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## Improving Military Healthcare

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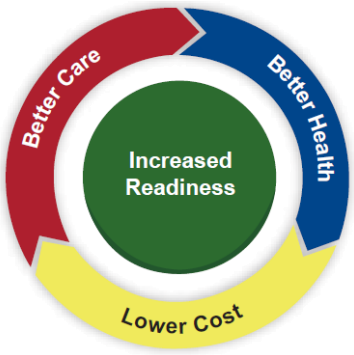
As healthcare costs continue to rise across the country, players across the commercial healthcare system are continually exploring new and innovative concepts that can bring cost savings to providers, insurance companies and beneficiaries. The Department of Defense's (DoD) Military Health System (MHS) is no exception. MHS has seen an increase in costs over the last ten years, driving the need for changes across the department's TRICARE plans, which serve approximately nine million military service members, their families, and qualified retirees. Similar to the Department of Veterans Affairs (VA), TRICARE beneficiaries receive their care at either direct care facilities (i.e. military hospitals and clinics owned and operated by DoD) or civilian providers through purchased care (a contractor-operated network of civilian doctors and clinics) which compliments the direct care system.

Unlike other federally funded health systems such as VA and Medicare, MHS is unique in its goals, often called the Quadruple Aim (Figure 1). While all health systems have the responsibility to cost-effectively provide quality healthcare, MHS has the additional mandate to maintain a medical force that is ready to deliver health care anytime, anywhere in support of the full range of military operations, including humanitarian missions. Due to this goal and the extensive use of the direct care system, MHS operates as a hybrid with attributes of a university hospital system, integrated delivery network, and commercial network, akin to the Federal Employee Health Benefit Plan (FEHBP).

***Figure 1: MHS Quadruple Aim.***




While the current DoD budget is less than it was ten years ago, the MHS budget has grown even with the decline of service member enrollment (see Figure 2). One major reason for this continued growth in the MHS budget is DoD's willingness to absorb the increased costs of care without passing it along to beneficiaries. In contrast to many commercial plans who push the increased costs to their beneficiaries through increased premiums, deductibles and copayments, the DoD's benefit plan has remained relatively unchanged. Figure 3 shows how the spending per active duty service member has grown, resulting in a 34% increase (2007–2017) in total healthcare spending despite a shrinking military force.

A growing MHS budget, particularly as a nondiscretionary item that consumes a growing portion of the total DoD budget, has significant national security implications, as strategically important initiatives such as shipbuilding and nuclear programs continue to remain underfunded. For example, the nonpartisan Congressional Budget Office (CBO) estimated in 2017 that to meet the Navy's plan to expand their fleet to 308 battle force ships, the Navy would need a budget increase of 29% over their typical allotment over the past three decades. In addition to shipbuilding, the Pentagon is struggling to modernize and sustain its aging nuclear force, with CBO's 2017 report citing the need for a $348B spend over the next ten

***Figure 2: DoD healthcare spending as a portion of the DoD overall budget; includes MERCF receipts & MHS budget.***

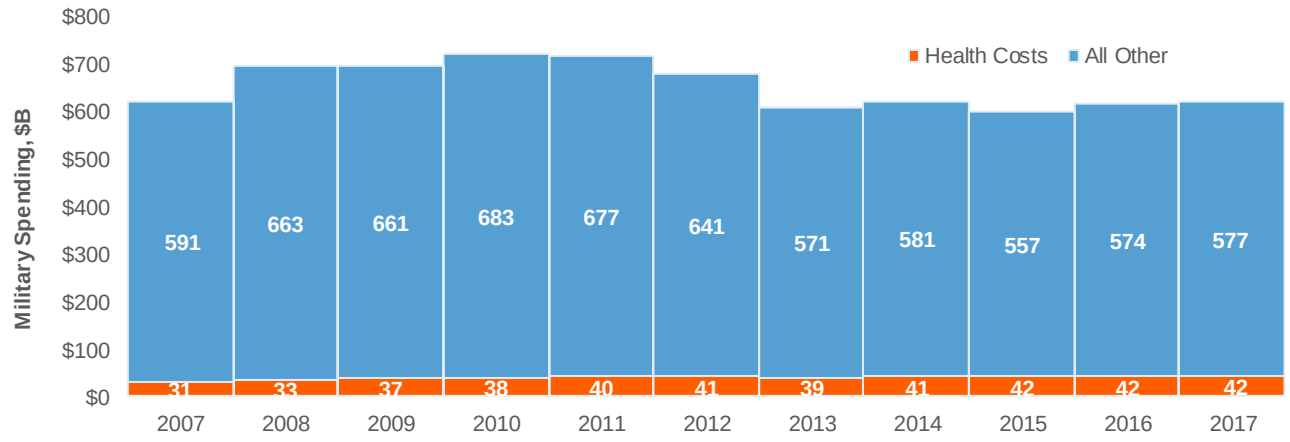
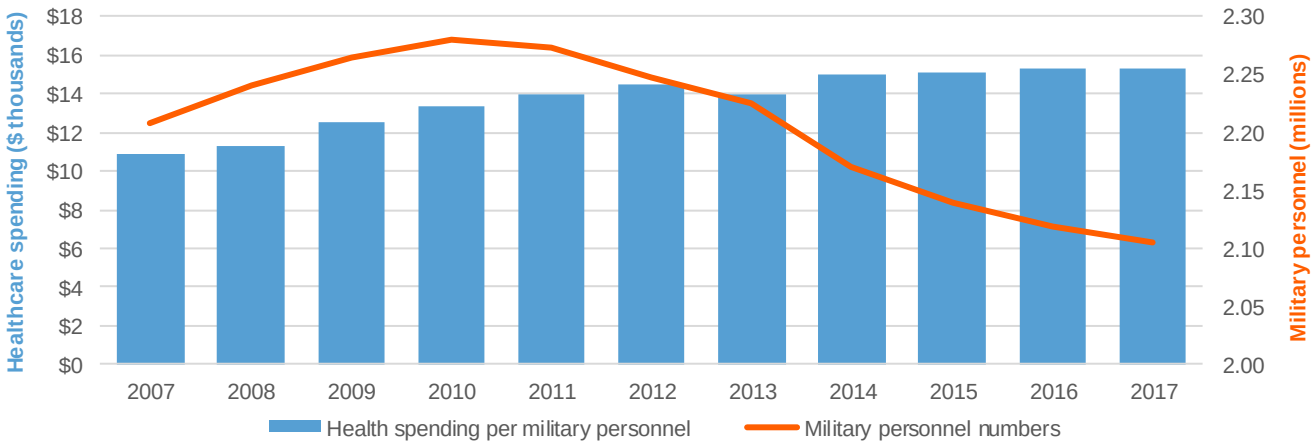



***Figure 3: DoD's military healthcare spending per employee (MHS budget) vs. military personnel enrollment numbers (DMDC)***

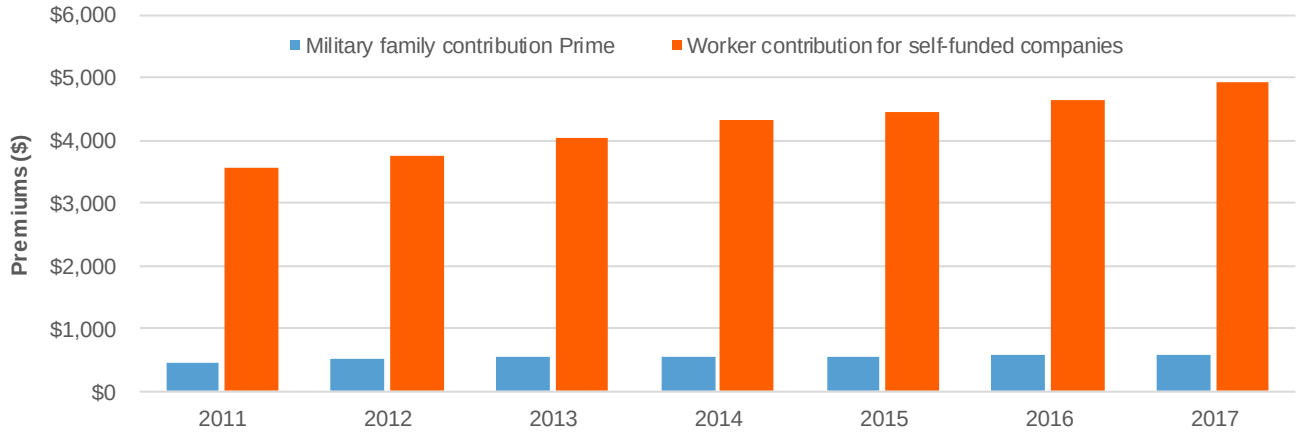



years, a 15% increase from their 2015 estimates. With large strategic programs like these still awaiting additional funds, even with the increased President's Budget for Defense for FY2019, it has become more important for MHS to manage its costs. If it fails to do so, it leaves itself open to harsh criticism similar to the F-35 program, whose continued price increase has drawn significant attention from congressional members and has forced procurement trade-offs within the Pentagon.

The MHS cost control imperative is growing—similar to the rest of the US healthcare industry—but the unique mandate and structure of the military system create complexity that requires customized innovation across all domains. NDAA FY2017 required MHS to make substantial changes to its TRICARE offerings and allowed wellness companies, integrated delivery networks, universities, and analytics companies to bring innovations from the commercial world. For example, Defense Health Agency (DHA) is running a value-based insurance design pilot program that reduces copayments on diabetes and hypertension medication, in an attempt to lower Emergency Department utilization.

However even with the immense changes the FY17 NDAA legislation brought to TRICARE, the overall cost savings estimated by the CBO were minimal. With copayments and premiums remaining significantly below commercial rates (Figure 4), beneficiaries saw a minimal increase in out of pocket expenses, with most out of pocket expenses going to future military retirees who join the services after 1 January

***Figure 4: TRICARE Prime enrollment annual fees (TRICARE website) vs average commercial worker contribution annual fees (Kaiser Family Foundation).***




2018. While the value-based care and wellness changes are expected to encourage better behaviors among beneficiaries and providers and lower long-term costs, immediate cost savings are minimal in a realm where the price tag for services continues to increase.

CBO outlined various paths MHS can take in tackling its growing budget in an October 2017 report titled, "Approaches to Changing Military Health Care." The report suggests various scenarios such as decreasing the direct care system, moving non-military and retiree beneficiaries to purchased care only, and charging beneficiaries higher cost shares or copayments for services. CBO's recommendations to move non-service member beneficiaries to an entirely purchased care system or FEHB plan would save money if the design is right. Currently, FEHB plans are considered efficient, considering they house an older government workforce and offer relatively generous benefits compared to other civilian plans. However, even these plans are no match to the rich benefit of TRICARE, meaning MHS would be forced to drastically increase premiums and copayments charged to beneficiaries, or take on the burden themselves, which would undoubtedly raise the price per beneficiary.

A second option CBO presents would be to move non-military members to a purchased care system currently run by the two medical TRICARE contractors, allowing for MHS to scale-back the direct care system. This would allow MHS to reduce the uniformed medical staff that focuses on areas such as gynecology and endocrinology, which are not traditionally considered relevant for military combat needs. Due to TRICARE's low negotiated rates, purchased care can be cheaper than direct care, particularly because direct care staff have other military responsibilities to complete in addition to seeing patients. This second option is more likely to be accepted by the military community; however, outside stakeholders have pushed back against this prospect, claiming that the additional doctors—who previously worked at military hospitals—would flood the commercial market and outstrip demand. In addition, there are sunk costs to consider, such as military hospitals and staff required to meet readiness standards. These military staff members could potentially see a decrease in efficiency as their patient counts decline.

The right balance of direct care and purchased care working together can provide cost savings without sacrificing other objectives. While these solutions presented by CBO have potential to decrease overall healthcare costs, the likelihood of CBO's recommendations taking hold in the immediate future is low. DHA has historically reacted to congressional mandates, but current leadership talks about being more proactive and leading changes to the US civilian healthcare system. This presents opportunities for solutions that DHA can implement to bring about cost savings and quality. MHS is ripe for private sector

inputs at both the DHA and congressional levels that will result in creative changes that other parts of the healthcare industry are already starting to embrace.

This creates several ways for companies to get involved. As solutions are explored, the Quadruple Aim, shown in Figure 1, is going to be an important consideration in assessing suitability for MHS. Below are three illustrative examples of ways to help MHS improve, while still fulfilling the Quadruple Aim.

1. **Population health.** Many self-funding organizations hire analytics companies to assess and interpret the large amounts of data they receive from their ASO insurance plans. With the separation of medical, dental, and pharmacy across several different contractors and direct/purchased care hospital systems, assessing the whole health of a person remains a challenge for a system this intricate. However, with this sort of data, DHA could better assess its benefit design each year, tailoring copayments and pilot programs to fulfill the needs of the population to achieve better health and better care among beneficiaries.
2. **Wellness initiatives.** NDAA FY2017 mandated MHS to introduce wellness initiatives to service members. As wellness strategies continue to expand in the commercial world, there are several opportunities to bring cost savings through healthier employees and reduced sick days. In addition, wellness can be used to help the military track potential beneficiaries that may begin to slip from military deployment standards. As Defense Secretary James Mattis continues to combat the growing obesity issue in the military, wellness companies can enable DHA to entice its population to meet military readiness requirements.
3. **Value-based analytics.** With the new NDAA value-based care requirement, DHA has the ability to expand its analytics portfolio, allowing it to better assess purchased care doctors and clinics. Like other large self-insured systems, quality is a large concern for DHA. As the medical sector moves from volume-based payments to outcome-based payments, value-based analytics help set the stage for payments based on set metrics which in return will help lower health care costs.

As the private sector looks to bring efficiencies and quality programs to MHS, the Quadruple Aim and DHA's unique complex mission is an important factor to consider. While commercial costs continue to rise across the country, Congress will continue to look for better solutions and strategies to bring about change. In federal health care systems, other departments often view Medicare as the leader in setting trends and inviting innovations from the commercial space. However, due to its critical mission, beneficiary population that mirrors the US population, and desire to cut costs, DHA has the ability to become a leader in the federal health sector and the broader US healthcare industry by working with innovative companies who bring innovation and expertise from the commercial sector.

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