Federal Health Update

MAY 2, 2014

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EXECUTIVE AND CONGRESSIONAL NEWS

- **First Lady Michelle Obama and Dr. Jill Biden authored an OpEd piece in MilitaryTimes.com announcing the Veterans Philanthropy Exchange, which brings together benefactors from all across the country to create a stronger, national funding structure for efforts that support military families.**
  http://www.militarytimes.com/article/20140430/NEWS/304300043/Opinion-Support-military-families-cannot-end-when-wars-over

- ***Stars and Stripes* reports the House Armed Services Subcommittee on military personnel rejected proposed cuts to commissary, housing and medical benefits that the Department of Defense argued in March are key savings, needed to balance its shrinking budget.**

  The House Armed Services Committee will move to the bill to committee next week for debate and a vote.

  The Budget Control Act of 2011, known as sequestration, requires lawmakers to make steep cuts in military spending in coming years — billions of dollars must be shaved, according to the law.

  The military personnel subcommittee draft of the bill would require that outside experts review the military commissary system and "identify efficiencies that could lead to cost savings without reducing military family benefits."

Members of the House did not take up a proposed 1 percent military pay cap, but instead left that issue to the Senate, which is slated to open its debate on the defense bill and the proposed pay cap Tuesday.

- **On April 30, 2014, the Senate confirmed Robert Work as the next deputy secretary of defense by voice vote.**

  Work's confirmation will permit the retirement of Christine Fox, who had been serving as acting deputy secretary.

  Hagel called the 61-year-old Work "an admired and tested leader, with a distinguished career of public service, including during his time as an officer in the Marine Corps and as undersecretary of the Navy."

  Work is a 27-year Marine Corps veteran and former undersecretary of the Navy. After retiring from the Marines as a colonel, Work joined the Center for Strategic and Budgetary Assessments (CSBA), first as the senior fellow for maritime affairs, and later as the vice president for strategic studies. He was Navy undersecretary from 2009-2013.

  Work has been the CEO of the Center for a New American Security, another Washington D.C. think tank, since stepping down as the Navy's under secretary.

- **The House passed H.R.4486, the *Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2015*, on April 30, 2014.** The legislation provides $71.5 billion in discretionary funding for military infrastructure and construction, as well as veterans' benefits and programs.

  For the text of the bill, please visit: http://beta.congress.gov/113/bills/hr4486/BILLS-113hr4486rh.pdf

MILITARY HEALTH CARE NEWS

- **The Department of Defense issued new initiatives designed to continue its efforts to eliminate sexual assault in the military, directed implementation of an updated sexual assault prevention strategy and released its annual report on sexual assault in the military for fiscal year 2013.**

  The department's response to sexual assault is fundamentally different than it was two years ago. Since May 2013, Secretary Hagel has directed more than 28 initiatives to enhance commander accountability, ensure the appropriate command climate, improve victim support, and enhance safety.

  - The new initiatives are available at: http://sapr.mil/index.php/news
  - The updated prevention strategy is available at: http://sapr.mil/index.php/news
  - The full report is available at http://sapr.mil/index.php/annual-reports
  - The fact sheet is available at: http://sapr.mil/index.php/news

  Victims are encouraged to contact the Safe Helpline at 877-995-5247 or visit http://www.safehelpline.org/ for confidential and anonymous crisis intervention services.

  For specific information regarding the military departments, contact the Army at 703-614-5302,

the Navy at 703-697-5342, the Marine Corps at 703-614-4309 and the Air Force at 703-695-0640.

- **The Army Chief of staff, Army announced the following assignments:**

  Maj. Gen. Joseph Caravalho Jr., commanding general, U.S. Army Medical Research and Materiel Command and Fort Detrick, Fort Detrick, Md.,to deputy surgeon general/deputy commanding general (Support), U.S. Army Medical Command, Falls Church, Va.

  Maj. Gen. Brian C. Lein, deputy surgeon general/deputy commanding general (Operations), U.S. Army Medical Command, Falls Church, Va., to commanding general, U.S. Army Medical Research and Materiel Command and Fort Detrick, Fort Detrick, Md.

  Brig. Gen. Barbara R. Holcomb to commanding general, Brooke Army Medical Center, Joint Base San Antonio, Texas. She most recently served as command surgeon, U.S. Army Forces Command, Fort Bragg, N.C.

  Col. Robert D. Tenhet, selected for the rank of brigadier general, executive officer to the surgeon general, Office of The Surgeon General, Washington, D.C., to commanding general, Northern Regional Medical Command, Fort Belvoir, Va.

- **The Department of Defense (DoD) released its 2012 calendar year DoD Suicide Event Report (DoDSER), which details the number of suicide attempts and deaths for U.S. service members.**

  The DoDSER includes an assessment of several areas for suicide prevention efforts, including demographic information, behavioral health history, circumstances at the time of the event, and deployment history. This vital information helps target resilience efforts and allows DoD senior leaders to make informed policy decisions to improve suicide prevention efforts.

  In calendar year 2012, there were 319 deaths by suicide among active component service members and 203 deaths by suicide among reserve component service members (73 in the reserve and 130 in the National Guard).

  Preliminary data for calendar year 2013 indicates that the overall totals and rates declined in most categories from 2012. The preliminary 2013 total deaths by suicide were 261 among active duty service members and 213 deaths in the reserve component.

  The military suicide death rate will now be calculated for each component consistent with the methodology used to report the incidence of death in the U.S. by the Centers for Disease Control and Prevention. Previously, each service branch calculated a suicide rate for their service members using different reporting intervals and statistical methodologies. Additionally, service component, rather than duty status, will be used to count suicide number for the total force (active, guard and reserve components). Later this year, the department will begin to issue suicide data results quarterly for all service components.

  The 2012 DoDSER findings are available at www.suicideoutreach.org.

- **Starting this spring, more than 400,000 military retirees and senior dependents in the Tricare for Life (TFL) program will owe the full amount for certain prescription refills if they use a retail pharmacy rather than a military pharmacy or a mail service.**

  The change, part of a pilot program created by Congress, is meant to help control the cost of

military health care and in its first year, is expected to cut $120 million from the $3.3 billion that the U.S. Department of Defense pays annually for Tricare For Life pharmacy needs.

The government insurance serves about 2 million military retirees and their dependents over 65, supplementing Medicare. TFL accounts for nearly half of the $7.1 billion that the Defense Department spends each year on its pharmacy program.

The pilot includes more than 400 medications – mostly brand-name – for chronic conditions, such as high blood pressure, diabetes and asthma. Prescriptions for pain relievers, antibiotics and other medicines for acute conditions aren't affected.

With the program, members can fill eligible prescriptions three times at a retail outlet, usually a 30-day supply for a $17 copayment. Then, if they don't switch, they're responsible for the drug's entire cost for subsequent refills, charges that quickly could climb into hundreds of dollars.

If they do switch, they'll owe $13 for each 90-day supply through the Express Scripts mail service or nothing when they use a base pharmacy.

After a year, members can opt out of the pilot and return to paying $17 for a 30-day supply for their retail refills. Nine out of 10 people who switch to the home delivery program decide to stick with it, according to Tricare.

TFL will grant waivers on a case-by-case basis due to "personal need or hardship, emergency, or other special circumstance."

Beyond savings and convenience, TRICARE officials said the move to mail delivery can help patients adhere more closely to their drug regimens by requiring less effort to get their prescriptions refilled.

That compliance can keep patients healthier, an obvious plus for them. It also can save insurance plans the expense of hospitalizations or other medical care.

VETERANS AFFAIRS NEWS

- **The Department of Veterans Affairs' (VA) Patient Aligned Care Teams (PACTs), VA's model for more personalized and accessible primary care delivery, is improving access to health care and veteran satisfaction, according to data released today by VA.**

  Since its inception in 2010, the PACT program has transformed the way veterans receive their care by offering a coordinated team approach squarely focused on Veterans' wellness and disease prevention.

  VA is the largest integrated health care system in the United States, caring for approximately 5.3 million Veterans in primary care settings. Over the past two years, VA has bolstered its support to all medical centers to expand established PACTs. Teams are comprised of a provider, a Registered Nurse care manager, a clinical associate, and an administrative associate. Clinical pharmacists, social workers, nutritionists, and behavioral health staff support PACTs.

  Since implementing PACTs, the number of primary care patients has increased 12 percent, and the number of encounters with veterans has increased 50 percent mostly due to telehealth, telephone and group encounters. Communicating with health care professionals through secure electronic means has increased dramatically as well. Despite the increase of primary care patients, access to primary care has improved and continuity of care is better.

  Additionally, approximately 65 percent of veterans requesting a same day primary care appointment with their personal provider are accommodated and 78 percent of veterans are able to see their own primary care provider for an appointment on the date they desire. Veteran access to primary care during extended hours (non-business hours) has increased 75 percent

since January 2013.

Over 72 percent of all veterans discharged from VA are contacted within two days to ensure they are following discharge instructions and check in on their condition. These critical post-discharge follow-ups are important to reducing readmissions.

Mental Health Integration is also a critical component of PACTs and the program's goal to provide coordinated care. Veterans now see mental health providers in the primary care setting. In just one year (FY12-FY13) using the PACTs model, mental health services offered in VA primary care clinics increased 18 percent.

Overall, PACTs program implementation has been associated with important utilization changes—fewer primary care patients are receiving care in urgent care settings (decreased 33 percent) and acute hospital admissions have decreased 12 percent due to improved care management and coordination from PACTs.

Equally important, both rural and urban veterans report a high level of satisfaction with VA services. Veterans also indicated they are more likely to recommend treatment at a VA facility than at non-VA facilities. This positive feedback is consistent with the 2013 American Customer Satisfaction Index, which reported that veterans strongly endorse VA health care, with 91 percent offering positive assessments of inpatient care and 92 percent for outpatient care.

The PACT model has allowed VA to create COMPASS—a dashboard program which extracts and derives these types of metrics and information from multiple VA sources to track the status of the implementation.

More information is available at http://www.va.gov/health/.

- **The Servicemembers' Group Life Insurance (SGLI) program will adjust its monthly premium rate from 6.5 cents per $1,000 back to the 2006 rate of seven cents per $1,000 of insurance, a modest increase to ensure the SGLI program remains in a strong financial position.**

  The Department of Veterans Affairs (VA) continues to place the interests of service members first and foremost by keeping SGLI premiums as low as possible while also maintaining the necessary reserve levels to ensure funds are available to pay claims to Servicemembers' beneficiaries. Since the start of the SGLI Program in 1965, monthly premiums have decreased from 20 cents per $1,000 to the current 6.5 cents per $1,000. (Chart below). There have been periodic increases and decreases, but over the past 30 years premiums have fluctuated only 2.5 cents per $1,000 of insurance.

  In July 2008, VA lowered the monthly premium rate for basic SGLI from seven cents per $1,000 of insurance to 6.5 cents per $1,000 of insurance to reduce excess reserve funds in the program. Insurance companies hold reserve funds to ensure they can pay future claims. It is common practice in the group insurance industry to adjust premium rates as reserve funds increase and decrease, which typically happens when there are changes in the economy and/or changes in the number of death claims.

  In order for the program to remain in good financial condition, it is now necessary to increase the premium rate by half a cent per $1,000 of insurance. Since 2008, as a result of the half-cent reduction and decreases in interest rates, reserve funds have decreased. Insurance companies hold reserve funds to ensure they can pay future claims. It is common practice in the group insurance industry to adjust premium rates as reserve funds increase and decrease. VA also uses actuaries, individuals who deal with financial impact of risk, to conduct program experience studies when evaluating and adjusting reserve assumptions; and each year, an independent auditor verifies the accuracy of their reserve calculations.

  For a service member with the maximum $400,000 of life insurance, this change will mean an

increase of two dollars a month.

The new premium rate will take effect on July 1, 2014. Individual Ready Reserve members who are drilling for points toward retirement or who do not receive pay for other reasons will be billed by their branch of service for the higher premium beginning in July 2014. For information on the new rates, visit http://benefits.va.gov/insurance/sgli.asp.

GENERAL HEALTH CARE NEWS

- **Enrollment in the Health Insurance Marketplace surged to eight million at the end of the first enrollment period, according to the Department of Health and Human Services (HHS).**

The final enrollment reporting period spans from Oct.1, 2013, to March 31, 2014, and includes "in line" and other enrollment activity (such as people enrolling due to a change in life circumstance) reported through Saturday, April 19, 2014.

Importantly, 2.2 million (28 percent) of those who selected a Marketplace plan were young adults ages 18 to 34 — a number that grows to 2.7 million when counting ages 0 to 34, the report found. The report also shows, for the first time, the race and ethnicity of the 69 percent of enrollees in the federally-facilitated marketplaces who voluntarily reported this information.

HHS also announced today that more than 4.8 million additional individuals enrolled in Medicaid and CHIP through the end of March 2014, compared to enrollment before the Marketplace opened last October.

The report also details state-by-state information where available. In more than a dozen states, enrollment has doubled since March 1. For example, Texas (149 percent growth), Georgia (127 percent growth), and Florida (123 percent growth) had some of the largest surges in enrollment in the country over the final weeks of the initial open enrollment period.

Key findings from today's report include:

- 8,019,763 people selected Marketplace plans from October 1, 2013, through March 31, 2014, (including additional Special Enrollment Period activity through April 19th). Nearly 2.6 million signed up in the State Based Marketplaces and over 5.4 million in the Federally-facilitated Marketplace. About 3.8 million people, including nearly 1.2 million young adults (ages 18 – 34), enrolled in the Health Insurance Marketplace plans in the sixth and final reporting period, which began March 2 and concluded on April 19. Those 3.8 million individuals represent nearly 90 percent growth over February's cumulative enrollment.

Of the more than 8 million:

54 percent are female and 46 percent are male

34 percent are under age 35

28 percent are between the ages of 18 and 34

65 percent selected a Silver plan, while 20 percent selected a Bronze plan

85 percent selected a plan with financial assistance

The federal Marketplace also reported, for the first time this month, the race/ethnicity of its enrollees. The application for coverage through the Federally-facilitated Marketplaces (FFM) contains questions on race and on ethnicity, both marked as optional. Thirty-one percent of enrollees did not report their race or ethnicity or chose "other." However, of those enrollees who reported race and ethnicity:

62.9 percent of those reporting are white

16.7 percent are African American

10.7 percent are Latino

7.9 percent are Asian

1.3 percent are multiracial

0.3 percent are American Indian/Alaska Native

To read the Marketplace Enrollment report visit: http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

- **The Department of Health and Human Services (HHS) released the National Plan to Address Alzheimer's Disease: 2014 Update, reflecting the nation's progress toward accomplishing goals set in 2012 and current action steps to achieving them.**

  The 2011 National Alzheimer's Project Act calls for all Plans to be updated annually; the 2014 Plan follows the initial Plan released in May 2012 and an updated Plan released in June 2013.

  The 2014 Plan was developed with input from experts in aging and Alzheimer's disease from federal, state, private and non-profit organizations, as well as caregivers and people with the disease. The 2014 Plan includes the following five goals: finding ways to prevent and effectively treat Alzheimer's disease by 2025; enhancing care for Alzheimer's patients; expanding support for people with dementia and their families; improving public awareness; and carefully tracking data to support these efforts.

  Highlights during the past year include:

  - Identification of 11 Alzheimer's risk genes, providing new insights about disease pathways and possible drug targets;
  - Training and support to more than 23,000 health care providers on dementia;
  - Focused and coordinated public-private efforts that reduced the inappropriate use of antipsychotics among long-stay nursing home residents with dementia by nearly 14 percent; and
  - Funding to states for development of dementia-capable long-term services and supports systems.
  - The 2014 Plan also identifies the following action steps led by HHS to better research, treat and prevent Alzheimer's disease:
  - Acceleration of efforts to identify the earliest stages of Alzheimer's disease and to develop and test targets for intervention;
  - Move research and care forward by increasing collaboration in science, data sharing, and priority setting among Alzheimer's disease experts, health care providers and caregivers;
  - Expansion of current work to strengthen dementia-care guidelines and quality measures, including meaningful outcomes for people with dementia and their families;
  - Help for health care providers to better address ethical considerations related to caring for people with dementia, including how to balance privacy, autonomy and safety; and
  - Enhance support for global collaboration on dementia, including hosting a February 2015 follow-up meeting to the December 2013 G8 Summit on Dementia.

For more information about Alzheimer's disease, visit www.alzheimers.gov.

To read the National Plan to Address Alzheimer's Disease: 2014 Update, visit http://aspe.hhs.gov/daltcp/napa/NatlPlan2014.shtml

- **Each year, nearly 900,000 Americans die prematurely from the five leading causes of death – yet 20 percent to 40 percent of the deaths from each cause could be prevented, according to a study from the Centers for Disease Control and Prevention.**

  The five leading causes of death in the United States are heart disease, cancer, chronic lower respiratory diseases, stroke, and unintentional injuries. Together they accounted for 63 percent of all U.S. deaths in 2010, with rates for each cause varying greatly from state to state. The report, in this week's issue of CDC's weekly journal, Morbidity and Mortality Weekly Report, analyzed premature deaths (before age 80) from each cause for each state from 2008 to 2010. The authors then calculated the number of deaths from each cause that would have been prevented if all states had same death rate as the states with the lowest rates.

  The study suggests that, if all states had the lowest death rate observed for each cause, it would be possible to prevent:

  - 34 percent of premature deaths from heart diseases, prolonging about 92,000 lives
  - 21 percent of premature cancer deaths, prolonging about 84,500 lives
  - 39 percent of premature deaths from chronic lower respiratory diseases, prolonging about 29,000 lives
  - 33 percent of premature stroke deaths, prolonging about 17,000 lives
  - 39 percent of premature deaths from unintentional injuries, prolonging about 37,000 lives

  The numbers of preventable deaths from each cause cannot be added together to get an overall total, the authors note. That's because prevention of some premature deaths may push people to different causes of death. For example, a person who avoids early death from heart disease still may die prematurely from another preventable cause, such as an unintentional injury.

  Modifiable risk factors are largely responsible for each of the leading causes of death:

  - Heart disease risks include tobacco use, high blood pressure, high cholesterol, type 2 diabetes, poor diet, overweight, and lack of physical activity.
  - Cancer risks include tobacco use, poor diet, lack of physical activity, overweight, sun exposure, certain hormones, alcohol, some viruses and bacteria, ionizing radiation, and certain chemicals and other substances.
  - Chronic respiratory disease risks include tobacco smoke, second-hand smoke exposure, other indoor air pollutants, outdoor air pollutants, allergens, and exposure to occupational agents.
  - Stroke risks include high blood pressure, high cholesterol, heart disease, diabetes, overweight, previous stroke, tobacco use, alcohol use, and lack of physical activity.
  - Unintentional injury risks include lack of seatbelt use, lack of motorcycle helmet use, unsafe consumer products, drug and alcohol use (including prescription drug misuse), exposure to occupational hazards, and unsafe home and community environments.

  Many of these risks are avoidable by making changes in personal behaviors. Others are due to disparities due to the social, demographic, environmental, economic and geographic attributes of the neighborhoods in which people live and work. The study authors note that if health disparities were eliminated, as called for in Healthy People 2020, all states would be closer to

achieving the lowest possible death rates for the leading causes of death.

REPORTS/POLICIES

- **The GAO published "Defense Health Care: More-Specific Guidance Needed for Assessing Non-enrolled TRICARE Beneficiaries' Access to Care," (GAO-14-384) on April 28, 2014.** In this report, GAO evaluates the processes, procedures, and analyses used by DOD to determine the adequacy of access to care for these beneficiaries. This report addresses the extent to which the TRICARE Regional Offices have assessed non-enrolled beneficiaries' access to care. http://www.gao.gov/assets/670/662772.pdf

HILL HEARINGS

- The House Armed Services Committee will markup the National Defense Authorization Act for fiscal year 2015 on **May 7, 2014.**
- The Senate Armed Services Subcommittee on Personnel will hold a budget hearing on **May 21, 2014**, to markup those provisions, which fall under the subcommittee's jurisdiction of the proposed National Defense Authorization Act for fiscal year 2015.
- The Senate Armed Services Committee will hold a budget hearing on **May 22-23, 2014**, to markup the proposed National Defense Authorization Act for fiscal year 2015.

LEGISLATION

- **H.R.4517** (introduced April 29, 2014): the *Examination of Exposures to Environmental Hazards During Military Service and Health Care for Atsugi Naval Air Facility Veterans and their Families Act of 2014* was referred to the Committee on Armed Services, and in addition to the Committee on Veterans' Affairs.
  Sponsor: Representative Kurt Schrader [OR-5]
- **S.2259** (introduced April 28, 2014): the *Helping Military Children Succeed in Schools Act* was referred to the Committee on Health, Education, Labor, and Pensions
  Sponsor: Senator Patty Murray [WA]
- **S.2268** (introduced April 29, 2014): A bill to establish grant programs to improve the health of border area residents and for all hazards preparedness in the border area including bioterrorism, infectious disease, and non-communicable emerging threats, and for other purposes was referred to the Committee on Health, Education, Labor, and Pensions.
  Sponsor: Senator Tom Udall [NM]

MEETINGS/WEBINARS

- The 2014 DoD/VA Healthcare Conference will be held **May 19-21, 2014**, in San Antonio, Texas. http://www.dodhealthcare.com/
- The AUSA 2014 Annual Meeting & Exposition will be held **Oct. 13-15, 2014**, in Washington

DC. http://www.ausa.org/meetings/2014/Pages/AnnualMeeting.aspx

- AMSUS Annual Continuing Education Meeting will be held **Dec. 2-5, 2014**, in Washington, DC http://amsusmeetings.org

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