

Federal Health Update

DEC. 5, 2014

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The Update will not be published on Dec. 26 and Jan.2, 2014.

EXECUTIVE AND CONGRESSIONAL NEWS

- **On Dec. 4, 2014, the House passed a compromise bill for 2015 National Defense Authorization Act (NDAA) bill.**

The legislation now heads to the Senate, where it is expected to be approved next week before the end of the lame-duck session.

The \$585 billion measure is the product of weeks of talks between the House and Senate Armed Services committees. The House passed its version of the National Defense Authorization Act (NDAA) earlier this year, while the Senate never brought one to the floor.

The NDAA is one of the few pieces of legislation that has always been renewed on time, with Congress passing it for 52 consecutive years.

This year's negotiated bill was named after the retiring chairmen of the armed services committees: Rep. Buck McKeon (R-Calif.) and Sen. Carl Levin (D-Mich.).

It authorizes \$521 billion in base discretionary spending for Defense Department activities, as well as \$64 billion for overseas contingency operations.

The bill also reduces benefits for troops and their families. It would raise the copay by \$3 for most pharmaceuticals under TRICARE, the military health insurance plan. It would also require beneficiaries who use non-generic prescriptions for long-term conditions to get them at a military treatment facility or through TRICARE's home delivery program.

The co-pay increases take effect as soon as the bill is signed but TRICARE likely won't be ready

to implement before Feb. 1. At retail outlets military family members and retirees would pay \$8 instead of \$5 for generic drugs and \$20 versus \$17 for brand name drugs on the military formulary.

Non-active duty beneficiaries using home delivery would pay \$16 instead of \$13 for a three-month supply of brand name drugs on the formulary, and \$46 rather than \$43 for non-formulary brand names.

The bill also keeps pay raises at 1 percent, freezes raises for general and flag officers, and reduces housing subsidies by 1 percent. The bill also cuts subsidies for military commissaries, where troops buy groceries, by \$100 million.

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MILITARY HEALTH CARE NEWS

- **The Department of Defense announced that Defense Undersecretary for Personnel and Readiness Jessica Wright submitted her letter of resignation to President Obama and Defense Secretary Chuck Hagel.**

Wright assumed the responsibilities as Under Secretary of Defense for Personnel and Readiness on Jan. 1, 2013, and after 40 years of government service, she has decided to step down from her position effective March 31, 2015, in order to spend time with her family and enjoy her retirement.

Wright is a retired Major General and former commander of the Pennsylvania National Guard.

- **On Dec. 4, 2014, Secretary Hagel released a report on the Department of Defense's recent progress in addressing sexual assault in the military, and announced four directives to further strengthen the department's prevention and response program.**

Preliminary survey data indicate that our efforts are driving progress. Service members experienced fewer sexual assaults in fiscal year 2014 than in fiscal year 2012 – an estimated 19,000, down from 26,000. Although this is a reduction, there is clearly more work to be done.

In addition, the number of service member victims choosing to report these crimes has increased by more than 50 percent over the same period of time. This indicates an increased confidence in the department's ability to support victims, and adjudicate these crimes.

While signs of progress are encouraging, the mission is far from complete.

The secretary announced today four directives intended to further improve the department's sexual assault prevention and response programs by: (1) creating a pilot program for select installations that will customize prevention efforts (2) requiring commanders to identify and prevent retaliation, (3) training first-line supervisors to lead sexual assault and prevention programs, and (4) further publicizing resources for victims.

The report is available online at

http://sapr.mil/public/docs/reports/FY14_POTUS/FY14_DoD_Report_to_POTUS_Full_Report.pdf

The directives are available online at

http://sapr.mil/public/docs/reports/FY14_POTUS/FY14_DoD_Report_to_POTUS_SecDef_Initiatives.pdf.

More information about the department's sexual assault prevention efforts can be found at www.sapr.mil.

- **On Dec 4, 2014, the Defense Health Agency announced a new initiative giving separating service members and their families more time to access this important information.**

TRICARE sponsors, spouses, and their dependent children 18 years and older have access to their personal information, health care enrollments, eligibility and other information through MilConnect, an online resource provided by the Defense Manpower Data Center (DMDC). A

Access to MilConnect is available three ways:

- Common access card (CAC) access;
- Having a Defense Finance and Accounting Services (DFAS) account; or
- Having a DoD Self-Service Logon (DS Logon).

Separating service members lose their CACs and access to their DFAS MyPay account upon separation. However, their DS Logon does not expire and can still be used to access certain applications such as DMDC's milConnect. To make this transition easier for family members, DMDC will give prior eligible family members age 18 and over six additional months to sign up for a DS Logon for use in accessing MilConnect after their sponsor's separation. This allows more time to view and print available correspondence (such as a disenrollment letter) within milConnect. Please note that in some cases the sponsor can see available correspondence for family members, regardless of their age in milConnect after separation.

For information about transitioning from the military, visit www.tricare.mil/LifeEvents/Separating. For information about creating an account or other secure services that can be completed online, visit <http://milconnect.dmdc.osd.mil>.

VETERANS AFFAIRS NEWS

- **The Department of Veterans Affairs (VA) has announced the appointment of five new members to the Advisory Committee on Minority Veterans.**

The committee was chartered on Nov. 2, 1994, and advises the Secretary of Veterans Affairs on the needs of the nation's 4.7 million minority veterans with respect to compensation, health care, rehabilitation, outreach and other benefits and programs administered by the VA. The Committee assesses the needs of veterans who are minority group members and recommends program improvements designed to meet their needs. The committee members are appointed to two or three-year terms.

The new committee members are:

- Patricia Jackson-Kelley: Lt. Col. (US Army-Ret) of Los Angeles, Calif.; Served as one of the first full time Women Veteran Program Coordinators at the Los Angeles VAMC. Currently serves as a member of the LA County Veterans Advisory Council; Board Member of Military Women in Need Organization and LA County Council Commander of the American Legion.
- Librado Rivas: Command Sgt. Maj. (USA-Ret) of Manassas, Va.; State commander of the DC Chapter, American GI Forum of the United States; national liaison officer in Washington, DC, for the National Office of the American GI Forum, and director of the Army Lean Six Sigma.
- Rebecca Stone: Staff Sgt. (USA-Ret) of Columbia, Md.; served in Operation Iraqi Freedom and was medically retired under the Wounded Warrior Program through Warrior Transition Units. She is a certified suicide negotiator/first responder. She was also the recipient of the National Association of Female Executives (NAFE) Women of Excellence Award.

- Cornell Wilson, Jr.: Maj. Gen. (USMC-Ret) of Charlotte, N.C.; currently serves as military advisor to the governor of North Carolina, where he also advises state agencies and veteran's organizations on the needs of Veterans.
- Anthony Woods: Army Veteran of University Park, Maryland; currently serves as the senior manager at Cisco System's Consulting Services and consults with the Department of Defense and the Army on IT transformations. Mr. Woods also volunteers with organizations such as Got Your 6 and Hiring Our Heroes.

The new members join current members:

- Marvin Trujillo, Jr., Committee Chairman, Marine Corps veteran
- Richard de Moya, Lt. Col. (USA-Ret)
- Elisandro (Alex) Diaz, Navy veteran
- Many-Bears Grinder, Col. (USA-Ret)
- Harold Hunt, Army veteran
- Sheila Mitchell, Air Force veteran
- Teresita Smith, Sgt. First Class (USA-Ret)

Minority veterans comprise nearly 21 percent of the total veteran population in the United States and its territories

- **The Department of Veterans Affairs (VA), under authority from the Veterans Access, Choice, and Accountability Act of 2014 (VACAA), announced expanded eligibility for veterans in need of mental health care due to sexual assault or sexual harassment that occurred during their military service.**

This trauma is commonly known as military sexual trauma (MST).

This expansion, which primarily pertains to reservists and National Guard members participating in weekend drill, gives the authority to offer Veterans the appropriate care and services needed to treat conditions resulting from MST that occurred during a period of inactive duty training.

VA works closely with trauma survivors to ensure a full continuum of health care services are provided to assist Veterans recovering from experiences of MST. Recognizing that MST survivors may have special needs and concerns, every VA health care facility has an MST Coordinator who serves as a contact person for MST-related issues. Every VA medical center and Community-based Vet Center offers MST-related outpatient counseling.

Currently, all VA health care for mental and physical health conditions related to MST is provided free of charge. Veterans do not need to have a service-connected disability or seeking disability compensation to be eligible for MST-related counseling and care. Veterans also do not need to have reported such incidents to the Department of Defense or possess documentation or records to support their assertion of having experienced such trauma. The determination of whether a veteran's condition is MST-related is strictly a clinical determination made by the responsible VA mental health provider. Finally, Veterans need not be enrolled in VA's health care system to qualify for MST-related treatment, as it is independent of VA's general treatment authority.

In addition to treatment programs, VA also provides training to staff on issues related to MST, including a mandatory training on MST for all mental health and primary care providers. VA also engages in a range of outreach activities to Veterans and conducts monitoring of MST-related screening and treatment, in order to ensure that adequate services are available.

Veterans can learn more about VA's MST-related services online at www.mentalhealth.va.gov/msthome.asp and see video clips with the recovery stories of veterans who have experienced MST at <http://maketheconnection.net/conditions/military-sexual-trauma>.

GENERAL HEALTH CARE NEWS

- **The Department of Health and Human Services released a [report](#), showing an estimated 50,000 fewer patients died in hospitals and approximately \$12 billion in health care costs were saved as a result of a reduction in hospital-acquired conditions from 2010 to 2013.**

This progress toward a safer health care system occurred during a period of concerted attention by hospitals throughout the country to reduce adverse events. The efforts were due in part to provisions of the Affordable Care Act such as Medicare payment incentives to improve the quality of care and the HHS Partnership for Patients initiative. Preliminary estimates show that in total, hospital patients experienced 1.3 million fewer hospital-acquired conditions from 2010 to 2013. This translates to a 17 percent decline in hospital-acquired conditions over the three-year period.

The data represent demonstrable progress over a three-year period to improve patient safety in the hospital setting, with the most significant gains occurring in 2012 and 2013. According to preliminary estimates, in 2013 alone, almost 35,000 fewer patients died in hospitals, and approximately 800,000 fewer incidents of harm occurred, saving approximately \$8 billion.

Hospital-acquired conditions include adverse drug events, catheter-associated urinary tract infections, central line associated bloodstream infections, pressure ulcers, and surgical site infections, among others. HHS' Agency for Healthcare Research and Quality (AHRQ) analyzed the incidence of a number of avoidable hospital-acquired conditions compared to 2010 rates and used as a baseline estimate of deaths and excess health care costs that were developed when the Partnership for Patients was launched. The results update the data showing improvement for 2012 that were [released in May](#).

To drive progress on the way care is provided, HHS is focused on improving the coordination and integration of health care, engaging patients more deeply in decision-making and improving the health of patients – with a priority on prevention and wellness. AHRQ has produced a variety of [tools and resources](#) to help hospitals and other providers prevent hospital-acquired conditions, such as reducing infections, pressure ulcers, and falls. The tools and resources include the Comprehensive Unit-based Safety Program, the Re-Engineered Discharge Toolkit, TeamSTEPS®, and more.

HHS will continue working with partners to capitalize on these promising results and continue on the path of improving patient safety and reducing health care costs while providing the best, safest possible care to patients.

- **According to the Centers for Disease Control and Prevention (CDC), state health officials have identified and designated 35 hospitals with Ebola treatment centers, with more expected in the coming weeks.**

Hospitals with Ebola treatment centers have been designated by state health officials to serve as treatment facilities for Ebola patients based on a collaborative decision with local health authorities and the hospital administration.

Ebola treatment centers are staffed, equipped and have been assessed to have current capabilities, training and resources to provide the complex treatment necessary to care for a person with Ebola while minimizing risk to health care workers.

More than 80 percent of returning travelers from Ebola-stricken countries live within 200 miles of an Ebola treatment center. During their active monitoring, state or local public health authorities

communicate every day with potentially exposed individuals to check for symptoms and fever for the 21 day incubation period of the Ebola virus.

The additional facilities supplement the three national bio containment facilities at Emory University Hospital, Nebraska Medical Center, and the National Institutes of Health (NIH), which will continue to play a major role in our overall national treatment strategy, particularly for patients who are medically evacuated from overseas. Facilities will continue to be added in the next several weeks to further broaden geographic reach.

CDC also released [guidance](#) for states and hospitals to use as they identify and designate an Ebola treatment center. The guidance covers the range of capabilities hospitals need in order to provide comprehensive care for patients with Ebola. HHS, through the CDC and the Office of the Assistant Secretary of Preparedness and Response (ASPR), also provided technical assistance to health departments and hospitals.

The 35 hospitals with Ebola treatment centers to date can be found at <http://www.cdc.gov/vhf/ebola/hcp/current-treatment-centers.html>.

- **Early data suggests that the current 2014-2015 flu season could be severe, according to the Centers for Disease Control and Prevention (CDC).**

So far this year, seasonal influenza A H3N2 viruses have been most common. There often are more severe flu illnesses, hospitalizations, and deaths during seasons when these viruses predominate. For example, H3N2 viruses were predominant during the 2012-2013, 2007-2008, and 2003-2004 seasons, the three seasons with the highest mortality levels in the past decade. All were characterized as “moderately severe.”

Increasing the risk of a severe flu season is the finding that roughly half of the H3N2 viruses analyzed are drift variants: viruses with antigenic or genetic changes that make them different from that season’s vaccine virus. This means the vaccine’s ability to protect against those viruses may be reduced, although vaccinated people may have a milder illness if they do become infected. During the 2007-2008 flu season, the predominant H3N2 virus was a drift variant yet the vaccine had an overall efficacy of 37 percent and 42 percent against H3N2 viruses.

Depending on the formulation, flu vaccines protect against three or four different flu viruses. Even during a season when the vaccine is only partially protective against one flu virus, it can protect against the others.

[Influenza activity](#) is currently low in the United States as a whole, but is increasing in parts of the country.

Influenza antiviral drugs – Tamiflu (oseltamivir) and Relenza (zanamivir) can reduce severe complications such as hospitalization and potentially death for people who are at high risk of serious flu complications or are very sick. Treatment of high risk patients should begin as soon after symptoms develop as possible, without waiting for lab tests to confirm flu infection.

Those at high risk from influenza include children younger than 5 years (especially those younger than 2 years); adults 65 years and older; pregnant women; and people with certain chronic health conditions such as asthma, diabetes, heart or lung disease, and kidney disease.

- **Health spending continued to grow at a slow rate last year the Office of the Actuary (OACT) at the Centers for Medicare & Medicaid Services (CMS) reported on Dec. 3, 2014.**

In 2013, health spending grew at 3.6 percent and total national health expenditures in the United States reached \$2.9 trillion, or \$9,255 per person. The annual OACT report showed health spending continued a pattern of low growth—between 3.6 percent and 4.1-- percent for five consecutive years. The report is being published today in Health Affairs.

The recent low rates of national health spending growth coincide with modest growth in Gross Domestic Product (GDP), which averaged 3.9 percent per year since the end of the severe economic recession in 2010. As a result, the share of the economy devoted to health remained unchanged over this period at 17.4 percent.

Total national health spending slowed from 4.1 percent growth in 2012 to 3.6 percent in 2013.

The report attributes the 0.5 percentage point slowdown in health care spending growth to slower growth in private health insurance, Medicare, and investment in medical structures and equipment spending. However, faster growth in Medicaid spending helped to partially offset the slowdown.

Other findings from the report:

- Medicare spending, which represented 20 percent of national health spending in 2013, grew 3.4 percent to \$585.7 billion, a slowdown from growth of 4.0 percent in 2012. This slowdown was primarily caused by a deceleration in Medicare enrollment growth, as well as net impacts from the Affordable Care Act and sequestration. Per-enrollee Medicare spending grew at about the same rate as 2012, increasing just 0.2 percent in 2013.
- Spending on private health insurance premiums (a 33 percent share of total health care spending) reached \$961.7 billion in 2013, and increased 2.8 percent, slower than the 4.0 percent growth in 2012.
- Medicaid spending grew 6.1 percent in 2013 to \$449.4 billion, an acceleration from 4.0 percent growth in 2012. Faster Medicaid growth in 2013 was driven in part by increases in provider reimbursement rates, some states' expanding benefits, and early Medicaid expansion.
- Out-of-pocket spending (which includes direct consumer payments such as copayments, deductibles, spending by the insured on services not covered by insurance, and spending by those without health insurance) grew 3.2 percent in 2013 to \$339.4 billion, slightly slower than annual growth of 3.6 percent in both 2011 and 2012.
- Among health care goods and services, slower growth in spending for hospital care and physician and clinical services contributed to slower growth in national health care spending in 2013. However, faster spending growth for retail prescription drugs in 2013 partially offset the overall slowdown.
- Hospital spending increased 4.3 percent to \$936.9 billion in 2013 compared to 5.7 percent growth in 2012. The lower growth in 2013 was influenced by slower growth in both price and non-price factors (which include the use and intensity of services). Growth in private health insurance and Medicare hospital spending decelerated in 2013 compared to 2012.
- Spending for physician and clinical services increased 3.8 percent in 2013 to \$586.7 billion, from 4.5 percent growth in 2012. Slower price growth in 2013 was the main cause of the slowdown, as prices grew less than 0.1 percent. Growth in spending from private health insurance and Medicare, the two largest payers of physician and clinical services, experienced slower spending growth in 2013, while Medicaid growth accelerated as a result of temporary increases in payments to primary care physicians.
- Retail prescription drug spending accelerated in 2013, growing 2.5 percent to \$271.1 billion, compared to 0.5 percent growth in 2012. Faster growth in 2013 resulted from price increases for brand-name and specialty drugs, increased spending on new medicines, and increased utilization.

In 2013, households accounted for the largest share of spending (28 percent), followed by the

federal government (26 percent), private businesses (21 percent), and state and local governments (17 percent).

Since 2010, the share of health spending financed by the federal government decreased—from 28 percent to 26 percent in 2013. At the same time, the share financed by state and local governments increased—from 16 percent in 2010 to 17 percent in 2013. These shifts resulted primarily from the June 2011 expiration of additional Medicaid funding provided by the federal government to the states through the American Recovery and Reinvestment Act of 2009.

The OACT report can be viewed at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

REPORTS/POLICIES

- **The GAO published “VA Health Care: Improvements Needed to Manage Higher-Than-Expected Demand for the Family Caregiver Program,” (GAO-15-245T) on Dec. 3, 2014.** This report looks at the issues surrounding the Family Caregiver program. <http://www.gao.gov/products/GAO-15-245T>
- **The GAO published “Private Health Insurance: Concentration of Enrollees among Individual, Small Group, and Large Group Insurers from 2010 through 2013,” (GAO-15-101R) on Dec. 1, 2014.** In this study, GAO examined how enrollment in the individual, small group, and large group health insurance market segments in each state was distributed among insurers in 2013; and how the concentration of insurers in these market segments in each state changed from 2010 through 2013. <http://www.gao.gov/products/GAO-15-101R>

HILL HEARINGS

- The House Veterans Affairs Subcommittee *on Economic Opportunity* will hold a hearing on **Dec. 10, 2014**, to the Transition Assistance Program (TAP).

LEGISLATION

- **H.R.5790** (introduced Dec. 3, 2014): To authorize the Director of the National Institutes of Health to design and enter into agreements for the implementation of prize competitions with the goal of improving health outcomes and thereby reducing Federal expenditures was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means.
Sponsor: Representative Todd C. Young [IN-9]

MEETINGS

- The 100th Annual Meeting of Radiological Society of North America (RSNA) 2014 will be held **Dec. 5-9, 2014**, in Chicago, Ill. http://www.rsna.org/Annual_Meeting.aspx
 - The 2014 Special Operations Medical Association (SOMA) Science Assembly will be held on **Dec. 8-11, 2014**, in Tampa, Fla. <http://www.specialoperationsmedicine.org/Pages/scientificassembly.aspx>
 - The AAMA 2015: The National Summit of Medical Administrators will be held on **Jan. 19-21, 2015**, in Clearwater, Fla. <http://aameda.org/p/cm/ld/fid=159>
 - The Heroes of Military Medicine Awards will be held on **May 7, 2015** in Washington, DC. <http://www.hjfc3.org>
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