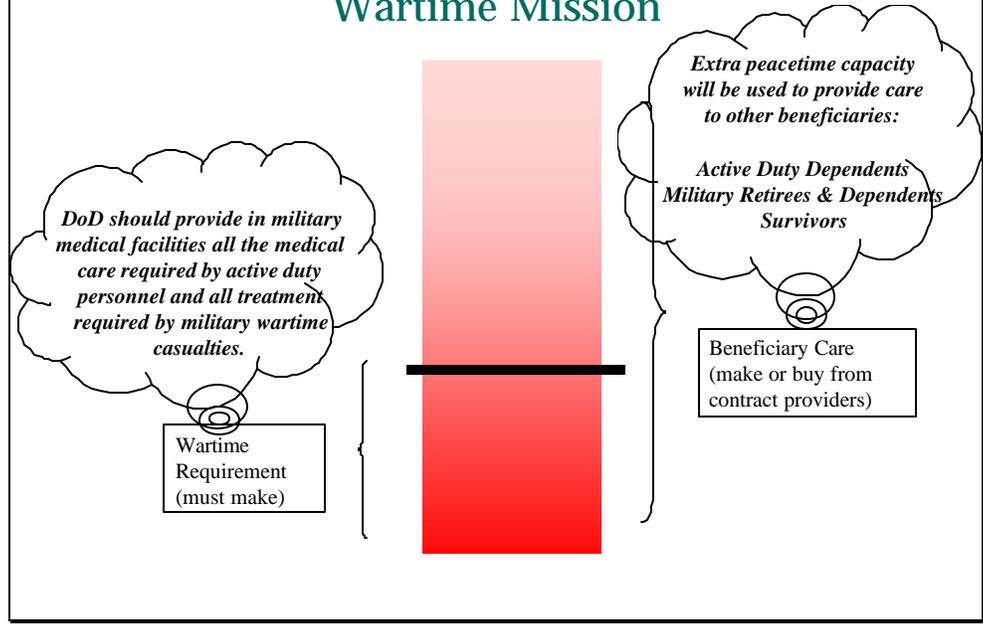
So let's go into the sizing of the military medical establishment. After the Cold War, there was congressional language in what we call section 733 that asked the department to consider what the right size of the medical establishment should be in a post Cold War environment. That study was done in the early 1990s and then was updated about 1998.

The policy guidance was as set forth there. All active duty care is to be provided or arranged by military physicians. Wartime casualties would be cared for in military facilities until they could either be returned to duty or discharged to the VA.

The implication then is that the in-house side, the MTFs, must be at least large enough to care for our expected wartime casualties. Beyond wartime requirements then, the policy guidance has been that one would provide care in the MTFs to the extent it is cost effective.

That means you will offer additional peacetime care to the military dependents, military retirees and to the extent that one has to serve that population, one would buy the extra capacity on the outside.

Benefit Mission is Much Larger than Wartime Mission



Which leads you to the picture here, which depicts that if you have a relatively smaller wartime requirement, you must make at least that volume of care; that is, you must provide it in your military medical facilities. If you have a much larger benefit mission to not the active duty, but to their dependents and to military retirees and survivors you're going to do a combination of making and buying.

The Total Number of DoD Physicians Exceeds the Requirement

	# of Physicians
● Wartime Requirement ¹	4,465
● Sustainment and Training Total	4,532
● Total Physician Base Requirement	8,997
● Physician Total	11,846
● Total as Percent of Base Requirement	132%

Source: 733 Update Study - April 1998

1. Excluding CONUS casualty care (counted in sustainment and training total)

The 733 update study also identified a different way of trying to measure capacity. There is excess capacity, at least as measured by the number of DoD physicians for the wartime requirement, plus what we call sustainment in training. So there is capacity available on the in-house side with which to treat the other beneficiaries.

Can a Larger Medical Establishment Be Justified?

10

- Justification rests on economic grounds.
 - Does DoD have a cost advantage?
 - Can DoD exploit its cost advantage if it has one?

The question is whether one tries to maintain that capacity or does one try to get rid of it? The justification and the policy guidance have to rest on economics. Do we have a cost advantage within the department and can the department exploit that cost advantage if it has one?

Two Studies Found MTF Case Mix Adjusted Costs To Be Less Than the Costs of Purchased Care

- IDA (1994) found purchased care 33 percent more expensive than the cost of MTF care
- CNA (2001) found purchased care to be 47-65 percent more expensive than the cost of MTF care

Sources: *Cost Analysis of the Military Medical Care System, IDA 1994, and Efficiency Analysis of Military Medical Treatment Facilities, CNA, 2001.*

There have been two studies of in-house versus purchased care, the make versus buy. When we're looking at case mix adjusted costs, there is evidence that the in-house side is cheaper than the cost of purchased care. This is a surprise to many people who haven't been immersed in this in the last 10 years.

The original study was completed by IDA in 1994. It found that purchased care was about 33 percent more expensive than the cost of in-house care. CNA, more recently, has used a different methodology, but has reached a similar conclusion and indeed found that purchased care is as much as 47 to 65 percent more expensive than the cost of MTF care.

Why Does DoD have a Cost Advantage?

- Don't fully understand all of the reasons for the advantage
 - » IDA found that about 38 percent of the cost advantage came from two items:
 - DoD spends little for indigent care; and
 - spends much less on facilities construction
 - » 42 percent of the cost advantage is accounted by the profits earned by private sector providers and the cost of their liability insurance
- Most savings accrue to the beneficiary
 - » savings to the government are about half of the total

Everybody wants to know the next slide, which is a surprising result. So why? I'll be honest and I'll say that we don't entirely know. The IDA study found that 38 percent of the cost advantage comes from the fact that we don't really have to care for indigents in the department and the private sector does have indigent care. Also, we do not spend as much on new facilities construction.

Roughly another 40 percent of the cost advantage can be accounted for by profits earned in the private sector and the cost of liability insurance. Of course the department self-insures. Now right away - an economist is going, well these are real costs to the government, and it's true. I wouldn't want to say that we ignore that. From the Department's perspective, neither of those are costs that we face.

It's also important to note that most of the savings accrued to the beneficiary because we tend to give away some of that cost advantage in the form of no co-pays, no deductibles to our beneficiaries. When one looks at how much actually we can take away from that cost advantage, how much of that savings goes to the government, it's actually about half of that.

Cost Advantage Cannot Be Exploited Without Enrollment

- DoD program generally lacks controls such as premia, copayments, deductibles, and enrollment
- Increases in capacity attracts people from TRICARE contractors plus those currently using private insurance.
- DoD saves money on the difference between DoD costs and contractor costs--but loses money on the whole cost of treating new users.
- Therefore, a relatively small number of new users is sufficient to tip the balance against "making" care.

The cost advantage that is observed has traditionally not been exploited by the department and cannot be exploited, if you will, without enrollment. You would need to put in some sorts of controls such as premiums, co-pays, deductibles, enrollment, etc.

You need to also be very, very careful because you have the problem of what we'd like to call ghosts. If you make the in-house system too attractive and end up bringing in people who are currently using private insurance and bringing in people who are currently using the Tricare contracts, then you'll erode your cost advantage very quickly.

A relatively small number of new users is sufficient to tip the balance. While there is a cost advantage, one has to be very careful about how one tries to exploit that cost advantage. To date, the department has not.

TRICARE for Life and the Make Versus Buy Decision

- TRICARE for Life gives the TRICARE Benefit to Medicare-eligible retirees and dependents
 - » If care is received in DoD facilities, DoD pays
 - » If care is received from a private sector provider, MEDICARE pays up to MEDICARE limits, DoD pays up to TRICARE limits (about 20%)
- Net effect--Less costly for DoD if care received outside DoD facilities.

Tricare for life and the make versus buy decision is actually pretty straightforward. Tricare for life gives the Tricare benefit to the over 65s, as we call them. The medical eligible retirees and dependents. Traditionally, if you were a military retiree and you hit 65, you were then expected to go on to Medicare. That is no longer the case.

What's interesting from a resourcing perspective is what happens on that side. If care is received in our facilities, in the department's facilities, we pay 100 percent. We bear 100 percent of the cost of treating those people.

If those people choose to go to a private sector provider, to their doctor down the street, Medicare is going to pay up to Medicare limits and DoD just pays the rest of that. DoD only pays about 20 percent, bears 20 percent of the cost of treating those over 65 retirees who go downtown, as we say.

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The net effect from a resourcing perspective is that we would much prefer to see those people go downtown. It's a lower cost to DoD in the end. There are medical concerns, treatment, professional clinician concerns about doing it for our in-house side. From a financial perspective and a resourcing perspective, the make or buy decision is straightforward.

Conclusions on Make Versus Buy

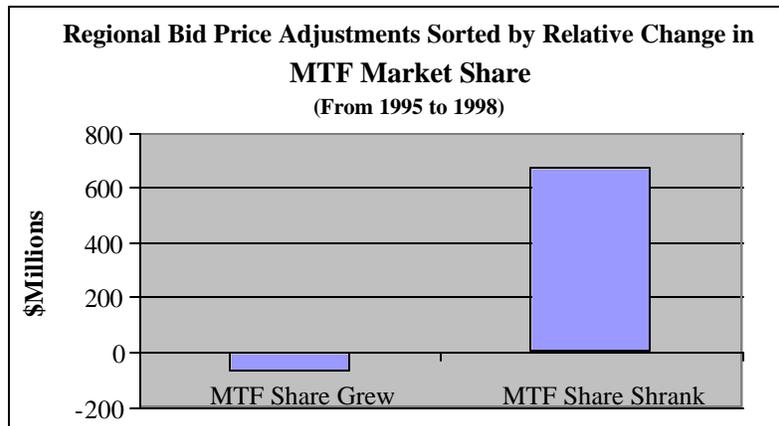
- Costs would be reduced by bringing work into the MTFs from the contracts (but not Medicare-eligible beneficiaries or new users).
- Free care in the MTF, plus a lack of controls on beneficiaries, make exploiting the cost benefit very difficult.
- Under these circumstances, the least cost solution likely to be:
 - » size to the wartime requirement; and
 - » buy remaining care.

So the conclusions about how much one would size the military medical establishment, you can reduce costs by bringing work in to the MTFs. However, you don't want to attract a lot of new users. It has traditionally been very difficult for us to benefit from the cost advantage. Under today's circumstances, then, what you are led to is generally that to minimize DoD's costs one would size to the wartime requirement and buy remaining care.

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Why MTF Utilization is Important to Purchased Care Cost

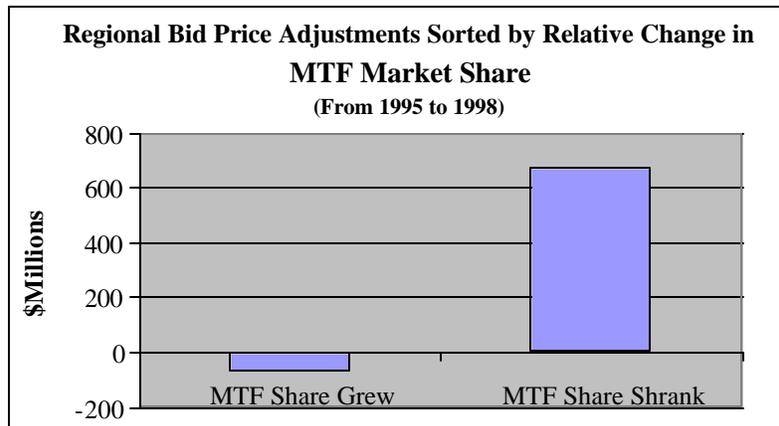


So how well do we make versus buy? There are plenty of people who say we don't do it terribly well. The link between the in-house side and the purchased care side is an important one, as we're trying to show on this chart. I've got to take a minute to explain it.

There are bid price adjustments that are made to the contractors or made to DoD. There is a certain level of workload that is expected to materialize, if you will, and certain patient load that's going to be seen in the in-house side. There is a certain patient load that's expected to be seen by the contractors.

If more people show up downtown than is expected, then the contractors are able to be reimbursed for that. If more work shows up in the MTFs than was expected, then the contractors need to reimburse the in-house.

Why MTF Utilization is Important to Purchased Care Cost

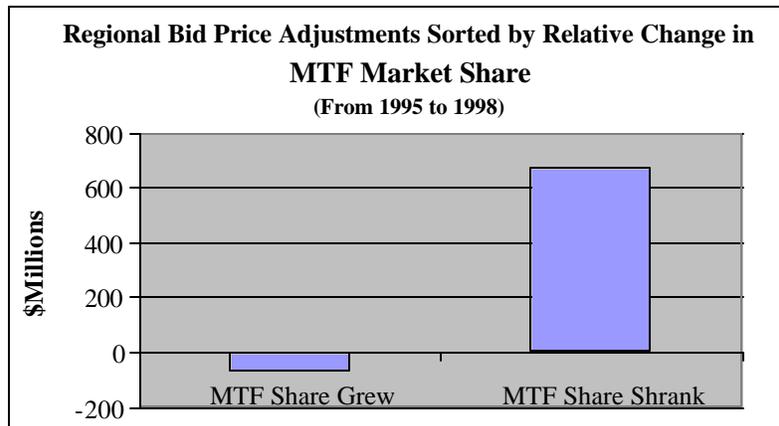


So there are payments that can go both ways under this system, and I'm speaking very, very generally. The people who are experts would probably qualify all that a little bit. There is an ebb versus flow. We can win, we can lose in the government, depending on where the people show up and where the workload is seen.

Here we tried to take four regions. We measured what we called MTF market share, and that would be the percentage of total work within the region that's seen in the MTFs. Then we tried to see how that compared with the bid price adjustments, the alterations, the payments to the contractors, or to the government within that same region at the same period of time.

What you end up with is this chart. On the left, the little bar that goes down were regions in which one saw MTF market share growing. Meaning that the in-house side was taking on a greater percentage of the workload within that region. One saw what we think of as negative BPA in the sense that the contractors had to pay the government for work because of the change in workload.

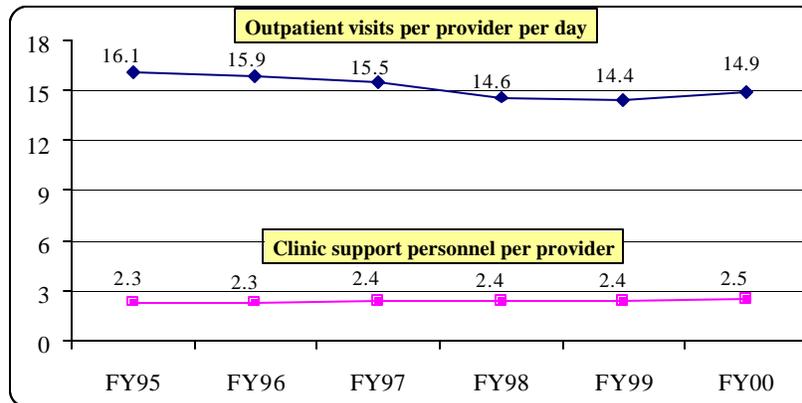
Why MTF Utilization is Important to Purchased Care Cost



In those regions in which you have the situation on the right, the bar on the right, MTF share was actually shrinking. Workload was migrating out of the in-house side onto purchased care. Indeed one saw bid price adjustments that were substantially positive.

In other words, government had to pay the contractor. It sounds like what one would expect based of the way I've described the contracts. The truth is that a lot of people had gone out and empirically tested the link. That's what we tried to do. It did confirm what one would expect.

MTF Productivity Fell Between FY95 and FY99



MTF productivity seemed to be falling between 1995 and 1999. Yet the situations observed in the MTFs did not change, at least as measured by clinic support personnel per provider. One heard that part of the reason the MTFs were having to force work out was because they were not being staffed adequately on the in-house side. At least this chart suggests that that reason was not sufficient to explain it. We have excluded same day surgery from this chart, which came up in an earlier discussion.

Financial Incentives for MTF Commander Under Current System

22

- Funding for MTF is dependent upon historical funding with adjustments for
 - » Changes in MTF enrollment from expected levels
 - » New activities/responsibilities
 - » In TRICARE 2.0, a small portion of MTF funding is based on the number of enrollees at the MTF¹

- MTF funding maximization strategy--enroll beneficiaries in the MTF, but send to the contractor for treatment.
 - » Enrollment increases budget;
 - » Reportedly, MTF frequently not billed for purchased care for enrollees (despite provisions in Version 2 of the TRICARE contracts)

- Second best funding strategy--limit enrollment
 - » MTF avoids entire cost of care;
 - » Only partially offset by funding reduction

¹ Incentives in version 1 are worse.

Let me just spend a minute then talking about the financial incentives for the MTF commander under the current system. In the course of PA&Es research, we've come to believe that the financial incentives in the system are tremendously important in figuring out the extent to which work is either retained in-house or sent downtown and received on the outside.

Typically, funding for a military treatment facility is done from sort of a budgetary perspective, government budgetary perspective. It's what you had last year, plus a little bit more, plus adjustments for changes in MTF enrollment from expected levels and any new missions you might have acquired along the way.

Now in this later versions of the Tricare contracts, what is generally called Tricare 2.0, they did try to put a small portion of MTF funding at risk and base it on the number of enrollees at that MTF. If you got a lot of people to sign up, you'd get a little kicker into your budget.

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If you look at the financial incentives faced by your military treatment facility commander, the best way to maximize your resources and minimize your cost is to go ahead and enroll as many beneficiaries as you can in the MTF, but then try to send them downtown for actual treatment. The enrollment is going to increase your budget a little bit, but you can send them downtown and you don't have to bear the costs of treating those people.

On top of that then, there seems to be some evidence that there's no penalty necessarily in sending the people downtown. Or at least it's not a penalty that the MTF commander really sees in a way that would affect his or her behavior.

The second best funding strategy, if you're an MTF commander in the current system, is to try and limit enrollment. Then you can avoid the entire cost of care. Due to the vagaries of government budgeting, the fact that you're not enrolling a lot of people doesn't necessarily mean it's a one for one reduction in your budget. So you get to keep most of your budget, anyway.

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Now let me say before everybody gets too excited that financial incentives are only one set of incentives faced by an MTF commander, and frankly may not be the most important ones. At least as important is the fact that the higher, more senior people up the MTF commander's chain can create their own incentives. That's part of what Mr. Cuddy, among others, does in his day.

Root Causes Of Perverse Incentives?

- DoD has attempted to overlay a managed care system (TRICARE) on an older system
 - » Inappropriately designed and ineffective financial and accounting systems
 - » Fractured command and control system--weak oversight of make versus buy decisions

Those facts notwithstanding, you do have some perverse incentives in there. You do need to somehow manage those incentives within your system. I would argue that what has caused these incentives is that we have been trying to sort of overlay new medical practices on an older military medical establishment.

Moving towards managed care has not been straightforward and simple. Of course the state of managed care has changed through the 1990s. It was generally viewed very positively as a way to control costs in the early 1990s. There's a bit of a backlash against it at the moment.

That notwithstanding, we traditionally have not had the sorts of financial and accounting systems that would enable our in-house side to operate or to even benchmark against outside care. It's been more of a clinician driven system as opposed to sort of a financial system. Again, I'm speaking in generalities and I realize how dangerous that is.

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Secondly, we have a very difficult set of management systems. Our command and control system is no real single authority to oversee the make versus buy decision. With the make decision, the authority predominantly rests with the Surgeons General. The buy decision predominantly rests with the TMA, Tricare management activity.

The two really don't come together terribly well. To the extent that they come together, they come together way up at the ASD(HA). For various reasons, the HA's ability to act is also quite limited. The command and control structure does create lots of problem of which most of the people in this room are aware.

Nevertheless, I hope this little presentation has given us something to talk about for the next hour or so and I turn it over to the panel.

Susan Hosek: Thank you. That was a very good overview of what is not an easy subject to make sense of. I think what we're going to do is move from my right to my left, if that's okay. And so I will start with Patty Lewis.

Patty Lewis: Thank you. That was an excellent overview. The Tricare Management Activity was established as a field activity and the history of field activities was to consolidate those services from the military departments. In fact though, it only consolidated a portion of that.

I think it's important to recognize that in the context of this dialogue, especially the make versus buy decision, the consolidation relates to a portion of the purchased care. Not the wartime requirement and not really administering the direct care system.

So I agree that the command and control issue is a significant one. Especially as we divide the country into regions and the role of the lead agent to manage those regions and to assist in making those make versus buy decisions without the commensurate authority and control adds to the dilemma that you so well articulated.

There's one other significant piece in my mind that drives a portion of the make versus buy decision. In fact, the size of the existing force beyond what's required for the wartime requirement. I think that's graduate medical education. Certainly that drives the need for a varied patient workload within the facility that doesn't neatly align to having the Medicare eligibles leave the system. Although that is the most cost effective way to provide care to those beneficiaries, as was recognized in the Tricare for life program.

So there are some significant dilemmas, but without addressing the management issues and what the patient population needs to be for the system to operate and what we want to do in house, then it becomes harder to determine whether or not to make this or that decision.

Susan Hosek: Ed Martin?

Ed Martin: I think again that Carla did a very good job of the make versus buy overview. I like Carla's point about this should be driven by the economic determinations. I can't remember any of the decisions over the last ten years that were driven by economic considerations or even good analysis. That's not how it went.

One of the key findings of the 733 report was associated with co-pays and deductibles. If anything, the co-pays and deductibles have been substantially decreased. If you tracked the trajectory, their expectation of the constituencies - and I would defer to Patty on that - but increasingly, the Hill's interest in that regard is to defer to the interest of the constituencies.

So one key part of the econometric analysis actually is moving explicitly and substantially the other way. The fact is, politics drove not only the formation of the DHP. It continues to drive what the benefits. A lot of the increased costs in the analysis done between the regions had to do with increased changes in the benefit. There's just a lot of the benefit now that you can't deliver in the MTFs.

So increasingly, huge amounts of expectations are having to be shipped on to contractors in areas like mental health and skilled nursing care, all of the other additional things. I think that has to be a part of the consideration. The part that is critically important and probably is most broken, you could argue about command and control and how to reorganize it. Since that has been going on since World War II, sort of incrementally.

I think Carla is absolutely right on about the incentives. If there were a single priority for Dr. Chu, Dr. Winkenwerder and Admiral Carado it would be how do you use the new contracts to yield the proper incentives, particularly for the MTF commanders. That is the number one overriding thing.

I think the second is a derivative of that. It has to do with can it be managed better. That was a hypothetical question. The answer is absolutely. There's a lot of inefficiency. I would take exception to potential conclusions from the productivity thing.

First of all, if you looked at 1995 to 1999, between 1994 and 1998, we dramatically changed how we counted. Mr. Cuddy will remember this. When you came in for an immunization and you were a pediatric patient, you were a 7. You got 6 immunizations, they counted you for DPTs, MMRs, rubella.

So when commanders were rewarded for the number of digits they delivered, they found very creative ways to get lots of digits. We changed the policy in 1995 so that one patient equals one visit. A lot of the 1995 to 1998 stuff was all of a sudden - it was probably the same number of patients and number of visits per actual practitioner in real terms is arguably the same.

The bottom line is the productivity level is much too low. It's about a half or a third of what it could and should be. The other point, of course, is that 3.5-support person per physician, if retained, will maintain something around that level of productivity.

In the private sector, which is the benchmark, that number of support personnel is two or three times greater, at a Kaiser Permanente or whatever. Again, issues of the incentive. The incentive could be different if you knew how many people the facility was seeing and you had some way of having an enrollment and capitation based way of rewarding them with proper incentives.

One closing comment that I would like to make, however, that I don't think is trivial. Certainly Susan and others here know that very well. A lot of times we look at the private sector as the benchmark in regards to the Holy Grail for how the MHS ought to work. Now that I'm in the private sector for the last three years, I can say almost unalterably we don't want to do that.

If there is a colossally broken system in this country, possibly beyond hope, it's the medical care system. Whether it has to do with incentives - and a lot of the issues about co-pays, deductibles, managed care, quality - all of those kind of issues are very much at this point problematic. Major employers from the private sector, sort of like DoD, are facing enormous potential problems.

I think one of the differences is it's within the ability of DoD and DVA to solve a lot of the kind of problems that you've got. I'm not so sure if I were in the state of California that I would know what to do with Medicaid. I certainly would not know if I were Tom Scully what to do with Medicare.

It is literally in a meltdown and I would submit in a couple of years, there's going to be a lot of conferences like this having been held about what happened. It's going to have the same kind of impact on our economy that this increase has had on DoD.

I think that the make versus buy and some of the other kind of considerations need to be looked at within that framework. I think the bottom line is it's incentives, it's optimization, it's improving the system and then making those marginal decisions about make-buy.

At the end of the day, the shift between DoD and Medicare doesn't save the American taxpayer anything. In fact I would submit that our 20 percent supplemental is going to drive up Medicare costs dramatically. It basically creates a full entitlement for people who have no reason now not to get all the care that they need or desire.

Susan Hosek: Thank you. I guess it's your turn.

Dennis Weaver: As we start and think about the make-buy I would like to go back to the broader level at this particular time. The conference is about the commercial goods activity, and health care is a commercial good. Yet I think you have to focus on the inherently governmental process of the military medical readiness mission.

If you start with that inherently governmental process and you think about the successes frankly in the conflict of today. You hear the stories last week at the Tricare conference related to health care being there in Afghanistan in the golden hour of health care. Then the amount of health care that's been provided in critical nature in the transport from the time that the soldier/sailor was injured to the critical care that's been provided in the transport back to the system that we have at this particular time. I would say that that's an inherently governmental function, and a very, very important function.

That is one mission that the DoD needs to continue to carry out. You then put it with a symbiotic, but not identical, mission of peacetime health care, which has a different set of drivers and a different set of activities. As you've said here, there's going to be a baseline associated with the amount of health care that needs to be provided for the readiness mission and then the cost effective nature of that health care that comes back in the peacetime system.

Clearly, the peacetime system then is not going to provide all of the health care. You're going to have to provide some wrap around. As you provide that wrap around to the health care system at this particular time, you now have two separate missions - a readiness mission and a peacetime health care mission. From a delivery in the peacetime health care mission, you have the direct care system and the wrap around system, the managed care support contractors.

That's a very complex system that needs to be managed, number one. You begin to think about just the specific incentives in the peacetime health care system. I think you need to think of it in the broader perspective of two missions and a very complex system of three departments delivering the direct care system. Then a number of managed care support contractors delivering.

You've got a very complex system. To define the exact set of incentives to make that entire system operate well is going to be a complicated matter. At this particular time, I'm not sure I'm ready to absolutely say that it's been done poorly. A very complex system in which, at this particular time, satisfaction is quite high. There is the cost effective nature to it. The system is fully funded for the first time and that system is performing very well.

I'm not entirely convinced that you start with incentives. You have to look at the overall accomplishment. The overall accomplishments of the system have been outstanding at this point.

Now you go to the next piece of it and you talk about the productivity issues. In recent years, there's been a question of whether the system is fully funded or not. If the system is not fully funded at the start of the year - you've talked about these perverse set of incentives. Managers, very good managers, are going to make short-term decisions that may not be the best for the entire system. They are the best decisions that they have with the funding streams that they have.

There are the incentives of the make-buy decision, but I think you have to look at it from the broader perspective of the downsizing that's gone on, the funding of the system. I have to compliment the system at this particular time. Being fully funded allows the managers then to make good solid long-term decision, both in the individual activities that go on, as well as in the capitalization efforts that are involved.

If you take the complexities of what I've talked about, I think the next thing you have to take a look at is the business model that you want to have when you get done and the program goals that are there. As you design those programs goals of these two missions and these complimentary systems, it's going to be a challenge to pick the appropriate business model that's going to make that system appropriately operate.

Once you pick a business model, you'll have to pick a contractual model. Once you pick a contractual model, you'll then have to pick a financial model and a performance measurement model that's going to make the system work. We go down then, to that particular level in those make buy decisions.

What's the most cost effective at this particular time? I think you have to take a look at all of the broader incentives that are there.

I think the system, for its complexity at this particular time does perform quite well. As you sit down and think about where does the system head at this particular point, we have to take a look at it from the perspective of what is truthfully the complexity in the system. The different missions, the different incentives that are out there across the entire system, and come up with what's the best way to incentivize the system.

John Cuddy: I was pleased to hear Dr. Martin's observation, since he's left our company. I think perhaps maybe it's time we start pulling the legs off the spider to see how he can jump. The challenge that we have really is to optimize subject to the constraints that are placed on us. Those constraints come from a variety of sources, whether it be the Congress or financial system process that we're subjected to when the funds are available.

I don't know anybody in the private sector who has to operate for three months under a continuing resolution. We're faced with things like that all the time. Readiness was mentioned. We have to understand that even readiness is not a term that's defined the same in the three services or utilized the same, for a variety of reasons because the three services have different missions.

The Army is the long haul guy and they are basically not into exercising readiness, but preparing for it and training. The Navy is the 911 force and it's out there all the time. It isn't happenstance that we happen to have the carrier battle groups when the reaction to 9/11 went down. It wasn't happenstance that we had an amphibious battle group there.

We don't keep the full up medical personnel in those battle groups. They would not get utilized, trained, whatever, when the battle group was at home. When the amphibious group goes out, we inject about 100 medical personnel. That's a variability in the system that we contend with to support the reason for the Navy and the Marine Corps being there.

So we have to recognize all of those things because they give us a challenge. It's not a challenge we're unfamiliar with. It's just a challenge that is different. As an example, make-buy goes back a long way in Navy medicine. At one time in the '80s, Health Affairs had the challenge of paying the private sector care bill. The services didn't have to content themselves with it.

Health Affairs got tired of going on hand and knee to Congress every year for a supplemental so that they could pay the bill. In 1987, they decided that they would transfer that responsibility to the service budgets. In my first year on the job, I had to go explain to the Navy budget officer why we had a \$263 million re-programming. After he got done breaking both of my kneecaps, we decided we ought to take a more business-like approach to things.

The Navy infused about \$130 million to get seriously into this make-buy business, to balance out the holes that were in Navy medicine. We were put under the microscope very early. We had a blue ribbon panel that tore Navy medicine apart. When that blue ribbon panel reached their concluding days, they had done the analysis that forecast almost to the month when the growth rate of what was then CHAMPUS would top out.

The make-buy is always a problem with the Navy as well. We have no control over a physician who decides that he can increase his rate of pay by a factor of 4 in leaving the service. We generally don't get a long-term notification of that.

What we need to understand is we have a tremendous lever in that those people that we do have in uniform and our civil unit force, because their rate of pay is legislated, that we can optimize if we look at the totality in Navy medicine.

As an example, Admiral Jerry Johnson, the now retired chief of the dental corps, stood on top of the mountain and looked across Navy dentistry. Realizing that the cost of health care purchased in the marketplace had a large variability going across the geography of the United States. He redistributed his blue suit assets so he could put the lower cost blue suit into the high cost marketplace and do his contracting in the lower priced markets.

You can do that if you approach this as a corporation and you look across. At one of the very early lectures I gave on this to a surgeon general's conference in 1989, I gave them the example of contracting for OB in the northwest and in the southeast. It's not a foreign subject to us. Perhaps the pressure wasn't on as it is now.

I think that our total energy should not be chipping away of what's gone on in the past - because as Dr. Martin indicated, there's a lot of reasons for the variability in our past. I think we need to have the rules of engagement laid out so that we all agree how we should proceed in the future.

I think we have a golden opportunity. It was mentioned that we're fully funded. After many years of asking, the Congress has put dedicated funds to coming up with optimization in the direct care system. I think that all of the talent in this room and all of the talent that's in our segment of defense should be concentrating its energies on the techniques and the process. This makes sure we can go back to the Congress and demonstrate that we've utilized those funds correctly so we get their continued support to get that fully funded system that we now have arrived at.

Susan Hosek: Thank you. I guess at this point we throw things open for anybody who wishes to comment.

Q: Susan, as you know, I don't know anything about this. So I hope I don't get this wrong. What I hear the panel saying is there seems to be a general consensus that if we set the readiness role of the medical mission aside and we look at the support of retirees and dependents and so on. There seems to be a general consensus that the holding quality constant, the department can provide the care for those people at lower cost than our contractors. Is that the sense of the group?

Susan Hosek: As Carla alluded, there have been two studies of that. Actually, both of them by Matt, so he may want to comment on this. Matt has done, what I consider to be a rather heroic job with the information available. If you look at the studies and compare them with the kind of research that is done in the civilian sector, the information just isn't available.

The whole issue is whether are we comparing apples and apples? Typically, cost analysis does not focus on the cost of a unit of service. I think what Carla's talk really comes down to is Matt has looked at it this way and then that way and then concluded that the cost of a unit of service is less in the military, but the systems don't provide the same units of service.

So the bottom line is it looks like taken as a package, it's not cheaper. But at a per unit of service level, it well may be. I still would like to stress may because I think that there is just a lot of unknown. A lot we don't know about what exactly is the make-up of the care. Are the MTFs providing care that looks like the care that's downtown?

Some efforts have been made to look at those, but they're primitive by the standards of some of the research I've seen. In any case, it turns out we don't know a lot about the cost drivers in health care anyway. DRGs and all of that stuff explains a surprisingly small fraction of the variation in cost.

I think this is a hard one to really be definitive about. I would like to give Matt a little bit of floor space on this because he's the one who has spent the most time studying it.

Matt Goldberg: We don't really know what it costs to treat an individual patient in an MTF and direct care. We can look at clinical areas. We can look at how much it costs to run a cardiology center at an MTF and we can ask how much it would cost to buy that cardiology care in the civilian sector, which is the most recent kind of comparison I made.

We didn't compare GME, medical education - we took that out. I was not asking the question of is it cheaper to run a medical school in Bethesda than it would be to run a similar school elsewhere. Strictly looking at the inpatient/outpatient care. I confirmed the finding that there is a substantial difference, substantially lower costs in the MTFs. You can't do it at a patient level, but you can do it at a clinical work center level.

We did adjustments, as Susan said, based on DRGs for the intensity of the care. One of the hypothesis people had was that maybe the MTFs look cheaper is that they are doing the easy care and shipping all the hard work downtown. We found that was not the case. It was very mixed.

Some of the work others have done in CNA found that you're just as likely in some of the clinical areas to find the more intensive work being retained, the more resource-intense being retained at the MTFs as opposed to being sent downtown. Differences in complexity was not the driver as far as we could tell, either on the inpatient or the outpatient side.

So like Susan said, we've done this a couple of different ways and received the same answer both times. There is an MTF cost advantage, notwithstanding GME, which I have not addressed.

My concern is that the cost advantage has been eroding a little bit in recent years because workload has been migrating out of the direct care system onto the contracts. So it's a very good news story to define the MTF cost advantage. However, you have to take advantage of that difference. You have to bring the work back in house.

The way to do that is to incentivize the MTF commanders. An approach that has been proposed and rejected in TriCare 3.0 would have their O&M budgets be made very sensitive to the amount of work that they keep in-house as opposed to the amount of work that they let migrate downtown. That way you have an advantage. You should use it to reduce the cost of the system.

Ed Martin: Just a couple of quick observations. Susan did point out the cost of care when you compare it even downtown. There is a great deal of difficulty in figuring out what care really costs and what care really is. When you make the distinction between units of care and the total care for groups of people or cohorts of people, now you get into a lot of important qualitative areas. That's not a trivial consideration.

For example, the MHS doesn't have 40 million uncovered people. It's outcomes are completely different. For example, the military health system met year 2000 goals for infant mortality in 1994 for Afro American populations, for Hispanic populations. The country still has not met those expectations. So there's a lot of difference.

As a pediatrician, that's not trivial to me. The units of care you need to provide good pediatric and good obstetrics care cost more. I'm just here to tell you that. If you're going to provide good prenatal care, good post-natal care, and good delivery care, there are a whole bunch of units in there that the MHS is obligated to provide, which makes the episode of care clearly more expensive. It's simply not provided downtown to large numbers of people.

Second point, which was touched on first by Patty, but I want to re-emphasize two pieces of it. Graduate medical education, probably one of the most difficult battles we faced in 1993-1994, was an effort to completely wipe out GME in the military health system.

Without GME and without the incentive to keep positions, you can make a great deal more money downtown. The destruction of GME would result in exodus of the exact kind of physicians that MHS has and wants to keep. It would be really a catastrophe for the really qualified people within the system that are physicians.

The second corollary point, we always talk about GME - and this really goes to one of the points that John Cuddy was making. The most important training in the military is not physicians. It's other than physicians. When Dr. Weaver mentioned the people who were moving casualties in the first golden hour, they weren't cardio-thoracic surgeons; they were corpsmen, they were medics.

Now that is a unique group of people. No matter what you think about EMS people, Special Forces medics and Marine hospital corpsmen are totally different. Their training is different, their capabilities are different. It is only within the military system that they could legally get the kind of experience and training.

You cannot take a corpsman or a medic and put them in even a major trauma system and allow them to have the kind of experience because of limitation or because of litigation threats that they are able to have in the military. Whenever we think about GME, we need to worry about that other great big group of people who are on the pointy end of the spear, which you have to protect.

Very frankly, the people that need to be there to train them need to be the best. In order to keep the best, I personally believe that you're going to have to offer the kind of quality environment, which includes GME. The bottom line is when you put all of those together, you have to take care of old people. Part of the reason why our active duty force is so healthy is that it cannot literally provide much opportunity for training.

Most of the dependents are quite healthy. It's only those of us who are approaching the TriCare for life who have the morbidity that allows a lot of the kind of things you have to do in combat to be trained. So you can't train that group of people on a whole bunch of healthy people. You're going to have to have a whole bunch of older and sicker - and they're almost synonymous, as I'm discovering - people who need to be cared for.

I think those pieces fit into the point that Matt was making about cost. As importantly to what John was alluding to about fundamentally what's different. Although I do think we can come up with a bunch of incentives that are pretty obvious that are going to help a lot.

Susan Hosek: On that point about the elderly - I don't know if anybody has looked at this. I think I've seen some data. I think I actually, over the past decade, the MTFs may actually be treating fewer of those people. This comes back to the comment that Dennis made about thinking about the incentives and the performance of the system overall.

Arguably, if decisions are being made about which patients to treat and which to not treat that are not serving the readiness mission that would be a very unfortunate outcome. I don't think that there is a system yet, a set of good metrics. There are a lot of little metrics. There are laundry lists of little metrics. However, there isn't a nice reasonable list of ones to get to the really big issues, particularly in the multiple missions.

Would it not be nice to be able to pick up an annual report that says as a military system, is this system performing well? Is it doing what it should be doing? I don't know what those would necessarily look like, but it would probably be helpful to the system to have those.

Mr. Cuddy: There's another factor, I think, that we need to be aware of that occurred in the early part of this period and definitely has an influence. That is as we approach the first part of the 1990s, we were dealing with a system with its umbrella spread over 60 percent of our population.

Forty percent were out of our reach and what is considered out of catchment. As we close that 10-year period, it flip-flopped. We've only got 40 percent now because of BRAC and 60 percent of outside of our reach. I think it's also important to pick up where Dr. Martin left off when he mentioned OB and peds. That is a dynamic of our population that is somewhat different.

When you take a young Marine's wife down at Camp LeJeune, and sometimes they are as young as 15 - some of them 17. The husband is out there on that deck half a world away and she's delivering her first child and you have no family support group to send them home to. You've got to provide a different kind of care than you have for the civilian population that has that kind of an environment to live in after the delivery.

So are we paternalistic in some of what we do? Yes. Do we have to be? If that Marine out there is worried about his wife and child, we're putting him in a dangerous environment that he doesn't need to be in. They've got to have the confidence that everything back home is okay and they can focus on what we've trained him to do.

Patty Lewis: I think the question we need to focus on is how much is enough to keep the system operative to accomplish what we want to accomplish. I agree with Ed that a major motivator in keeping the quality military medical health care force there is graduate medical education.

In the years I've studied special pays and worked those issues and even the support staff issue, the key that keeps those physicians in the military is the opportunities in those training programs at earlier points in the career than they would otherwise see that outside. Certainly you need a patient population in order to maintain those programs.

How much do you bring in and how large a program do you maintain? Do you bring every eligible population within the direct care system? Do we have the end strength given what the service secretaries have testified over the past week or so, about their need for end strength growth, to keep that within the direct care system?

I think the question is, how much of that do you need to maintain and where do you draw the line for the beneficiaries and what they get in-house and what you have to purchase to provide for them.

Ed Martin: We said make-buy decision. It's actually, I'd submit, a bunch of make-buy decisions. There's a whole bunch of them that you need to make. I want to build on what Patty said. There's a distinction - let's just pick Walter Reed.

There's a distinction between Walter Reed as an institution, its capability to train, its capability to provide care, its surge capacity for casualty and its ability to deploy big bunches of people quickly. The uniform personnel piece of this and the services are very different in this regard. The Air Force is having to sort of accommodate now.

The Air Force is predominantly active duty personnel. It is now having a very different mix of civilian and uniformed personnel. The Army probably has the richest support complement of civilians, which has some advantages. Certainly the Navy does where it has its big facilities, where it has to deploy people.

When you look at a Walter Reed, the issue of end strength, how many people, and the make-buy is a different make-buy. It's how many uniformed personnel sometimes versus how many civilian personnel and support personnel. That's not a trivial issue - it's a variant of the make-buy. It is also going to have to be a part of the decision making process if you're trying to optimize the care.

Dave McNicol: This is a question that goes more towards the second part of Carla's brief and something that Ed Martin and John Cuddy might both want to address. They both spoke of financial incentives. My question is, who is in charge and who should be in charge?

They are perverse incentives. This is presumably something that is not rocket science to fix, and yet they've been perverse for years and years. So who is in charge? Controller, TMA, the surgeons, the military departments. If Secretary Rumsfeld wished to apply to someone to get this problem fixed, to whom would he apply?

Susan Hosek: Well actually, Dennis and I both -- trying to look at that question. It's a problem. The VA did something kind of interesting a few years ago. They attempted to - they also have had a problem of who is in charge. It sure wasn't the assistant secretary.

They restructured themselves in a regional way, but with very clear lines of authority at work in a program/budgeting system. RAND did a study of this and when I talked to people, I was struck by their enthusiasm for their new system. Even those who have lost some under the system really like the fact that authority is delegated to the working level. They have a significant control over resources.

You talk to people in the military system, you talk to MTF commanders and you almost always hear the same thing. If you just give me a clean line of authority, an understanding of what my budget is going to be so I know what I have to work with, I could manage this thing. That's not the way it works right now.

Dennis Weaver: That same question has been asked back to Hoover, I think.

Susan Hosek: Actually, Eisenhower was the first person to ask the question.

Dennis Weaver: It's been asked and asked and asked again. I'm not sure that it is an organizational issue. I think over a period of time, form follows function. From that perspective, the concepts that are being discussed here today about what are the program goals. I mean, where you started from the beginning. What are the program goals? You've got two different missions that both need to be accomplished.

When you look at those two different missions, you then need to decide programmatically how you're going to accomplish them. Then build an appropriate business model to accomplish them. Then support the business model with the business processes organizationally.

I'm not sure the first place to start is organizationally. I think the first place to start may be to clearly understanding what you're trying to accomplish and incentivizing those accomplishments as we're talking about here today. Then the department struggles with organizational change.

Is that the kind of thing that you want to push through the department, organizational change? Or do you want to focus on getting a good solid business model, a good solid incentivized structure so that everybody in the system - understands they are on the same track.

Susan Hosek: Yes, and actually there's several talked about incentives and I think the incentives are an important question. I think also some attention needs to be paid to the authorities. You can incentivize somebody to do something, but if he's tied up 50 different ways, he's not going to be able to accomplish what you want him to do. I think that both pieces probably need some attention.

Dennis Weaver: Accountability, responsibility and incentive-based all fit together. Form follows function.

Ed Martin: A little bit different. First of all, again, I'm sort of thinking of the private sector or even the DVA comparison. If you take a look at military officers who are now in charge of facilities and things like that, they use words like "accountability" and "chain of command" and "authority."

Let's face it, I don't know of any system that is more carefully honed to do all of those things. It's designed to do that. So the conclusion has to be not that there aren't those things there, but they are very clearly a different set of incentives.

The fact of the matter is an MTF commander is not going to make O-6 or be eligible for O-7 or be rewarded based on anything associated with their economic performance or running their facility. There's a whole bunch of other things, including that stuff they're asked to do.

So you have to sort of re-frame it. I agree completely with Sue relative to one element of the system. Health care is a community thing. When you talk about how you really run it, you do not run it from the Pentagon. You don't run it, frankly, from the lead agent office. You run it from the facility. I mean, that's where it's got to work.

If it doesn't work at the MTF and the clinic, it isn't going to work. So what you have to do is figure out how you do that. I do take exception in regards to DVA for two reasons. Number one, the VA doesn't have to deploy people. I can tell you right now, if all of a sudden you had to move 150 VA people, it would be roughly having the same emotional trauma as moving a graveyard in downtown Boston. It could not happen.

The second thing is, they created 26 separate corporations. One of the things that Ken Kaiser wrestled with, Roswell will now inherit, and Tony Principi's very concerned about is that there was not a lot of relationship. Although they're trying to make it happen, between where the money went and where the people were. That was a huge problem.

The separate organizations essentially determined what the benefits were, like the constituencies. But it is not a unified system in the wildest sense of the word. At least Army medicine or Navy medicine or Air Force medicine has some kind of reasonable consistency across the three services. The DVA is very different.

That would be something I'm not sure you would want. Although I think the ultimate unit that you're going to have to figure out how to manage is the region, not the MTF, because that is where the readiness and civilian care come together.

Patty Lewis: I'd take a step back and when you're asking who is in charge or who is responsible, there are two questions that I think you need to answer. One, who is responsible or in charge along the lines of the nature of the benefit. The second piece is the delivery of that benefit.

The nature of the benefit derives from demands within the department and there's certainly a lot of Congressional responsibility there. I'll use TriCare for Life as an example. It was the Chairman of the Joint Chiefs of Staff who demanded we meet the commitment of health care for life for our military members.

He said it was a recruiting issue and came to Congress and demanded that something be done. Now certainly that gained political weight and force and it did, in fact, occur. But it was the Chairman of the Joint Chiefs of Staff who came to Congress and said that we must eliminate co-pays.

Those sorts of issues revolve around the nature of the benefit. Not only do you have the military medical departments trying to administer the program, but also you have the bigger department and the Joint Chiefs and the Congress helping you define that benefit package. Then the health community has to deliver that benefit.

So there's two different sorts of oversight and command structures, and certainly I agree with Ed. However, in the delivery of care, there's a rather defined structure. Although we do have the three services and some of the resourcing issues are not clear. We certainly don't have consensus, authority, and direction on the nature of the benefit and the delivery of that benefit in one place.

Dennis Weaver: I think one of the things that gets complicated down that path, Patty, is the issue that the department has an employer function they must provide. The employer function is to determine how much of the dollar of the budget is going to go to pay for health care and what kind of benefit do they want to provide.

So you go then from an employer function to a delivery of care function. In the delivery of care function here, there's responsibilities to be both the payer organization and insurance type of organization for that, and then a delivery of care function.

So once again, I'm not sure there's another health care system in the world that has to take on the responsibilities of being the employer, the payer, and the provider.

So one of the things that you have to figure out is which hat are you putting on? Am I in my employer function today, am I in the payer function, am I in the provider function and the complexities associated with all of those?

Ed Martin: Should we focus on delivering care to our beneficiaries, or on making sure that if we have to go to war tomorrow, we can? When you add that dimension, there is literally no analogous system in the world.

Dennis Weaver: Then you get back to the challenges. I think we've all noted the importance of a robust direct care system. However, then there is the issue of incentivization to ensure that that performs optimally. And then to ensure that the total package that you provide the beneficiaries has a good wraparound, that they have an excellent quality of life from a peacetime benefit.

Ed Martin: One thing Dr. Weaver said that I want to just mention. He was talking about the fact that there's a big difference when you approach the military health system as if it's woefully and totally broken. It needs life support and resuscitation.

That attitude or perception which, by the way, is really much around in the late 1980s and up to the mid 1990s, does change the character of the kind of questions you're asking and the character of the discussion and debate. I don't think the military health system is broke.

I think I went to the best Tricare conference ever. Competent people running a very complex system under enormous stresses, responding extremely well to September 11th, which is a fundamental mission. They did a lot better than we did in the Gulf and in the Gulf we did a lot better than we did in prior cases.

It's a question of what kind of grade do you give them for doing this very complex thing? The next set of questions is, what are the things that they need? The first thing they needed was full funding. We were able to fund it fully in 1995 and 1996, but not against these new requirements.

I think some of the key questions concern what are the things they need and what are the incentives they need to actually make the system work better.

I think that changes the character of the kind of questions that we're asking. Is it broke and desperately needs fixing? I would certainly rather be in the position Dr. Winkenworder is than an awful lot of the people who are state Medicaid commissioners. Let alone do that plus run an HMO, a health department, and be the employer of 8 million people.

Dave McNicol: Hold on just a minute, though. You're giving the answers at 50,000 feet for a ground level problem. Someone said one of the reasons that we have declining productivity that we're pushing people out the door is that the system wasn't fully funded. We had an agreement that the financial incentives on MTF commanders are perverse.

I don't see anybody immediately on hand from the controller's office. Why don't I say that Dr. Zakheim is in charge of those problems and should fix them forthwith. It's costing us a billion dollars a year in unneeded expenditures.

Ed Martin: I happened to be there with you when we had a controller that thought he should do that.

Dave McNicol: Well, the fiscal guidance, at least.

Ed Martin: He was actually a DepSecDef. At the end of the day, we decided that possibly managing the delivery of care as opposed to the benefit probably required a different set of skills than a biochemist. With all the deference to the Comptroller, I think what the secretary, the Comptroller, and frankly Dr. Chu needed to do on the delivery side is to do exactly that. There is no reason why OSD, if it puts its mind to it, could not do it. I can speak personally to the fact that if the assistant secretary wants to do something even that is difficult, with the support of the secretary, you can do it.

Consolidate GME, create regions, make people get decent licenses, do certification. There are whole bunch of things services didn't want to do that we did do. So I think you're correct. You've got the Secretary, the Comptroller, and the Under Secretary supporting and directing somebody to do something, it will happen. It will happen for a very simple reason - they've got the money. The services are going to blink when it comes to that.

The other part about this is a lot of these things, the services want to do too. It's not like there's necessarily apposition.

Mr. Cuddy: I think perhaps where Dr. McNicol is going is on the here and now, how do you make it happen? How do you get control? I think there's probably three different solutions out there that represent the three different cultures that are the three different services.

I'm not sure that - there don't always have to be three. I mentioned earlier that readiness is different for the three services because they are supporting a different mission. I'm not sure the culture of management in the three services may turn out to be that they are derived from the mission that those three services have. Maybe we all can't get in the same boat and face the way when we pull on the oars.

I can only speak for my service. My service has imposed a very tight discipline in financial management. It's the school I grew up in. I can impose that on Navy facilities and it works in the Navy. I'm not sure it would work elsewhere. So I'm not going to stand on top of a mountain and say they all should do what I do.

However, I think we can all learn from each other. I think perhaps we ought to spend some time looking at how the three of us do things and where there is common ground that we can export back and forth to each other, and we're doing some of those things right now. I think that's the way to make the entire system move forward. I think we do definitely need to acknowledge that there are service cultures that we probably cannot trample.

Susan Hosek: I'd like to come back to the benefit issue for just a minute. I don't think anyone owns the benefit issue. I think everybody is afraid of it. If you think about it, we've been increasing pay and we've been increasing benefits. I would bet you that most employers would not have put them on anything like DoD did.

That's partly because the people who are thinking about this are not thinking about both of them as a combined benefit package. Dr. Chu is actually interested in starting to do that, and I think that would be an enormous and beneficial step.

From the point of view of the system, this benefit changes in a significant way every year. What we all want people to do is sit down and figure out how to do a better job managing that benefit. I think it's probably a good time to stop making these significant changes so that these guys have to enroll over 65s now. This is a whole other big thing. I just think there is a way to get management over the benefit. It would be an important starting point.

Patty Lewis: The one silver lining in the cloud -- over 65 benefit is - at this point in time, we know we have a responsibility to all those beneficiaries. Prior to knowing that, there was this uncertainty in how much should be absorbed within a system and how many we had to turn away.

The good news is, I think we know what's there now. Where before there was that uncertainty and that put incredible pressure within the system to absorb more, and a lack of satisfaction no matter what was accomplished.

Mr. Cuddy: I think one of the greatest challenges we have, and that is with the freedom of choice that we've given our beneficiaries with their new entitlements, we need to be very careful that we can market to and keep engaged with the right mix of beneficiaries we need across the system. Because otherwise, the over 65 represent the retired group which is in love with military medicine. We all grew up with it. We never found anything wrong with it and we will rush to embrace it.

With freedom of choice, if we're not careful how we manage the total beneficiary population, we can dis-enfranchise the younger ones. When they get of age and retire, they won't have that same experience with our system. We could be digging ourselves into a death spiral, because we'll be 20 or 30 years from now not having that beneficiary flow and they will be just as happy to go down the street.

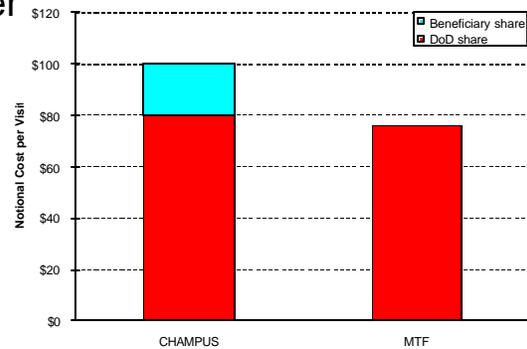
So we've got to really come up with a way of over sighting that total mix. We can't rush to bring all of the over 65s in the door. Not just for financial reasons, but because we'll dislodge folks who are not from that age group.

Susan Hosek: I believe that we're at the end of our time. As usual on this topic, if we've solved anything, I haven't figured out what it is.

Backup

MTF Care is Cheaper per Episode

- MTF care is about 25% cheaper per case than purchased care.
- Saving mainly accrues to beneficiaries, who avoid co-pays and deductibles.
- DoD budget saving ~5% per case on average.

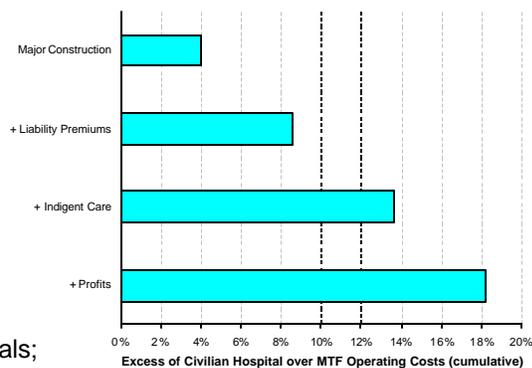


Source: 733 Study

The chart is notional. In fact, standard CHAMPUS pays 80% of allowable cost for active-duty families, only 75% for retirees. The overall 24% cost advantage is actually a weighted average of the two.

External Validation of MTF Unit-Cost Advantage--1994 Estimates

- Unit-cost advantage based on comparison of MTFs to CHAMPUS.
- External validation based on analysis of American Hospital Association (AHA) and other civilian-sector data.
 - » additional cost elements that DoD would have to pay to purchase care.
- Still other cost elements, more difficult to quantify:
 - » lower physician salaries at MTFs (even including bonuses);
 - » MTFs enjoy quantity discounts on large purchases of supplies, e.g., pharmaceuticals;
 - » MTFs avoid taxes and tax preparation expenses.



Source: 733 Study

By law, pharmaceutical manufacturers must sell to DoD at prices no greater than the wholesale prices they charge non-government retailers (e.g., CVS) or non-government medical providers (e.g., Kaiser). These are the so-called Distribution and Pricing Agreement (DAPA) prices. Currently, DAPA prices apply only to pharmaceuticals purchased by the direct-care system, not by CHAMPUS participating pharmacies or TRICARE managed-care support contractors (e.g., Foundation Health).

Virtual Hospital Efficiency Government Costs Only

Even when compared to just the government's costs for purchased care, MTFs are still less expensive than the purchased-care alternative

	Total ratio	Gov't-only ratio
1997	1.65	1.31
1998	1.45	1.17
1999	1.47	1.21

$$\text{Government-only ratio} = \frac{\$ (\text{government cost for purchased care})}{\$ (\text{actual MTF cost})}$$

Sources: *Efficiency Analysis of Military Medical Treatment Facilities*, CNA, 2001

Here we summarize virtual-hospital efficiency from the perspective of government costs only. Because the beneficiaries must pay deductibles and co-payments for purchased care, the government cost of purchased care (the numerator of the ratio in the slide) is lower than the total cost of that care. Thus, consideration of only the government cost tends to make the purchased-care alternative look less expensive. Nonetheless, MTFs are still less expensive than purchased care (i.e., the ratio exceeds 1.0), though by a smaller margin than when we considered the total cost of care.

DoD Beneficiaries--FY2002

