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MILITARY HEALTH CARE REFORM, COMPENSATION
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P R O C E E D I N G S

MR. O'HANLON: Merry Christmas, happy Hanukkah, happy holidays. I'm Mike O'Hanlon, from the Center on 21st Century Security and Intelligence. We are privileged today to have an all-star cast on the important subject of military healthcare reform.

We are going to hear from Assistant Secretary of Defense for Health Affairs, Dr. Jonathan Woodson, first. He is responsible for the \$50-billion plus enterprise that takes care of almost 10 million people, including DOD, active duty personnel, their families, retirees. It took care of more than 50,000 wounded on the battlefield, and that is a very large player in our national healthcare system.

And for that reason, after we've heard from Dr. Woodson, we're going to assemble a panel of distinguished scholars who range across not only the military domain, but also the broader healthcare and economics domain in our country, as well. And I will have the privilege of moderating that panel, and introduce those participants a little bit later on.

But for now, I'd like to give Dr. Woodson the floor. Let me say just a brief additional word about him. He is a physician, one of the country's best vascular surgeons. He has experience as a soldier in the military himself, deployed several times in the nation's wars. He, as I say, is now a businessman par excellence, because he's running an organization -- or a set of organizations, many organizations -- with a combined annual expenditure of well in excess of \$50 billion, which is now more than 10 percent of the base budget of the Department of Defense -- so a remarkable set of responsibilities, no matter how you look at it.

And, Dr. Woodson, thanks for being here today. Without further ado, the floor is yours.

Please join me in welcoming him.

DR. WOODSON: Well, thank you very much for that kind introduction, and it is indeed a privilege and honor for me to be here today, particularly with such a distinguished panel and old colleagues and friends, like Bob Hale.

So, I want to thank the Brookings Institute and Mike O'Hanlon for inviting me to talk about what I really deal with every day, and I think it's important and timely to not only the national scene, national defense, and security strategy, but healthcare in general.

You know, I typically speak to forums and audiences that are more DOD and medical-centric, so it's really great for me to talk to an audience and get feedback from the audience that has a broader perspective on national security in American healthcare. And so I'm going to try and set the table a little bit here about the military health system, in order to key up the discussion that will follow about the reforms that are underway and both needed down the road.

So, the military health system, first of all, fills a number of roles and responsibility in support of the national security defense and military strategies. And to properly assess its value, we need to understand these roles, particularly in the emerging global health engagement environment being able to meet all of its mission -- and, most importantly, to deploy anywhere in the globe at a moment's notice.

It's important to state that this is not a pick-up game, and that you need to have a well-honed and organized system to support that national security and military strategy.

And it's important to realize also that the most important role is to be a key enabler of the war fighter, as exemplified by this iconic figure on this photograph. We need to keep this individual healthy in all dimensions -- mind, body, and spirit. We need

to be able to repair him or her when ill or injured. We need to move rocks from this individual's rucksack by caring for the families, and making sure that they don't have to worry about the family when deployed.

So, to paraphrase Gretzky, we need to learn to skate to where the puck will be as we make reforms going forward. We have opportunities to increase the value of our system to policymakers, beneficiaries, and to the country at large, but only in the context of understanding the larger roles and the capabilities of the military health system. It's an evolving system of health, healthcare, and medical force generation, born historically from independent medical systems which were generated decades ago, when medical care was much simpler, and the way we thought about medical care was less involved, costly, and technological.

So, the military health system is in a transformative period after 13 plus years of war. We have performed well, but we need to position ourselves to be stronger, better, and more relevant to the future.

Essential to preparing for the future is an understanding of the volatile, uncertain, complex, and ambiguous environments that define the national security scene in healthcare in America. And I think many you have heard that term -- VUCA -- volatile, uncertain, complex, and ambiguous -- before.

And it's important to understand this, because the MHS is not immune to the changing requirements in these other domains. And so if you accept the Edward Deming principle or philosophy, what we need to do as we skate to where the puck will be is design the system to get the outcomes that we want when measured against all of the missions and functions we are asked to perform.

So, this slide talks to the MHS roles, functions, and missions. This really is the military health system. It is part of the fighting force, and its principle mission is to

ensure that our forces are medically ready to go to the fight. And it's also important to understand that one of its main missions is to generate the medical providers, that medical force to go and be key enablers.

Apart from its deployment mission, however, the military health system is a microcosm of American medicine. We operate some 54 plus hospitals, well over 300 clinics. We have about 150,000 medical personnel. We operate a health plan which really is a defined benefit masquerading as an insurance product, and that's really important to understand -- that what we do is defined by Congress, not what a corporate structure defines as a benefit in sort of a profit motive system.

We're a public health system, responsible for not only prevention of disease but broad responsibilities of those that would normally be seen in state and local governments. And remember that, historically, the major reason soldiers were taken out of the fight were for the disease and non-battle injuries. So, this is really important. It goes back to the core of our history -- why we exist.

We're a medical and education training system, producing over 26,000 medical enlisted graduates every year, in a number of medical specialties. So, radiology technicians, pharmacy technicians, et cetera, et cetera -- and, of course, the combat medic, which is so important to saving lives on the battlefield. We have 217 graduate medical education programs in which we produce physicians with advanced capabilities. We have advanced nursing programs which produce nurses with advanced capability.

And one of the important issues, getting back to our connection with American society, is if anyone thought that we could outsource this, and produce generate the medical force we needed, you need to just understand a couple of things that are changing in the American medical education scene.

So, today, as we speak, there are a bunch of senior medical students

who are scurrying around the country, looking for residency programs to do advanced training. It turns out today, because of a lot of factors, there probably are going to be about 1,000 few positions available to train in than there are going to be American medical graduates.

What I'm suggesting to you is that the ability of the American public to generate the medical force that we need may not be there. And so we need to maintain a base for generating the medical force -- the doctors and nurses, et cetera -- that are going to be the key enablers, again, for folks who are going into harm's way.

We also operate one of the most advanced medical research and development programs in the country, which is tied to our mission. And this is becoming increasingly important, as the expectation of American leaders, and the American public, and the warrior is that we will close the gap on medical knowledge where it doesn't exist - and traumatic brain injury is such an example. We have been challenged over the last decade to rapidly close the gap in terms of neurosciences to improve the outcomes from traumatic brain injury and other problems, such as post-traumatic stress disorder.

But infectious disease, mental health, and other issues are also predominant, so we must maintain this R&D capability. And if you look at what has happened recently in the Ebola region, one of the reasons they came to the Department of Defense is because we had been doing work in these emerging infectious diseases, and how to prevent these issues from spreading, and mitigate the effects.

So, these are the pieces of the military health system -- again, totaling more than \$50 billion a year. And they need to work together in order to be available to support the national security defense and military strategies, and unraveling a piece of this without considering its effect produces a real vulnerability for this country.

Just last year, you know, as the combat operations in Afghanistan were

winding down, we thought we were going to get this sort of brief period of sort of respite from kinetic activities. And then Ukraine, and ISIL, et cetera, et cetera breaks out, Ebola comes, and it reframes all of the issues about the military health system, in terms of its need to be ready.

So, the military health system is an important and indispensable part of the national security effort. But whether or not it continues in the same form relates to the issue of, what are the expectations for military medicine? Because they're higher than ever before. Our American leaders and public expect comprehensive, coordinated care for servicemen and women who are ill or injured -- and, as noted before, closure of gaps where knowledge doesn't exist.

We've seen its effect relative to the Ebola crisis. And for those of you who are not familiar with this, this is really a seminal event -- not only because we brought expertise to this issue, but heretofore, NGOs -- non-governmental organizations, like Doctors Without Borders, would hold the military and the military medicine at an extraordinarily long arm's length because they didn't want to be tainted by what we do.

But they saw this catastrophe unfolding, and they were the first ones who called and said, "You need to get the American military here to help out," and they spoke about us having battalions of individuals who had special capabilities to deploy in austere environments and assist with these issues. So, there are new expectations from all dimensions -- both our leadership, and society, and around the world -- about what we can do.

Another piece of information you need to be aware of -- that, particularly since about 2008, with the global economic crisis, many countries, including our allies, have decreased their spending on their militaries. But what they really have decreased their spending on are their military medical systems. So, we interface around the world,

and one of the common refrains is, how can we come and partner with you for training, for preparedness, for deployment, for humanitarian operations, or to kinetic operations? We are looked at as the full spectrum of military medical system upon which others can plug and play.

So, the American military health system is not a turnkey kind of operation where you can turn it off, and expect it to be ready. You need to be supporting all of these integrated operations and preparations for missions.

From a value perspective, one of our core expectations is that -- from our commanders, our combat commanders, service members, and family -- is that we will save lives on the battlefield. And by that measure, we have been successful. We've achieved the lowest lethality rate in the history of warfare, the lowest disease and non-battle injury rates in the history of warfare -- so that if an individual is injured today on the battlefield, and is brought to a combat support hospital, they probably have about a 98-percent chance of survival.

Now the slide on the right indicates that despite what we call the injury severity score, which is an index of how severely injured the individual is -- and they are desperately injured as a result of IEDs -- it indicates that the chance of survival, the case of fatality rate has declined -- so more severely injured, fewer deaths.

And this has occurred as a result of many, many integrated issues. It's a result of the practice of clinically complex healthcare in our hospitals and clinic, which then transport those skills to the combat zone, an emphasis on public health and prevention, as I noted before, the research and development system, which invested in issues of research and hemorrhage control; also, body armor and a disciplined study of what works in terms of trauma systems -- that is, where medical care meets those human systems in taking care, evacuating patients.

This has led, also, to other benefits -- a reduced medical footprint, far forward logistical trail, higher survival, social impacts, so that we now marry the injured soldier up with the family sooner, which has a real important set of positive social consequences for the healing environment and for family dynamics.

And all of this has been supported, of course, by increased training and technical competency of the medic on the field -- 19 and 21-year-olds who are doing amazing things because of the education that they received at the Medical Education and Training Center, a joint operation in San Antonio.

We are taking these lessons, of course, from the battlefield, and transferring them to civilian practice and trauma centers around the United States. Physicians who led trauma care in the military have taken care of events such as the awful events of Congresswoman Gifford. When the Boston bombing occurred, they called us for advice, and now there are victims of the Boston bombing being treated at Walter Reed.

In the picture on the left, you see a wounded warrior -- a quadruple amputee -- talking to a Boston bombing victim, and the transfer of not only medical knowledge but motivation has been incredible. Through our military adaptive sports program, we have redefined the issue of ability versus disability. Soldiers, wounded warriors, are now fully engaged in life and even in competitive sports -- diving, surfing, skiing, whatever.

There's a new attitude and expectations that we will make the service member whole -- not only in mind, body, and spirit, but a commitment to the family unit and financial stability.

One in five amputees stay on active duty. Many have returned to the combat zone. We have separated ourselves philosophically from a decades-old way of

thinking, particularly when we had a force that was conscripts, wherein if a soldier became ill or injured, they expected to separate from the service, and society expected them to separate from the service.

Nowadays, we have a professional volunteer force in which when they become ill or injured, their expectation is that we will retain them as long as possible to demonstrate their ability to continue to serve. And that's a commitment that we make to both them and they expect of us. So, the whole issue of the dynamics of what we have to field and be ready for in rehabilitation has changed. It's not automatic that they'll go to the Veterans Administration, and receive that care.

And, finally, we have to make this commitment for decades. So, the issue is that we know that the wars will have a tale relative to the medical system that, for example, an amputee -- to walk on a prosthetic device, it takes 20 to 60 percent more energy, depending on whether it's a below-the-knee, above-the-knee, a single amputee or a bilateral amputee. And if we don't commit to their health over decades, and let's say they gain weight, they smoke, you will see the quality and the quantity of their life diminished, so that they accrue more diabetes and more cardiovascular disease if we don't protect them for decades. So, it's a commitment to them for decades.

So, you can see that this is a complicated system. The slide on the right there is a graphic or an advertisement from the American Association of Orthopedic Surgeons. It's not a military advertisement, but it clearly suggests that what we do in the military system has value for the American medical system.

So, hopefully, I've highlighted some of the values of the military health system as it brings to the war fighter and to the nation. But we are in a period of transition now. Operation Enduring Freedom really has closed. ISAF has stood down. Operation Iraqi Freedom has ended a few years ago, but there's still kinetic activities

going on.

In the absence of war, there may be a tendency to say, what do we need this complex system for? And so it's important to understand what, in fact, is occurring in the national security environment, the national health environment, and the fiscal environment to understand what reforms need to be made, and how we can continue to be of value.

I'm not going to go through the national security environment, because all of you probably know that better. Again, uncertain things are popping up all over, and, again, we're a key enabler. Sometimes, we're at near the tip of the spear as an enabler, but as this issue of global health engagement becomes a new instrument of national power, sometimes, we're going to be at the tip of the spear, and hopefully build capacities in nations that may stabilize nations, and actually prevent kinetic wars.

In a national health environment, there are a whole bunch of changes, as well. So, we have more specialization, more technology, rising costs -- although admittedly, have moderated in recent years. Beneficiaries expect more choice. The baby boomers are getting old and need more care. There's an absolute or relative doctor shortage for some of the reasons I talked about before.

And so there's an eroding provider base, more competition; the ACA is out there. More will be insured. More will have access to care. There's more issues with chronic disease -- diabetes, obesity. And more care has shifted to outpatient care, and less relies on inpatient care.

This has led us to develop the quadruple aim in the military health system, which looks at better healthcare -- better health, I should say; that is, prevention - better care -- that's what we do when you've got established disease -- and lower cost, but, most importantly, addressing the issue of readiness. How do we keep the force

medically fit, and provide that medical force of providers?

If you look at that, basically, if we can produce better health, better care at lower cost, and produce the readiness that's necessary, that's our value statement, and that's what we've got to work toward. That's skating to where the puck will be.

This slide here, I think Bob Hale would recognize. And we have talked about this in the past, but this represents sort of the growth by percentage of the defense health program as a percentage of the DOD baseline budget. The important point here is that if you had projected the slide a few years ago, you would've seen a much more steep rise in the cost. So, there are some things that we have been doing to reduce the cost, and put us in position to be competitive and add value in the future.

Previous government agencies predicted that by 2017, in fact, we would be at a budget of \$61 billion and escalating up from there. We're not going to meet that, because we have taken certain management strategies, such as pharmacy reforms, outpatient prospective payment systems. Admittedly, healthcare inflation has moderated. We still track a little bit above what the national average, and there are no bets that it will remain as low as it's been over the last few years.

But at the same time, of course, because we have TRICARE and, again, its defined benefits. Benefits have been added. So, we have TRICARE for life. We have had Congress decrease the caps. We don't have the ability to raise premiums or co-pays unless Congress agrees. We've added TRICARE Reserve Select to the system, and, as a result, the beneficiary contribution has shrunk from initially 27 percent down to 9.3 percent.

Now the issue is, collectively, we've got to decide where we want this to be. We want -- and the service members deserve -- a robust benefit -- and at lower cost because of their service. But this is a collective decision we all need to make as to where

that should be.

I throw this slide up here -- and don't worry too much about the numbers; they probably are a little out of date. This was designed mainly as a visual graphic, to show you how our budget is divided up. It's divided up into budget area groups. And the issue is that (inaudible) where the money is, you'll see that we spend a lot in private sector care -- about 70 percent of the dollars that go to patient care and in the direct care system.

And so it's important to ensure that the two are optimized. The dollars we invest in the direct care system -- which is going to be a lot of fixed cost -- the direct care system is optimally utilized. Also, remember, by the way, this is where we generate the medical force to go as key enablers in harm's way.

But the key, also, is to focus on those tiny little dots which are to the right of the screen, which talk about management activities -- because in some sense, you say, well, you're not going to get much efficiency by reforms here. But that's not true. The important issue is to modernize our management with an enterprise focus, because it's the management that drives the changes and the optimization in those two big bubbles on the left side of the screen. And those really are the takeaways, and that's where we're going.

So, as I begin to sum up here, I want to leave you with some strategic imperatives and directions we're heading in. First of all, about two years ago, I put out my guidance in terms of where we were going, and I organized them around six lines of effort. And this coordinated very well with the Secretary's priorities, as well.

The first was to modernize the management with an enterprise focus, and we've begun to discuss that a little bit already. But one of the key changes made was to establish Defense Health Agency, which is responsible for designing and

providing common business processes and clinical processes which produce those economies of scale. And I'm proud to say that we, through our first year -- even though the Defense Health Agency is not at full operating capability -- projected originally a modest savings of about \$80 million, and we have eclipsed that. It's \$248 million in savings. So, the first year is successful.

But it's also about standing up what we call the enhanced multiservice market strategy. For those of you not familiar, we have these large geographic areas around the country where multiple services operate. They operate their own military treatment facilities, and, in fact, we purchase care in the private sector. Designing business practices that optimize the use of the military treatment facilities, as well as provide what is needed care in the private sector is key, but you can only do that if you've got a management strategy that is enterprise-focused.

We also needed to find and deliver on the medical capabilities of manpower that are needed in the 21st century, which are rapidly changing. We could spend a whole day talking about what this represents, but it's getting away from the notion which line leadership often thinks about, which is, if you've got a building that says hospital on it, they think that's a capability, but it's not in the 21st century.

We have to talk about real medical capabilities to drive the medical outcomes and what are needed across a whole spectrum of issues. And part of our capability is developing new leadership that can really operate and make decisions in this dynamic world, fielding new capabilities like the electronic health record that is at least a generation 3/4 with decision capability, and can tie to other business systems that will enable leaders, commanders, and clinical providers to make more decisions -- correct decisions easier, and make their work more efficient.

We need to invest and expand our strategic partners, and it's really

important to identify strategic partners, whether or not it's academic, medical centers, the federal partners, like the Veterans Administration, and understanding what we need to do with the VA.

So, between the VA and us, we have about 211 hospitals in various stages of aging, at the average cost of replacing a hospital of about a half a billion dollars. The question is, what efficiencies can we drive there, and actually meet the mandate -- or even solve other issues as it relates to clinical training and the like?

We need to assess the balance of our medical force, so we have an active force of providers. We have a reserve force of providers, and we have civilian personnel. Well, we know that with the increased growth of specialization, we can't keep on active duty and train efficiently a lot of specialists. And we've got to look at new ways of tapping into the reserve component.

One of the things I point out to people whenever they'll listen to me is that when I was in academic practice, if I went to the NIH, I could sign a contract with the NIH. And if I wanted to do research 40 percent of the time, they would pay 40 percent of my salary to the institution. Well, if we need individuals to serve on active duty, the question is whether or not we need to redesign some of the Cold War reserve policies so that we develop contracts with subspecialists, and we say, they're ours 40 percent of the time. It makes for harmony in terms of the family dynamics, but as everybody knows, what mom or dad is doing, how they're spending their career, makes for harmony with employers, and we get a professional force that is going to be available for us. So, we need to think innovatively about our workforce.

We need to modernize the TRICARE program. And this is not just about fees, but this is about decreasing the administrative burden, and making sure that it provides a robust benefit that the beneficiaries desire. They get what they deserve, but

at lower cost.

And then lastly, again, it's about defining the MHS's role, competencies, and requirements in global health engagement, which is becoming much, much more important.

So, to finish off here, the MHS is clearly an important asset in the national security, military, and defense strategy, and is a resource for the nation. But it's at an inflection point. Its value -- it will be determined by how well we organize to do our missions against the costs, both financial and otherwise, that all of our leaders and stakeholders see us consuming. And remember, again, the failure to do that competes with the line to train, man, equip, and modernize the force.

But we're managing through it, and the future is bright, clearly, for the military health system. It will require collaboration, but it will have to prevent simplistic algorithms that stakeholders might suggest that don't integrate all of the missions that we're required and we're graded against.

So, I'm pleased to be here today, and I want to thank, again, the organizers for having me to sort of set the table. And I look forward to the discussion.

And I think we might have time for one or two questions, so I'm happy to entertain those questions at this time.

Yes?

MS. KAUFMANN: Hi. My name is Kristy Kaufmann. I'm the Executive Director of the Code of Supports Foundation. I was a 12-year Army wife, as well.

One of the things that I think might be missing in terms of priorities is really having a deep understanding of the population that we're serving after 13 years of war. What do those military health advisory teams that were deployed in theater to really understand, particularly behavioral health-wise, what was going on -- I got the sense

when I was an Army wife that a lot of the stuff that we were doing was reactive, and we could've saved a lot of money and probably done a better job if we understood the population we were serving.

So, I'm wondering if there's, you know, a way to fit that into our strategy and our plan -- of having a deep understanding of the impact of how many people are still in the military that have served, particularly multiple deployments, and how that affects the health of the force?

DR. WOODSON: So, great question. Thank you for asking it. And I think you're right, but let me provide a little context.

I think today, as we sit here or stand here today, we have a number of studies, such as the Army STARRS Study and a lot of other studies that are deeply exploring the population, and getting a better understanding.

But to the heart of your question, if you go back a decade as to where we were, one of our failings was to just accept where the American medical system and the public was at in terms of mental health. And this gets to what I was talking about before, about expectation.

We just can't accept that we have a mental health system in general in American medicine that's in disarray, disconnected, poorly coordinated, and expect that that's what will serve servicemen and women optimally. So, we play catch-up. There's no doubt about it. And we're still playing catch-up.

What happened is that problems were recognized by our national leadership, by military leadership, by the medical community, that we were not producing optimal systems and optimal outcome. And so there was a lot of money that was thrown at it in a crisis mentality, and a lot of programs that were established. And we are just sorting through those, and putting metrics against those to decide which are effective,

which are not, even as we understand better the populations that we need to serve -- not only now, but on into the future.

So, you're right. We had to play catch-up, but it was partly because of where the entire American medical and mental health system was at. Parenthetically, I would say, you know there have been a number of recent studies that have come out from IOM and other organizations evaluating our system based upon our request. It turns out there are still some very critical elements in those studies, but when you ask the people who are experts in this about, "Well, what do you do in your system?" They say, "Wait a minute; you've got to understand. We're going to adopt what you're doing, because you're ahead of what we do in the private sector in mental health systems and coordination."

And I think we see elements of that every day, as these celebrated cases of violence, et cetera, have come out. So, much more work to do. We did play catch-up, and we are trying to sort some of this out.

Yes?

DR. POPLIN: I'm Dr. Caroline Poplin. I'm a general internist. I worked as Fort Belvoir as a GS civilian physician for seven years, and Bethesda Naval Hospital for five.

I was wondering if you could say more about the VA. Many soldiers can't stay with the military. They have to transition to civilian life, and it seems to me the connection between the active-duty military and the VA was terrible, symbolized by the fact that we had two incompatible electronic records systems -- and that apparently they'd given up trying to harmonize them. We're working on a third generation of something else. This is after billions of dollars and 10 years, at least.

DR. WOODSON: Well, I won't get into exactly the number. I'll accept

wholeheartedly the spirit of your question, and I'll answer it in a couple of different ways.

First of all, we all need to appreciate, again, the historical context. The military health system and the VA system initially had different missions. And the whole idea was, you know, after the Second World War and the wars before now, if you got ill or injured, you were going to move onto the VA. And so that degree of coordination, particularly at a time when healthcare was more simple, it served its purpose. Fast-forward to, you know, the 21st century, and that's neither acceptable nor desired, because of the complexity of care.

So, we have committed, in fact, to harmonizing and working on that transition. And I cochaired the Health Executive Committee with the Undersecretary of the VA to work across some broad areas -- so information technology, clinical programs, business operations. And, again, I could just stand up here for hours talking about what we've dealt with over the last couple years.

But I want to address your issue about these enabling systems, like this electronic health record. First of all, I think it was a little bit naïve by everyone to think that just because if we built a single system, that it would talk to each other. If you go to Kaiser, or (inaudible), or whatever, and you look at all of their hospitals, particularly their early experience, just because they inserted a software program at one hospital didn't mean that it talked to the other.

And it turned out because there's something called data standards that you have to deal with, right? And that's really the heart of it. So, if I were to ask everyone in this audience to hold up their cell phone, we would see a variety of cell phones. We would see iPhones, Galaxies, Samsungs, Blackberries, et cetera, et cetera. But you all could text each other. You all could email each other. You could all phone each other, send each other documents, manipulate those documents -- and because

there are data standards.

Within electronic health records and what really was a nascent sort of business system called an electronic health record -- which, remember, was originally designed as an archiving system -- so if I encountered a patient, I would record their history -- not a computing system -- what would happen is, you would see in one system, they would call a water bottle a water bottle; in another system, they would call it a goblet; in another system, they would call it a plastic vessel to hold fluids or something, and you couldn't talk to each other.

What am I saying? We've gone a long way now to dealing with the interim operability of data. And so we, particularly last year, have made great strides in harmonizing between the VA and the military health system -- this issue of data transfer interoperability. And we expect to make more strides, even as we modernize our system.

So, a complex issue, but I appreciate the spirit of your question, and it needs to be solved, and we're working on that.

Other questions?

Okay, I think we're out of time. So, thank you so much for listening to me this morning.

MR. O'HANLON: Thank you, Dr. Woodson. I'll invite the panel to come up now. We'll move straight into it. And we're glad you can stay for a little bit, as well, but thank you again very much for the remarks.

Thank you. Well, again, Secretary Woodson, thank you very much for those remarks.

I'm going to be brief in introducing our distinguished panelists, so we can get right to it. Let me say a brief word about each, because we really have an extraordinary panel, and a lot of good friends, and a lot of former bosses of mine, by the

way. It's a bit of a CBO alumni gathering here. I think only Henry Aaron hasn't worked at CBO out of this crew, and Alice Rivlin actually created it. and I'll get to her in just a moment.

But sitting immediately to my right is Bob Hale, who was, along with Jack Mayer, my direct boss at CBO. But he made up for that part of his career by doing amazing things thereafter, even though he had to supervise me for a while.

He was Comptroller of the Air Force in the 1990s, for much of the Clinton administration. He was, until just about a year ago, the Comptroller of the entire Department of Defense. In between, he did various other jobs, including running a National Comptroller Association. But I always learned a great deal about defense strategy from Bob, as well.

This is the year he probably is glad going into the Christmas season not to have to be the Scrooge again, because he's the guy that had to handle sequestration. And it probably also made him feel a little like the -- in terms of his workload -- like the Grinch's dog at times, trying to pull all those presents to the top of the mountain, but he got through it -- and remarkably, actually.

I think it's a huge credit to Bob and to many others in the military that DOD kept functioning through this incredibly difficult period -- and a lot of other accomplishments, as well.

He'll be putting this current issue in broader context, in terms of military compensation reform and the Department of Defense's overall budget challenge.

Carla Tighe Murray is a PhD economist from the University of Illinois. She also works at the Pentagon, but she's now at the Congressional Budget Office. And she has written recent options papers and studies on defense healthcare that have talked about the ways in which, among other things, some of the cost might be shifted a bit

more -- within reason -- to the actual members of the military and their families, because I think, as many of you know, this is a very generous system, in terms of the cost sharing.

And I think most of us would agree with that philosophy -- that it should be generous, that co-payments and other costs and premiums should be much lower than the national average -- but they are extraordinarily low, and at a time when DoD is feeling a budget crunch, one of the questions it has to face is, can it really afford to be quite that generous? And so this is an issue we'll be talking about, as well.

As I mentioned, Alice Rivlin, in addition to having founded the Congressional Budget Office, as Brookings nears its 100th anniversary in 2 years, I would nominate her as our greatest scholar/public servant in our history. She was not only the Founding Director of CBO; she was the Director of the Office of Management and Budget in the Clinton administration. She was Vice Chairman of the Fed.

After all of that, she decided to try to help D.C. fix its finances. And then last year, when our Engelberg Center for Health Care Reform here at Brookings needed a new Director, she volunteered for that job. I'm not sure if volunteer is the right word, but we'll leave it at that in the holiday spirit -- and has done a great deal of work on healthcare over her career, as well.

Henry Aaron is simply one of the greatest healthcare economists in the country, and has been at this for a long time in our Economic Studies Program. He's affiliated with a number of other organizations around the country that work on matters of healthcare, including the Institute of Medicine, the American Academy of Arts and Sciences, and a number of other organizations.

I looked through his resume recently, and realized that we should probably make greater use of him in the Foreign Policy Program, because I think his masters degree was actually in Russian Studies. So, that may even help for some of the

aspects of our healthcare system, I suppose.

And then finally, Jack Mayer, Executive Vice President at Booz Allen Hamilton. We've been very glad to have Jack part of our Brookings efforts over the years, as well, just as Bob and others here have kindly helped us previously, too.

Jack runs the Military Healthcare Program at Booz Allen Hamilton; has also had a distinguished career there on issues ranging from energy policy to homeland security. He, too, was at the Congressional Budget Office. He's a West Point grad and a former Army officer. Bob Hale is a former Navy officer, I should have said before.

So, we really have a great deal of experience across all these issues. And I realize I went on a little bit, but I thought they deserved a little bit of praise here, and you deserve to hear some of their credentials as we broach this big topic.

So, Bob, without further ado, if you could please put the military healthcare problem within broader DOD budget perspective for us.

MR. HALE: Okay. Well, Mike, thank you, and thanks for the chance to be here.

John also did a great job of outlining the many things the military healthcare system needs to do. I want to talk about it more from a budgetary perspective. And the first point I want to make is, there have been significant changes in military healthcare that actually has slowed the growth in healthcare spending significantly.

Just a few examples: Five years ago, the administration allowed the Department of Defense to use the VA drug pricing schedules, significantly reducing its cost. The Congress allowed use of Medicare rates for small hospitals and outpatients. DOD has implemented the Defense Healthy Agency, as John said. Congress mandated a five-year test program of making mandatory use of mail-order pharmacy, which, again,

cuts costs significantly -- and some benefit reductions -- or increases in fees, I should say.

And TRICARE -- about a 15-percent increase there in indexing, at least partially of those fees, and significant changes in co-pays for pharmaceuticals.

Bottom line, \$3 to \$4 billion of savings a year, which will go on in perpetuity, unless they need to be reversed, and has actually reversed the growth in healthcare costs. They've declined over the last three or three years in DOD, which has helped the Department absorb some tough budget times.

But the budget restraints will continue. More needs to be done, and so I'll finish up this answer with two areas where I think the Department needs to head, in terms of further changes in military healthcare.

One John alluded to already, which is some changes in the fees and co-pays in the TRICARE program. This needs to be looked at in the context of overall military compensation, because it's an important part of the benefits. And two years ago, the Joint Chiefs, with John Woodson and many others participating, led an overall look at compensation that suggested changes like holding down pay raises, some of which have been adopted, but it also proposed some significant increases in co-pays and fees in the TRICARE program, taking healthcare that, right now, is entirely free and imposing modest co-pays and fees.

This was proposed last February to the Congress. Congress did not act on it; did not allow it to go into effect, but I hope the Department will resubmit these proposals, at least in some form, and I hope that Congress will go forward with them. They'll save a couple billion dollars a year, so they're not insignificant.

The other thing I think the Department needs to do is a tough one, and that's streamline the military treatment facilities. There's some significant underutilization

of some of those facilities. Efforts had been made to do that, but, frankly, the military services have tended to resist, in part because they're not convinced they're going to get to keep the savings. DOD budgets for healthcare centrally. The services feel if they agree to these changes, which are tough, in their view, they may not get those savings from modernization and training.

One of the things the DoD may need to do is think about changing the way it budgets for healthcare, giving the money back to the services, but requiring that they centrally manage -- they'll centrally run the activity, requiring that they pay for them on a fee-for-service basis, using a structure called working capital funds that are pretty common in DoD. Maybe that would change incentives, and make it easier to streamline these facilities, because some of that is going to have to happen.

So, in the budget context, there have been some important successes. We need to recognize that, and I hope to see more of that in the press. But there is more to do with regard to changes in benefit structure, which DOD has proposed and, I think, some streamlining of healthcare.

With that, I'll stop. And after my colleagues have had a say, we can have some further discussion.

MR. O'HANLON: Great. Let me go -- before we go onto Carla, let me ask you just one more question. And this is obviously a fraught question to give a short answer to, but how would you describe the overall state of military compensation today? You alluded to the recent review that was done. As we talk about potential cost-shifting towards more for the families and the personnel, how should we think about the backdrop to this whole issue?

MR. HALE: Well, the DOD has got to maintain a strong compensation program to attract and retain the people it needs, and, I think we would all probably

agree, a generous one to recognize the service of the men and women in uniform, which has been very taxing and continues to be.

At the same time, I think the Department has recognized -- its senior military leaders have recognized they need to slow the growth in compensation costs to free up money within the constrained budget for training and modernization.

Some of that has occurred -- limits on pay raises, for example, being the largest dollar amount; some changes modest in commissaries and housing allowances. I think there's more to be done. And you're right; we need to look at the healthcare in that context, and there have been some modest changes in benefits there, probably some more needs to occur, as well, as part of overall slowing of growth in military compensation.

MR. O'HANLON: And I'm going to do one more follow-up, and then it'll be a segue to Carla, because if there were going to be a big reform -- because what you, and Dr. Woodson, and others have promoted have been significant, as you say, but sort of within the spirit of the existing system, to a large extent, I think it's fair to say -- you can correct my premise in a second if you wish -- if there were going to be bigger, broader reform in any element of military compensation policy, do you think it could conceivably or should conceivably be within healthcare, or should it be more the retirement system? I mean, you come out of these debates, I know, looking at all these questions in great detail.

MR. HALE: Well, I think you need to look at all of it. And I think there has been, I would call it, significant reform. I don't know whether it's fundamental. You're right; it has not changed the structure, certainly, of military compensation. And in the environment we're in, I'm not sure that's realistic.

But I think it needs to look at all of these elements -- healthcare, the

compensation pay itself, and other benefits -- not just focus on one, because all of them are important for the military members, but also important to the efforts to slow the growth and free up money for training.

MR. O'HANLON: Carla, you've written about options that might save in the ballpark of -- as I do the math or read your studies -- maybe \$8 to \$10 billion a year once they were fully implemented within military healthcare itself -- not necessarily reducing the overall cost, but shifting the cost more towards the beneficiaries -- and especially military retirees.

Recent retirees who are not in the VA system, who are not injured, but who are in generally reasonably good health, I think, and may have other jobs -- obviously, that's a complex issue and a complex group of people with a lot of challenges. I'm not suggesting everything's easy for them.

But could you explain a little more about your options, the logic behind them, and how much more they might save beyond what DOD's been requesting in recent years?

MS. MURRAY: Okay. Thank you, Mike.

So, when I think about these sorts of questions, I think it's useful to think about what the drivers of healthcare costs have been. You saw Dr. Woodson's chart earlier. By my calculations, spending on DOD healthcare since 2000 has more than doubled, in real terms. That is, it's increased by 130 percent over and above inflation in the general economy.

So, I think it's worth spending a minute talking about what was driving that increase, and what might be driving increases in the future.

In addition, I think it's also useful when we think about options to kind of think about the relative magnitude of the sorts of options. So, you can assess, really,

where you want to put your efforts.

So, for example, you know, what sort of options are going to give you savings in the millions of dollars per year, perhaps, versus options that might give you savings more in the billions of dollars every year?

So, in a report that we published in January, we kind of took that approach, and we looked at what the drivers of military healthcare costs have been since 2000. And, you know, one thing it's not was the cost of the wars. So, DOD spending on contingency-related medical care peaked in 2000 at about \$3 billion, I think, and it's come up since then. That's on a \$50-billion program. So, that has not been -- definitely important work being done, definitely resources needed to be devoted to medical care, of course, to support the war, but it was not a primary driver of that 130 percent, if you will.

Instead, we felt that one driver has been the increase in new benefits and the expansion of benefits by the Congress since 2000. TRICARE For Life is one of those. It is a Medicare wraparound coverage for those retirees who are eligible for Medicare -- that is, over age 65. And it's been a popular program. As of 2014, 2.1 million people have enrolled in TRICARE For Life.

This program essentially reduces the out-of-pocket cost for military retirees and their families almost to zero. There's some small cost. But, basically, Medicare pays, then Medicare Part B pays, and then TRICARE picks up the remainder of those costs -- or close to them. So, that's been a driver -- and other expansion benefits, as well.

A second driver, we felt, is the financial incentives to use TRICARE so that the out-of-pocket costs for active duty members, for their families, but also for military retirees, is significantly below what other options are for civilians, either through the private insurance market or through employment-based insurance.

And these financial incentives -- so, for example, a military retiree can purchase care in TRICARE Prime, which is the health maintenance organization type plan offered by TRICARE, and they can purchase that with an enrollment fee of about \$550 per year for their family -- and then there are co-pays as they use the system. That's below what most civilians face.

So, this creates two incentives. First of all, it encourages people to join the system, and you saw that, of course, as civilian healthcare costs were rising dramatically, the enrollment fees for TRICARE were constant, basically. And so you saw people joining the system. And that financial incentive is continuing so far.

In addition, you also see people use more health services. Those who are in TRICARE tend to use about 50 percent more healthcare services than people using civilian HMO plans of comparable age. So, you see more people joining, and those people who join tend to use the system more.

For those reasons, then, we went ahead and looked at what some different options might be, and we looked at some on, you know, things that have been suggested on the civilian sector. We looked at things like instituting disease management programs. These are programs where you try to coordinate care more, and get more routine maintenance prescription drugs and care so you avoid the flare-ups and the need for people to go to emergency rooms for those people who have chronic conditions.

We looked at options like relying more on scholarships, and training medical students through civilian universities, and closing the DoD-operated medical school. We looked at some management-related efficiencies along the line of creating the Defense Health Agency, trying to eliminate some administrative duplication. Those sorts of options may be worthwhile.

From a budgetary effect, the effect is relatively small. We estimated savings in the range of, you know several tens of millions of dollars a year to maybe \$150 million a year. So, then you turn, and you say, okay, going back now to what we thought were the primary drivers of healthcare costs, and suppose we look at options that would change that cost-sharing relationship -- in other words, again, keeping the cost for service members and for the service members' families the same, low, but increasing the share of costs borne by military retirees and their families.

And we found that you were able to save more like billions of dollars per year, compared to some of these other options where you're talking in the millions of dollars per year.

So, in CBO's judgment, increasing the share of costs paid for by military retirees and their families addresses both the primary drivers of healthcare costs, and has the potential to generate savings in the billions of dollars per year. There are other considerations, of course, and they'll probably come up in discussion, but that's (inaudible).

MR. O'HANLON: Thank you. That's very, very helpful.

And, Alice, if I can now turn to you, really, with two big questions for both you and Henry. First of all, just taking all of this in, how does it strike you, from your broader perspective in the healthcare reform debate?

And then secondly, our experience with ObamaCare, the Affordable Care Act, other recent developments on the civilian healthcare front -- do these offer any lessons, any new opportunities, any new choices for the Department of Defense?

MS. RIVLIN: Well, let me start -- I think Dr. Woodson outlined beautifully some of the special missions of military healthcare, and nobody, I think, would want active-duty military to have less than optimal care and follow-up. And there are some

special needs for surge capability, because we don't know what the future's going to bring.

But, as he also suggested, I'm struck by the commonality between the challenges that we face in the civilian system and its several systems, as the military has several systems -- and then the VA is somewhere in between.

But there's this paradox that everybody faces -- increasingly effective medical care coexisting with a lot of inefficiency and lack of coordination. We talked about the electronic health records. That's also true in the civilian sector. They don't talk to each other very well -- and other evidences of duplication and overuse of care.

Now on the civilian side, people are tackling this in two ways. One is to try to get more organized competition among health plans so consumers can make more intelligent choices, and providers of health plans can make more intelligent choices about what to offer, and how to reduce their premiums and still offer good care. And that's one avenue.

And the other is changing incentives, both for providers and bundling payments for a whole episode of care so that you aren't using lots of different, uncoordinated services -- you can think about, what does this patient really need? And, also, the incentive that Carla alluded to for patients to manage their care more efficiently.

So, there's a lot of commonality, and I have the feeling that we ought to be addressing these problems together, because the other two challenges that face closed systems are American lifestyle -- not very healthy -- and the aging of the population, which certainly shows up in the VA system and then the retiree system.

And here's one thought about how we might be addressing all of these things together. It's a little radical, but should we be thinking about how some of the military systems might transition their people to the ACA exchanges? And especially in

sparsely-populated parts of the country, where one of the problems for the Affordable Care Act exchanges are, there's just not enough people who live there.

Military faces that problem, as well. TRICARE has an option for sparsely-populated places. Maybe they should come together. Maybe we should be thinking about whether we can give both military personnel and their families and veterans choices on the ACA exchanges, with the appropriate subsidies. And that would benefit everybody, because it makes a bigger pool in the exchange.

MR. O'HANLON: Thank you. Just, by the way, I want to make sure I understand -- you would consider that for military personnel who are currently being provided healthcare through the DOD, as well as perhaps some veterans who are being provided healthcare through the VA.

MS. RIVLIN: Well, it's just a thought. And the other thought would be, can we go the other way? Are there underutilized military facilities that civilians could opt to use a plan which used that?

MR. O'HANLON: By the way, before going to Henry, just let me give one quick data point -- and there are many people in this room who know this issue much better than I, but for those who are generalists -- of course, we're talking primarily today about the Department of Defense military health program, which is the \$53-billion annual operation that Dr. Woodson oversees.

The Department of Veterans Affairs, we've referred to several times, but it's a separate organization with a separate budget, and the overall Veterans Affairs budget is now about \$170 billion a year -- three times the military healthcare. Now much of that is direct payments -- either in the form of disabilities, GI bill, et cetera. But I believe roughly half of the Veterans Affairs budget is actually the Veterans Affairs medical program, which is separate from, although increasingly related to and interlinked with, we

hope, DoD's.

I just wanted to make sure everybody understood that basic set of bureaucratic and budgetary facts.

But now, Henry, over to you for your perspective on what you've been hearing, and where you think we should go.

MR. AARON: What I'm going to say is, I think, in many ways, going to reinforce what Alice just said.

There are three distinct groups here who are, I think, related and under consideration. There are the active-duty military. There are former active-duty military, which is to say veterans. And there are the family members associated with those two groups.

The case for a special supply-of-services system is particularly strong, it seems to me, for the active-duty military. For the families of the active-duty military, the case of having a dedicated supply system is, it seems to me, very much weaker. And that suggests the possible appeal of the option that Alice just mentioned, which is to help families of active-duty military have fair, well-financed access to the general healthcare system.

Now in particular, it seems to me that one should step back and perhaps look at this from the other side. We now have a healthcare system in which if your income is less than four times the official poverty threshold -- which, for a family of four, is now in the vicinity of \$90,000 a year -- scaled down for smaller families, of course -- you are eligible for subsidies, refundable tax credits, and assistance with cost-sharing on a sliding scale that starts with essentially complete coverage of what's called a silver health plan. And that is the premium that is charged for a healthcare plan that covers 70 percent of the covered healthcare services on an actuarial basis. Plans can provide that

coverage in different ways.

Many people also want more generous coverage, or they receive it through employer-sponsored plans. If you buy through a health exchange, you can buy plans that cover up to 90 percent of the cost of coverage, which leaves relatively small amounts for deductibles. There may not be any -- or cost-sharing, only for certain services. It's very generous coverage -- perhaps not as generous as TRICARE is now described as being, but close.

So, the question I have is whether it wouldn't be desirable as part of the national healthcare system to provide for the base level of coverage to be a general responsibility not of the Department of Defense but of the overall healthcare system that is serving the rest of the population.

Now for special reasons, as part of compensation, the Department of Defense may want to provide more generous coverage than this silver healthcare package. They may want something approaching or even surpassing platinum coverage. If that's the case, that is a responsibility of the Defense Department, as an extra recruitment benefit that is provided to attract the kinds of soldiers we want to have. If that is the case, then the Defense Department would have to consider -- and I think it would be a close question -- as to whether the most effective way to attract the kind of force we want to have is to spend money on a particularly generous healthcare plan, higher cash payments, or some other form of compensation. They would have to judge, what was the best way to attract the force that the Defense Department needs?

But my fundamental point here is, this is a nation that has embarked on achieving a degree of close-to-universal and relatively uniform access to the healthcare system. That's a national obligation. It is not, in my view, a Defense Department obligation. It isn't clear to me why the basic costs of TRICARE for non-active-duty

personnel really is a Defense Department responsibility.

MR. O'HANLON: Thank you very much. And that sets up a lot of the questions that, Jack, I know you want to get at, including the additional one of whether this overall system strikes you as relatively efficient or in need of fundamental reform, above and beyond the issues of who's the beneficiary, what their packages are, how generous those packages are, is the system itself in need of fundamental reform, and anything else you'd like to address, please.

MR. MAYER: Thanks, Michael. I appreciate the introduction, as this part of this august group of scholars. Unfortunately, I can't claim that mantle, because I come from this much more from a perspective of being a management consultant influenced by my experience as both a consumer in the past of military healthcare, and as a businessman.

I appreciate Dr. Woodson's comment about thinking innovatively about the workforce. The exception I would take with that is, I think that the workforce is only one component of the system. And indeed, if we're going to change the military health system to be something better in the future, then we need to be thinking of it as a system, and be thinking innovatively about all parts of this.

I agree with Henry that I think that there are multiple populations when you think about this. You have the active-duty population that I have never heard anybody who thinks that they should have anything other than the best healthcare possible. And I think that the civilian population benefits from that -- certainly from history in burn centers, and what we're seeing now with prosthetics and traumatic brain injury. Nobody does that better than the military, and we all benefit from things like that.

But the second population is the dependent population. Indeed, when I think about this from a management perspective -- and as a businessman -- you have to

be thinking about the benefits that you are willing to be able to have for everyone. Not everybody in the military is able to take advantage of the benefit of having full medical care covered for dependents. Indeed, many of the people in the military are dependent.

And if the military benefit program is going to be fair, then you would think that you would have a baseline that everybody is covered at one level, and then those who decide that they're going to have dependents, they're sharing in the cost with the dependent care in the future, much like it is done in any other business that we see. It is rare that a business provides free healthcare for all of its employees and all of the dependents of its employees.

And then the third population that Henry talked about is that population that has retired from the military and their dependents. Only about 10 percent of the people who were ever in the military retire from the military, all right? So, we're not talking about huge numbers with military experience. Those people, the majority of them go on for other careers, do other things, and have the opportunity to be able to enjoy healthcare either through the ACA or through other employers.

And indeed, having a program where they go in and get free healthcare, and do it as often as they want, seems to be a burden that the American people shouldn't have to bear. I think there have been enough studies done to let people know that as soon as you provide a free good for people, it will be used more. I think Carla referenced that, with the TRICARE cost. So, we know that. And one of the ways in the country we are looking at getting healthcare costs under control is putting more of the burden of the cost of healthcare onto individuals. And people are sharing more in the expenses of that, and, indeed, in the co-pays and in the deductibles that they have to pay.

Part of what the military is doing right now is looking at how they improve the lifestyle, and the way people in the military think about their own health. I think that

this is important. And the programs that Dr. Woodson has established that are in their infancy right now get at some of the education. But I think it can't be just done by the people who are responsible for healthcare, because so much of what occurs in the military is influenced by leadership and commands.

We all know that smoking is bad. We all know that it has tremendous impact on the lives of people, and it costs a lot in the military healthcare system. We all know that obesity is bad, and it drives up the cost of all healthcare systems. And yet, in the military, we still subsidize the sale of cigarettes in the exchange system so that it's far below what someone would pay if they went into a Wal-Mart or something like that to be able to buy it. I don't think you can keep everyone from smoking in the military, but you certainly shouldn't subsidize it.

And I think the same thing in terms of the health habits of people. People in the military have weight standards that they have to maintain, which is a great thing in order to be able to do, but that isn't always maintained by healthy eating habits that we know serve them.

So, it needs to be a command that gets involved in this in order to be able to do it in the future. Innovation in the health system, I think, is an important thing.

MR. O'HANLON: Thank you very much. We're going to go to you now. I think we'll take two questions at a time, because my guess is that once we get a question, we'll probably work with it for a while up here. So, I think in the interest of getting a few of your comments on the table, we'll go straight to you -- and two at a time - - before we go to our panel.

So, the gentleman here in the fourth row, please, and then, also, here, in the second row.

MR. BARRON: Yeah, good morning -- Mike Barron, from Military

Officers Association of America.

I guess I'm always concerned when I hear some of the comments from the panel, and I appreciate your thoughts and experience this morning. But when you're looking at the challenges that DOD is facing, their budget -- clearly do, as a retired professional Army officer, understand what's going on with that -- why there's never any comments made about the real problem with acquisition reform out there. I mean, there's a well-publicized, well-researched study by a government accountability office -- \$500 billion in cost overrun, which could really easily almost pay for the sequestration burden there.

But why is that never addressed here? And, really, the focus of the panel seems to go on, as I would call it, the low-hanging fruit, and we're going to kind of go directly at the personnel side of it here. It kind of bothers me on that part.

The second part of the question is, at the same time we're reducing that, the uniform leadership has already put a letter up on the Hill that's been well-publicized in different articles, where the uniform leadership in particular has asked for protections on their pay and compensation -- while at the same time, they want to reduce it for the rank-and-file of the military, which kind of bothers me in terms of a disingenuous piece there for leadership.

So, I'm kind of concerned about how you would address those things that are going on here -- either of those two points. And I've seen where you have not talked about either of those two, particularly the acquisition reform component.

MR. O'HANLON: As we go to the second question, let me just take the - fall on my sword over the topic. I asked everyone here today to speak about military healthcare reform, so that's why we're not talking about acquisition. But the rest of your points and questions are certainly worth addressing.

Sir, over to you.

LTC. STITZER: Distinguished speakers, thank you for being here today. My name is Lieutenant Colonel Rich Stitzer. I am a War College Fellow at Georgetown, and I'm a Health Services Officer, often given the distinguished honor of moving reserve forces to and from active duty, based on the nation's needs.

And I can tell you from my perspective that that's one of our most difficult challenges with the healthcare system are moving reservists in and out of the system. It's, for lack of a better word, very much like a patch quilt system built from the top down - - very, very difficult. It's written with congressional and individual complaints that, again, take a lot of our time to deal with.

So, I wanted to ask you, from your different perspectives or responsibilities, if your reform will include reconsidering how the reservists access the system -- maybe come up with a fresh point of view, and build it from the individual up -- because we know that, in the future, in DoD reform, the reservists have to be part of the solution. I mean, using the reserve components is going to save us money ultimately, so if we could redesign the program where they could access the system a little bit easier, perhaps have benefits correlate with their social security number, as they are entitled or authorized to go onto active duty -- something like that approach, perhaps.

Will reform eventually include redesigning the program for reservists to access the system a little easier?

MR. O'HANLON: We'll work on the panel. Also, maybe I can, at the end of that, give Secretary Woodson a chance, if there's something that still needs to be said at that point -- or maybe you want to begin. I don't know what's better for you. Here's a microphone (inaudible).

DR. WOODSON: Yeah, thank you for that question.

One thing I was trying to allude to in my comments was just that we need to reexamine a lot of Cold War policies that don't allow us to tap into easily the skill-rich pool of the reservists. So, I'm a reservist, and I also was, again, the Assistant Surgeon General responsible for mobilization. So, I would go to projection platforms all the time, and I would hear from reservists.

I love the work. You know, they're true patriots; don't hesitate to be called up -- but hated the transition from inactive to active duty.

So, one of the things I was alluding to when I use that example of buying 0.4 FTE is to create these comprehensive packages for select groups of reservists, so that you could bring them on and off easily. It helps them, and then we can manage benefits better, just to start the discussion.

MR. O'HANLON: Thank you.

Bob?

MR. HALE: Well, going to the gentleman's question about other issues - and acknowledging, as Mike said, that this panel focused on healthcare. There have been a variety of proposals that you're probably familiar with by the Department, and I can't speak as a Department official now, but as a former one that tried to look for ways to hold down costs -- everything from looking for ways to make do with fewer civilian employees -- that affected healthcare, but it also affected many other activities, like cutting back on contract payments with things like the Navy's contract court that looked for lower priority activity, strategic sourcing that tried to gather together purchases and make use of the Department's buying power.

Acquisition reform was certainly part of that. You'll be familiar with the better buying power initiatives that have been going on for a number of years. There are some fundamental constraints there, in terms of the Department's desire to continue to

field weapons that are technically superior in the rather limited amount of competition that we have that is clearly the best way to hold down costs.

But there are a number of initiatives taken there. So, I think the fact that we're focusing on healthcare today shouldn't be taken to mean that's the only thing that DOD is looking at. They're looking at a variety of issues, to include acquisition reform.

MR. O'HANLON: Other thoughts from the panelists for any of these questions? Anybody else want to weigh in?

Alice, please.

MS. RIVLIN: Well, I think there are a number of transitions that have been alluded to, including the last one of, what happens to reservists when they go on active duty and come back? And that's clearly just one. And the transition between DOD and VA is another one.

And within the civilian sector, people moving from Medicaid onto the exchanges as they change their incomes or their job security.

So, I think the general point is, we've got to figure out how to have a common set of identifiers so that if you move from one system to another, your record moves with you, and they know who you are, and what's happened to you, and all of that -- is clearly an imperative. And if we can think about all of these things as a national health system, as Henry said, we may be able to make some progress, and maybe with a system that really moves people in and out of their different statuses with ease.

MR. O'HANLON: Henry?

MR. AARON: Concern was expressed about the fact that higher cost-sharing and restricting the medical benefit would fall disproportionately on the lowly-paid members of the military. At least, that's the way I interpreted it. The health benefit's a big part of the compensation of a sergeant. It's not so big a part of the compensation of a

colonel.

So, if you're raising the cost of healthcare, aren't you disadvantaging the more lowly-paid? I don't think that has to be the case at all. There are lots of ways to go about doing this. You can have an income-related premium. That's the essence of the way health reform works. You can have additional compensation in other forms that is part of the package of changes in health benefits.

So, the issue of what the distribution of compensation is across different ranks -- is it something one can decide separately from the question of, how much of the cost of healthcare should be shouldered personally by people in the military or their families?

I think I'm with you on the distributional side of things, but I think it's a problem that can be dealt with.

MR. HALE: Just to add to that, the proposal the Department put forward last year did have lower co-pays, for example, for -- I think it was E5s or E4s and below. So, there was an attempt to do just what you said, Henry. It's of great concern, I think, to the military to take care of more junior enlisted.

MR. O'HANLON: Other questions?

So, we'll take two more -- Jason and the woman in the fifth row.

MR. TAMA: Hi -- Jason Tama, a Federal Executive Fellow here at Brookings -- active-duty Coast Guard officer; really enjoyed the discussion.

And I'll be one to say that I agree that there are opportunities for reform in total compensation. And some of the ideas are worth considering.

I guess my question is, in the context of the overall federal budget, politically, can we ever get there? Should we ever get there without a broader discussion on the other drivers for the rest of the population -- impacting the cost of the budget?

I guess similar to the acquisitions question, but some of the same challenges exist where there are other entitlement programs, and I feel like it'll be very difficult to get to the military piece politically, without the appearance of, you know, balancing the budget on the back of the vets, without, at the same time, addressing, you know, Medicare/Medicaid rising entitlements. And how do we look at that, going forward?

Thank you.

MS. RUEDISUELI: Hi. My name's Karen Ruedisueli. I'm with the National Military Family Association, and I'm also the wife of an active-duty Army officer.

I would like to understand a little bit more about your ideas for streamlining the military treatment facilities, and transitioning some military beneficiaries into the ACA. Having lived in some of these sparsely-populated areas, I'm well aware that there is also a lack of civilian medical resources in a lot of these areas.

And if you were to offload military beneficiaries into the civilian medical community, what would the plan be for ensuring that military families had adequate access to quality healthcare?

MR. O'HANLON: Let me just add one clarifying word before we take the first volunteer on these questions -- and, again, framing the discussion today -- as you're aware, we've got an active Assistant Secretary, we've got a former Comptroller, and we have other people who are brainstorming. And so you're hearing different ideas in different veins, and I just want to underscore that point.

So, I think that was something that Alice was driving at earlier, and I'll maybe start with her, if you wish to begin with either of those questions.

MS. RIVLIN: Well, let me -- certainly, one of the problems is, there's political opposition to anything that looks like a benefit reduction to anyone. And that

applies to military, to military retirees, to the Medicare beneficiaries. And it's one of the reasons, I think, for looking at these changes across the whole system at the same time.

And it's certainly possible that Medicare, which is, at the moment, having some success in holding down costs, as is the military health system, can survive over the longer term if it takes advantage of the payment reforms that will enable beneficiaries to have better choices, and the providers to have the incentive to use their resources more efficiently. And that seems to be starting to happen.

But the more we think of this as a national how do we solve the problem together question, I think the more we can pull the specific groups that are really worried about what happens to us together into the conversation.

On the sparsely-populated areas, I wasn't saying, close down the military health system, and throw them into inadequate civilian facilities. But if you have areas -- which both the civilians and the military are concerned about -- where there aren't enough facilities of either kind, then this is a problem which may be soluble together easier than it's soluble separately.

And it might involve using military facilities to fill civilian needs, or it might involve putting the military, or veterans, or whoever we're talking about, into the system to create a larger pool of more beneficiaries and more ability to support a system where there aren't that many people.

MR. O'HANLON: Other comments or answers for these questions?

Okay, we'll take the next two.

MR. HALE: Oh, let me add one thing --

MR. O'HANLON: Please, please, please.

MR. HALE: And that is, I think as a citizen, I understand we need to get at other entitlement programs, but we also need to think about the revenue side of

government. I believe that the Joint Chiefs, and the Secretary, and Department of Defense have decided they need to look at compensation programs to include healthcare, because the law now limits total military spending, and, therefore, if they don't slow the growth in military compensation, they'll be less available for training and modernization. And I think they are very concerned that there isn't adequate training right now, especially coming off 2013 and sequestration.

So, I think the bet would be their answer, and it seems to be a logical one to me, that they need to look at the military, because of the limited total spending. And so we need to find dollars for training and modernization.

MR. O'HANLON: I'm going to quote my good friend, Mackenzie Eaglen, who's a scholar at the American Enterprise Institute. And she likes to say, in her sweet Southern drawl, that we have two sacred contracts with our men and women in uniform. One is to take care of them and their families in the way that Abraham Lincoln spoke of, but, also, as they are in uniform and in service. But the other is to make sure they are the best prepared for the fight, so that when there's a fight, they live, and the enemy dies.

It's a powerful way to put it; sounds better coming from her than from me, but it is a good way to underscore, I think, this point that there is tradeoff right now, and based on current law and budget caps, to some extent, between all these different programs.

Yes, ma'am? And then we'll come up here. I think you had a question, as well? Was I right? Okay.

QUESTIONER: Are you factoring -- oh, there he is -- are you factoring in the fact that the military healthcare system can be much more efficient and lower-cost than the civilian system, just by using Medicare hospital rates, and by negotiating prices for drugs? The military system is less expensive than civilian healthcare, and it can be

made much more efficient still.

MR. O'HANLON: That question in a second, and one more up here, please.

QUESTIONER: Thank you.

As a military spouse -- I'm sorry I got all coughed up -- the question of moving military families onto the national healthcare system -- is it being taken into consideration when the family's overseas? What is the ramification of moving them back to the DOD? What is the expense of that, and what are the time constraints, as well?

MR. O'HANLON: I'm going to say one more clarifying thing. Again, I think that kind of idea is one that we're framing here -- some of us at a more theoretical level. I don't think it's an active proposal of either Secretary Woodson or anyone else in the Department at the moment, just to be clear.

But, Bob, you want to say more about that?

MR. HALE: Well, on the use of rates, as I said in my opening remarks, there has been progressive on that score. I mean, five years ago, DOD was not using Medicare rates in small hospitals or for outpatients. They were allowed to do that by the Congress, and I think that has yielded some savings; similarly, use of the VA drug pricing schedules, which a drug company sued and lost, was helpful to the Department.

So, there may be more there. But I think it's important we acknowledge there has been progress.

And I think I'll defer to Alice or Henry on the exchanges.

MR. O'HANLON: Okay. Jack, I wondered if I could draw you out, if you like, on this issue of how efficient we should think of the DOD healthcare system at large. You spoke to that earlier already, with some very, I thought, informative illustrations. I wondered if you wanted to comment more generally on how you see the set of

institutions.

I mean, one thing I was struck at, just trying to prepare for this event, is that I think there are 140,000 DOD fulltime employees in the DOD healthcare system -- 80,000 plus who are civilian; 60,000 plus who are military. It's a big organization. On the other hand, by some metrics, it doesn't look inefficient, doesn't look expensive. I just wondered if you wanted to add a word on that.

MR. MAYER: So, I mean, by nature, being government is never going to be efficient, all right? I mean, it isn't designed to be that way, because there are things that it has to do that no other health system has to do, all right? So, it has to take care of the active-duty military.

But one of the problems that we always have when we want to do change in any big organization is that organizations are tied to the way they've done things in the past and tradition. And it becomes very, very difficult to be able to do change. And what always drives people to be able to come up with that change is when they need to have money to do other things that have a higher priority.

I think Bob alluded to that when he said that there's only so much money that the DOD is allowed to spend now under law. And so if they're going to spend more money modernizing, they've got to find other ways to be able to reduce it.

I'm very sensitive to the idea that the military goes to remote places, and is deployed overseas, and that there are challenges in terms of being able to get medical care in some of those places. But holding onto places, like I learned yesterday, in the Air Force, where they may be getting only 10 people through a facility a day is probably not in anybody's best interests.

There's got to be better ways to be able to provide medical care, because the overhead cost of maintaining that facility is absurd in comparison to what

you would want to be able to do.

So, when I talk about innovation and how you want to think about this, I'm not trying to get to the most efficient way. If I wanted to get to the most efficient way, that becomes a very mechanical approach, all right? But I think that if you're thinking about innovation, you have to start thinking about ways that you can do things better for the future, and be willing to let the past go.

MR. O'HANLON: Thank you.

And then Carla.

MR. HALE: I wanted to go back to the issue of inefficiency or efficiency in cost, and invoke the reference that was made to the impact of the price of care on the quantity of care that's used. Expenditure equals price times quantity -- simple equation.

It's now about a quarter of a century since the best and largest social experiment ever carried out was completed. That was on the impact of cost-sharing -- premium differences on the use of healthcare -- done by the RAND Corporation. Free care cost resulted in about 30 percent more use of healthcare services than did a normal health insurance plan back then.

We've just heard the statistic that the use of healthcare under TRICARE -- the quantity of services is (inaudible) for comparable populations at even larger percentage.

Now if there were evidence that the difference in the quantity of care had a big impact on healthcare, then you're into the business of -- and health -- you're into the business of doing tradeoffs. Is it worth it to spend more in order to get the additional benefits?

But the evidence is that the impact on health is negligible. There are some differences that were detected back a quarter of a century ago. And I suspect you

would find some if you did a comparable study today. But they're teeny-tiny.

And so I think it's fair to ask whether this is a good expenditure of funds by a cash-strapped, perhaps not sufficiently trained and ready military at the present time.

I'd like to make one other comment, and it's triggered by the reference to supposed inconsistency between the federal government and efficiency. About 10 years ago, a very, very careful study was done of the likelihood that people would receive the care indicated for the condition they have when they go into a hospital or see a physician. Tens of thousands of records were examined.

And the results were really quite startling; didn't make any difference -- the likelihood that you would get the care that was recommended. Didn't make any difference, really, in those percentages if you were rich or poor, old or young, male or female, black or white. They were almost identical percentages.

There was one place that stood out for having a higher probability of people receiving the care that was recommended. That was the Veterans Administration.

Now that was the one part of the healthcare system that was managed and run by the government. It used to be something of a sinkhole. It had a terrible reputation. But then, during the '90s, a real revolution occurred in that delivery system. It was a pioneer in electronic health records, and it vaulted way over its previous standard. And in at least this one study, this wholly government-managed healthcare delivery system did a better job in delivering recommended care than the rest of the healthcare system did on the average.

Now there are, no doubt, within the private sector particular places that did absolutely sterling jobs, but it was this one group. So, I think it's the case that if innovative managers, whether they're within government or outside of it, are given their

heads, and are supportive, and given the flexibility to effectuate reforms, we can see efficiency in both places.

MR. O'HANLON: Thank you.

Carla?

MS. MURRAY: Well, I guess I was thinking a similar thing along those lines. But it's price times quantity, and that as an analyst, I've found it very challenging to -- and I have not really seen one answer about whether in-house care is cheaper than private sector care. I've seen, depending how you measure it, practice patterns, how long does it take before you replace the knee in the military system versus how long civilian patients wait before -- how much physical therapy they have to take before they can go ahead and put in the knee -- that sort of thing -- hotel amenities in hospitals, if you will, wards versus private rooms, and so on, and so forth.

So, it's a very challenging -- you know, the rates are fantastic when you can get them. Bob talked about -- but I do think that make or buy decision is not really an easy one.

MR. O'HANLON: Alice, did you want to --

MS. RIVLIN: Well, I think that's right. But it reinforces the point that, on the average, there are a lot of improvements that can be made across these systems. And we need to be thinking about them in the same way, and changing the incentives, both for the providers and for the beneficiaries so that we get better healthcare for less money.

MR. O'HANLON: There are a couple more questions. Let's just go right here, to these two women in the fourth row, please. Then we'll do a final round.

MS. GOLDEN: First of all, thank you very much for your time today. My name is Karen Golden. I'm with the Military Officers Association of America.

I just had a comment about -- I very much appreciated the two quotes you had about our military needing to be the best-prepared, and we need to take care of the people that wear the uniform today, and those in service. My husband is an active-duty Marine, and I most certainly acutely understand the need for our military to be best prepared.

But I noticed absent in that statement is the 10 percent -- someone mentioned the 10 percent who have given their life, a lifetime of service and sacrifice to our nation. And I wonder if the panelists could reiterate how they feel the nation has an obligation to them in terms of healthcare, and to our retirees.

And also absent in that statement is our military families, of which I am a military family member. What is the obligation to our military families, in terms of providing healthcare?

I'd be interested in what each panelist thought about those obligations to retirees and to military families.

MS. HUCK: Good morning. My name is Eileen Huck. I'm with the National Military Family Association, and I'm also an active-duty family member.

Part of the rationale for including family members and retirees in the military healthcare system is to ensure that military healthcare providers have a sizeable, diverse population on whom to practice.

So, if we remove family members and retirees from the military health system, either by one of these innovative ideas requiring them to participate in the ACA, or by removing the financial incentives for them to be part of the military health system, what impact would that have on our military providers? Would their training and preparation suffer by not having this diverse population on which to practice?

MR. O'HANLON: Thank you.

Jack, you want to start?

MR. MAYER: So, let's talk about the one about the people who retire. I think that there is an obligation on the part of the federal government that when someone comes into the military, and they want them to continue to a retirement age -- whether that's 20 years or 30 years -- that there is a contractual obligation to adhere to that.

I would argue that -- so those people who are currently in the military, and are going to stay to retirement, that you meet that obligation. I don't think that needs to be something that is perpetuated far into the future. I think that there are -- obviously, if it's cost considerations as to whether you can afford to do that or not, then you can change what the contract is for new people coming in.

And so you end up with a situation where you grandfather the ones who are already in the military, but you're providing a different benefit system for those future people who are going to be coming in. Now this is not inconsistent at all with what you find in almost every other place in life. I mean, indeed, we saw the great turmoil in Wisconsin when the governor changed the contract agreement with public sector employees that had been employees for some period of time. I'm not proposing doing something like that. But I am proposing looking at what that benefit is in the future.

You need to be able to balance the benefits as part of the total package of what you need in order to be able to continue to attract the quantities, and the quality, and skill set of people in order to be able to defend this country, because we have a volunteer military, okay, and it's not a conscript anymore. It is purely one of economics -- of, how do you attract the people that you want to have, and how do you keep the numbers that you need to have in the future (inaudible)?

And it's a combination of things that you're able to do, and it doesn't have to be the same things that we've done in the past.

MR. O'HANLON: Way down -- Alice.

MS. RIVLIN: I think we should distinguish what is the obligation from what kind of healthcare do we want people to have -- and the obligation to the active-duty military, to former active-duty military, is something that I think has to be decided politically. But whatever obligation we have, we want people to be in a system that is effective and not wasteful, duplicative, and subject to problems of handoff between one facility and another.

And one of the ways that people think we could get a more effective system is to have plans, whether military or civilian, competing against each other. And for that, you need a fairly large pool of beneficiaries.

And so if you're thinking about the system as a whole, you might want to put in place a system which maximized the ability to deliver good care, especially in these sparsely-populated areas, to everybody, and think about how you use the facilities that are both civilian and military to do that. That was all I was suggesting. I think it's quite independent of what the subsidies are for various categories of beneficiaries.

MR. O'HANLON: Thank you.

Carla?

MS. MURRAY: I guess in responding to this -- well, first, the details of the options that we explored are available on the website. And probably for those people who want to know, really, the (inaudible), I would encourage you to go look at that -- cbo.gov.

I'll say that for the options that we looked at -- for example, one of the options was to take the -- say, what would the enrollment fee and co-payments be if you took what they were in 1995, when TRICARE was stood up, and if they had kept pace with the increase in per capita medical inflation, what would they be today?

So, in essence, taking the financial burden that was -- if you want to call it a burden -- established for retirees and for service members when TRICARE was stood up, and keep that burden essentially the same, if adjusting for inflation. And that resulting in -- you know, you approximately double the enrollment fee. So, it goes from maybe \$550 a year for family coverage to \$1,100 a year.

And that's what you see is -- we estimate -- that people do leave, but not everybody leaves. And people do consume fewer services, but not everybody consumes fewer services. And so you have these behavioral effects.

I don't want to give the impression that somehow, people are forced out of the system when you change the financial arrangement. TRICARE will still look financially -- if these options took place, TRICARE will still look financially attractive to many, many people.

MR. O'HANLON: Bob, anything to add?

MR. HALE: I think Department of Defense recognizes they've got an obligation to both retirees and active-duty family members, and nothing they've proposed would fundamentally change that.

It would take, say, TRICARE Prime from largely having no co-pays to having I would describe as fairly modest one -- zero for the most junior enlisted; \$10 in military treatment facilities or, if I remember the numbers right, \$20 for in-network if you go outside the military treatment facilities.

That and many other proposals they made last February save about \$2 billion a year. Roughly half of that comes through reductions in overutilization that has been discussed here already. So, only about half of it actually comes from the fees themselves; the rest from reductions in utilization.

But I don't think there's any question -- at least when I was there, and,

I'm sure, hasn't changed -- that there remains a feeling there's a commitment to both retirees and active-duty family.

MR. O'HANLON: What we'll do now is, we'll take one last round of questions -- two more -- and then I'm going to invite the panelists, starting with Bob, to respond if they wish, but also to add any final, concluding comment if there's something they want to make sure we hear today that we haven't yet.

So, ma'am, here in the third row, and then towards the back, in uniform.

MS. BEASLEY: Hi. My name's Kathy Beasley. I'm with the Military Officers Association, and I'm a retired Navy nurse. And so I've been in the system for 30 plus years, so I'm well-acquainted with military medicine.

My question, I think, for Secretary Hale -- sir, I know we've discussed in the past the cost of readiness. I mean, there is a cost to readiness, and it's of various forms. Can you comment on that?

CAPT. MARSH: Good afternoon. Thank you very much for everything you've said up there today. My name's Captain William Marsh. I'm an Army trauma nurse, a 10-year veteran; Air Defense officer, as well.

And two points that I was concerned about -- one is, we talk about separating the military health system and readiness. The military health system goes to war every day, for the civilians in the area, in trauma centers, and taking care of the soldiers on the home front, even when there isn't a war. So, I think we need to be cautious as we proceed down that road, because we have to maintain our medical readiness to treat, with or without a war. As Dr. Woodson stated, we deployed for Ebola.

The second point I would like to ask is, we talked about overutilization on the TRICARE benefits. Has there been research into frivolous healthcare -- as in an appointment kept is seen as actually frivolous ER usage, primarily is where I'm thinking --

and potentially once a visit is deemed as frivolous, that person would then pay a co-pay. Has there been consideration in that to recoup some of those benefits?

MR. O'HANLON: Thank you.

Bob, would you like to start?

MR. HALE: Well, let me start on the readiness. I mean, readiness is one of the hardest things to define. You could make a plausible case that the entire Defense budget contributes to readiness. That's why at least the base portion of the budget -- and we pay separately if we're actually those forces in conflict. You could take it to even much more limited things, such as flying hours, et cetera, that put you in the \$50-billion range.

But I think we should back off from the specific numbers, and recognize there is a strong commitment to readiness in the Department of Defense. And there should be, especially in a world where we face as many threats, and they come up with as little warning as they do. And healthcare is most assuredly part of it.

And so I think these discussions -- I can tell you from personal experience -- when discussions are made about benefits, about what we're going to do to the healthcare system, military readiness is always something that gets raised. And it should be, and it will continue to be.

MR. O'HANLON: And could I -- since we are now concluding, and I want to invite you to add anything you might wish, but I'm going to pose one final question to you -- given the responsibilities that you've had, given how much you've contributed in this domain, realizing that you're now out of service in the Department of Defense, having been Undersecretary, but I think I'm hearing you today say that the military healthcare system is in reasonably good shape, but it needs a lot of work. The compensation system is reasonably fair, but there are certain specific significant, yet not revolutionary,

changes we can and should consider. And we don't need an overhaul, but we do need a lot of work in specific areas.

Is that a fair summary?

MR. HALE: Mike, if you started with a clean sheet on military compensation, I wouldn't design it the way it was. I think it was Brookings published a book called The Military Pay Model. And it most assuredly describes the current system as very complicated, just remarkably so.

But politics is the art of the possible. I don't see starting over in this kind of an environment, and, therefore, I would say, yes, it is doing its fundamental goal of attracting and retaining people, and so I think it's most realistic to (inaudible) on the margin.

But I would like to give some of the other panelists a chance to comment on that realization, and then I'll come back and talk about the emergency room (inaudible). You probably know better than I do that if it's a real problem in the military.

MR. O'HANLON: And so we'll finish with you, but we'll go down the row first.

Okay, Carla. Any comments or --

MS. MURRAY: I think -- well, I don't want to speak for DOD. DOD's --

MR. HALE: Nor do I, anymore.

MS. MURRAY: Right. I think DOD has tried to wrestle with those sorts of things. I hesitate to call them frivolous, but, certainly, you'll see in the civilian sector the sort of plans that you outlined -- that, you know, if you go to the ER, and then it's deemed it wasn't an emergency, the deductible is higher or there's a fee that's (inaudible).

I don't think that those sorts of things have proposed officially by DOD

(inaudible).

MR. O'HANLON: Alice?

MS. RIVLIN: Let me stick with frivolous, because I think it's an unfortunate word, usually, in this instance. There's certainly good studies that will tell you that care coordination, particularly for chronic disease, will help avoid running to the emergency room when you're really sick. It avoids getting really sick, and getting into the condition where you have to go to the emergency room.

And some of these studies have to do with things that you don't ordinarily think of as healthcare. We were looking at pediatric (inaudible) recently. And if you can get children into a cleaner environment and one with less mold and hazard in the household, they're much less likely to have emergency room visits for asthma. That's not a healthcare thing. But it is a disease management thing that can save money.

MR. O'HANLON: Thank you.

Henry?

MR. AARON: Just continuing, again, on Alice's theme -- virtually any contact that you have with the medical system has some probability of helping you. It may be a high probability if you walk in with a broken arm, and you get it set. It's pretty sure you're getting a benefit. It may be a very low probability -- and there are some cases in which actual harm is likely to occur.

There is no clear distinction anywhere on that probability distribution that a contact with the medical system is, in one case, clearly indicated or clearly not indicated. So, inevitably, you are making a decision about a policy change that has the effect of reducing the degree to which somebody uses healthcare. There is some probability of benefit.

Now the point that I think Carla made and I made, citing the RAND

health insurance study from many, many years ago, is that within the U.S. healthcare system, there's an awful lot of contact with the healthcare system where the probability of benefit is really -- I'll use the non-argumentative term -- modest.

And so this isn't an on/off signal where you know it when you see it. It's inevitably an ambiguous and difficult decision.

So, when we speak about changing cost share in ways that will have some effect on people's willingness to demand care, that usually goes, incidentally, with the fact that preventative care is free, and vaccinations are free, and well baby care is free. No cost sharing there, because we know those pay off big time, but there is cost sharing for other things.

Sure, there's some sort of tradeoff, but the evidence is that the medical benefits that are sacrificed from imposing some charges there are really very small.

MR. O'HANLON: Thank you.

And Jack?

MR. MAYER: I don't think there's any doubt that medical services in this country are going under transformation. It started with the ACA, and it's not done yet, because we all know the ACA has things that need to be fixed. Military service delivery and system will be part of that.

My experience in this town and in business is that the best solutions are ones where all of the stakeholders can come together, and recognize that there's going to be change, and be willing to work together in order to get that change possible -- not exactly what each stakeholder wants, but what's possible. And many members of MSOs in this room today -- I strongly encourage you to get in the fight -- not to justify or protect what you have, but to establish what's right for the future, for the country and your constituents.

MR. O'HANLON: Thank you.

Bob? Last word to you, if you have anything more you'd like to add at this point.

MR. HALE: Well, first, I don't know that we answered our captain's question. If I remember the numbers right, emergency use is about four times higher per capita in the Department of Defense than it is in the private sector after appropriate adjustments. There is worry about the medical effects of that. I'm not a doctor, but I think there's real concern on the Surgeon General's part about follow-up care when it's being that heavily used.

I would worry about trying to adjudicate what's frivolous use, but I think some kind of fees/co-pays for emergency room use are clearly appropriate (inaudible).

Now let me back off to the broader issue, which is, we've got a military under a lot of stress, doing a lot of good things for the country. We owe a lot to the men and women in uniform -- and to the civilians who support them, I might add -- we don't talk enough about them sometimes. And that includes healthcare, reasonable healthcare. I think all of us would agree to that.

The discussion today, is can we do it more effectively, whether it's to tap into the broader resources of the national system, whether it's some changes of incentives, whether it's budgeting differently? I think that's the budget that needs to happen. We are committed -- I think the Department is clearly committed to a strong military healthcare system for all the current beneficiaries.

MR. O'HANLON: And before we thank the panel, I'm sure you'll all want to join me, as will all the panelists, in making sure we're also applauding for our men and women in uniform, their families, retirees, veterans, and everyone else who's contributed so much to our nation. But thank you all for being here, as well, and happy holidays.

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CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Carleton J. Anderson, III

(Signature and Seal on File)

Notary Public in and for the Commonwealth of Virginia

Commission No. 351998

Expires: November 30, 2016