

**STATEMENT BY
DAVID J. BAKER
PRESIDENT AND CEO
HUMANA MILITARY HEALTHCARE SERVICES**

**TESTIMONY FOR THE RECORD
BEFORE THE
MILITARY PERSONNEL SUBCOMMITTEE
OF THE
HOUSE COMMITTEE ON ARMED SERVICES
October 19, 2005**

Mr. Chairman and distinguished members of the Subcommittee, on behalf of the dedicated men and women of Humana Military Healthcare Services Inc., I appreciate the opportunity to update the Subcommittee on our current efforts in providing access to high quality, affordable health services to the members of our most deserving military community. At a time when our country is facing the global war on terrorism at home and abroad and responding to recent natural disasters in our own country, our company understands the special trust the Government has bestowed on us.

As President & CEO of Humana Military Healthcare Services, and as a TRICARE beneficiary myself, I want to personally thank the Committee for its support of the Military Health System (MHS). Delivering health care services under TRICARE is a complex undertaking. However, in partnership with our Department of Defense (DoD) customers, we believe we are effectively and efficiently achieving the objectives the Congress has established for the TRICARE program. Thank you for the opportunity to share my perspectives with you.

Company Background

Humana Military Healthcare Services (HMHS) is a wholly owned subsidiary of Humana Inc., one of the nation's largest health benefit companies. Our subsidiary was formed in 1993 to focus exclusively on delivering military health solutions through the TRICARE program. We were awarded our first TRICARE contract in 1995, and we began serving military beneficiaries in 1996.

Under a contract with the Department of Defense (DoD), today our company is responsible for administering the TRICARE program for 2.8 million TRICARE-eligible beneficiaries in DoD's South Region of the United States. The South Region includes the states of Georgia, Florida, South Carolina, Alabama, Louisiana, Mississippi, Arkansas, and Oklahoma, as well as most of Tennessee and Texas. Our company is made up of more than 1,400 employees, many of whom are beneficiaries of the military health system. We provide services in more than 60 TRICARE Service Centers located throughout the South, and I am pleased to report that all are back in operation following the devastation wrought by Hurricanes Katrina and Rita.

As part of our South Region contract, we are responsible for processing all claims for TRICARE services rendered outside the United States, and we administer the Continued Health Care Benefits Program (CHCBP). Supporting us in these endeavors is an exceptional team of partners, including: Palmetto Government Benefits Administrators, LLC (PGBA) of Columbia, South Carolina (for domestic claim processing); Wisconsin Physician Services of Madison, Wisconsin (for foreign claim processing); ValueOptions, Inc. of Norfolk, Virginia (for

behavioral health services) and Blue Cross/Blue Shield of South Carolina (for South Carolina operations). As a team, we have more than ten years of TRICARE experience.

Under separate contracts with the Department, Humana Military Healthcare Services also furnishes limited TRICARE support for active duty members and their families in the Commonwealth of Puerto Rico, and we provide patient appointing support for several military treatment facilities including: Keesler Air Force Base, Mississippi; Fort Bragg, North Carolina; Wright Patterson Air Force Base, Ohio; Fort Carson, Colorado; the United States Air Force Academy, Colorado; Peterson Air Force Base, Colorado; and Barksdale Air Force Base, Louisiana.

Your invitation to today's hearing indicated your focus on four elements of the Defense Health Program (DHP): (1) status of the DHP for Fiscal Year 2006; (2) medical and dental readiness of the reserve components; (3) TRICARE provider satisfaction and its effect on beneficiary access to health care; and (4) sharing and coordination between the Department of Defense and the Department of Veterans Affairs. My perspectives on these important subjects follow below.

Status of the Defense Health Program for Fiscal Year 2006

As we begin the new fiscal year, I believe the operational status of the TRICARE is very good. Today's TRICARE represents one of the most -- if not the most -- comprehensive health care programs in the nation. Thanks in large part to the oversight and tangible support of the Subcommittee, active duty military personnel, retirees and their family members have exceptional access to a rich array of health care services. All available evidence indicates a high degree of satisfaction among TRICARE beneficiaries. In fact, a recent satisfaction survey

conducted by Wilson Health Information (a leading independent consumer satisfaction research company) found TRICARE to be the number-one rated health insurer in the country.¹

While we at Humana are proud of our part in achieving these results, we recognize they represent the culmination of collaborative efforts between the Congress, the Department of Defense and private industry dating back to the early 1990s. Our challenge, as we move into Fiscal Year 2006 (and beyond) will be to maintain the momentum in the face of major structural changes introduced into TRICARE during the past 18 months. Since these changes will begin to mature during the next fiscal year, it may be helpful for the Subcommittee to look back at the extremely complex transition to today's TRICARE program.

In the South Region, we believe the transition was smooth, and that it was achieved with minimal beneficiary disruption. Success resulted from extremely effective collaboration with -- and oversight by -- our Department of Defense customers. In the South, we also had the advantage of a stable team of companies, with whom we had worked on TRICARE for many years. Finally, we were fortunate to take over operations in Texas, Oklahoma, Arkansas and Louisiana from Health Net Federal Services Inc., an experienced managed care support contractor, totally committed to the long-term success of the TRICARE program.

We are particularly pleased that we were able to achieve stability of almost 98% of the provider network previously in place in the legacy contracts in the South. This overlap was important to maintaining the high quality of clinical services provided, because previously established care patterns were preserved for virtually all beneficiaries. In fact, only 1,400 of the 1.1 million TRICARE Prime enrollees (0.1%) in the South were required to change primary care managers (PCMs) as we transitioned into the new contract.

At the same time, we were able to maintain (and often improve) the high levels of service in terms of claim processing (speed and accuracy), telephone responsiveness, timely processing of referral and authorization requests, and responsive customer walk-in service.

While we are indeed proud of accomplishments, several components of the TRICARE program were profoundly changed, and other operational elements did not go as planned. Taken together, they represent areas of risk/concern for the program in the future. Included are:

- Non-availability of the automated Enterprise-Wide Referral and Authorization System (EWRAS) as envisioned by the Department. As a consequence, all contractors have been forced to employ an inefficient and costly facsimile based system of processing requested referrals/authorizations.

- Introduction of a new interface between the Government and contractors, called the TRICARE Encounter Data (TED) system. Full implementation has still not been achieved.

- Establishment of a new Government regional management structure and a new system of governance that continues to undergo a maturation process.

- Implementation of performance requirements unprecedented in the industry. Included are requirements for contractors to ensure that network providers submit all claims electronically and that they provide written consultation reports (under very strict timelines that are difficult to compute and enforce) for care rendered to all beneficiaries enrolled with military primary care managers. The long-term effect of these requirements on network stability remains unknown.

- Revision of the financial incentive structure in a manner that has, until recently, hampered efforts to optimize services delivered in military treatment facilities.

- Carve-outs of selected services (such as retail pharmacy, marketing, and TRICARE-for-Life claim processing) that add complexity for beneficiaries, providers, contractors and Government personnel alike.

As the Subcommittee evaluates the operational outlook for TRICARE during Fiscal Year 2006, the dynamics noted above represent potential risks that may not be evident from an initial examination of the very successful transition to the current generation of TRICARE contracts.

Notwithstanding our operational successes, we share the Subcommittee's concern regarding FY 2006 funding for the Defense Health Program. As we examine the landscape, we note that several factors will place additional pressure on DoD to execute its complex missions, including:

- Annual health care cost trends that, in the South, we estimate will be in the 13-17% range. We are aware of (and fully support) the efforts of the Department and the Army, Navy and Air Force to moderate these trends by "optimizing" the delivery of services in military treatment facilities, and we applaud recent gains in this regard. We look forward to continuing the collaboration with our military partners in identifying additional "optimization" opportunities.

- Settlement of several change orders related to our current TRICARE contract. One of the most significant involves the manual workaround process we (and the other prime contractors) were forced to employ when the Government's automated Enterprise Wide Referral and Authorization System (EWRAS) was unavailable at last year's start of health care delivery.

Together with the professionals within the TRICARE Management Activity (TMA), we are working diligently to settle the EWRAS change order, as well as several others that remain outstanding.

- Resolution of our April 2005 Request for Equitable Adjustment (REA) and August 2005 clarification related to significant financial impacts that our company (and the other TRICARE contractors) sustained in light of the Iraq War and a corresponding decrease in the volume of work produced in military treatment facilities. Despite the length of time that has passed since our submissions, we remain hopeful that the Department will shortly choose to collaborate with us on a fair settlement.

In summary, we are proud of the successes achieved during the past year, and we are confident that we are operationally ready to discharge our responsibilities during FY 2006. At the same time, we note that several operational challenges remain, and we trust that the Department has programmed sufficient dollars to execute its complex missions in a manner that is fair and equitable to all parties.

Medical and Dental Readiness of the Reserve Components

Because Humana Military Healthcare Services supports the readiness of the Guard and Reserve forces solely by operating specific support programs, I have elected to confine my comments to two important issues: (1) current status of the TRICARE Reserve Select (TRS) program; and (2) proposed legislation contained in the FY 2006 Defense Authorization Bill (S. 1042) that would extend TRICARE benefits to members of the Select Reserve.

Established in April 2005 under authority contained in the FY 2005 National Defense Authorization Act, the TRICARE Reserve Select program provides health coverage for

Reservists who have exhausted their benefits under the Transitional Assistance Management Program (TAMP). In brief, each TRS eligible beneficiary serving 90 days or more in support of a contingency operation who agrees to continue serving in the Selected Reserve can enroll in the program. TRICARE Reserve Select allows access TRICARE Standard/Extra benefits for a premium of \$75 per month per person or \$233 per month for a family.

TRICARE Reserve Select is fully operational in the South Region, and today, approximately 5,100 beneficiaries (of nearly 300,000 eligible) are enrolled. We expect some growth in this number over time, but based on the trends we have seen to date, we expect that average enrollment will settle in the 7,000 (or 1.7-2.0 %) range.

We are aware of the amendment to the FY 2006 Defense Authorization Bill (S.1042) to extend TRICARE benefits to members of the Select Reserve, and we have conducted some preliminary analyses of its potential effect in the South. Operationally, it appears that more than 700,000 people would be eligible for the program in the states covered by our TRICARE contract. With the exception of a few remote areas, we believe we have sufficient network coverage to offer a viable program. At the same time, however, we caution that a reasonable transition period will be required to ensure that the program (including testing of the supporting automated data systems, recruitment and training of new personnel, and so forth) is fully operational at implementation. We recommend six months as a reasonable period to allow for the transition.

In sum, we think the TRICARE Reserve Select program is fully functional, and with a reasonable lead time, we could operationalize the program envisioned by the Senate in S. 1042.

TRICARE Provider Satisfaction and its Effect on Beneficiary Access to TRICARE

Overall, we believe that beneficiary access to TRICARE services in the South is very good. Our network is large and growing, and it has been very stable over time. Further, the rate of participation in TRICARE by non-network providers indicates that most are willing to support the men and women of the armed forces.

Today's network of TRICARE providers in the South Region includes 15,466 primary care managers (a growth of 17% during the past year); 28,556 medical/surgical specialists (up 23% since November 2004); 8,978 behavioral health providers (an increase of 14% in the past 12 months); and 953 hospitals (representing growth of 18% in one year). Stated a bit differently, our network includes approximately one-third (33%) of all licensed practicing providers in the 10-state South Region. By comparison, the 2.8 million TRICARE beneficiaries in the South represent approximately 3.7% of the total population in the Region.

Throughout our history, we have maintained a very stable network of TRICARE providers. On an annual basis, turnover from all causes (including dissatisfaction, relocation, retirement, etc.) has approximated four percent – which compares favorably to industry norms.

Finally, we recently performed an analysis of our claim experience as it pertains to non-network providers in the South. We discovered that (including our network) approximately 90% of the more than 150,000 individually licensed providers in the South had submitted a claim on behalf of an authorized TRICARE beneficiary during the past year. In doing so, these providers agreed to: (1) see TRICARE patients; (2) file TRICARE claims directly with us (rather than

forcing beneficiaries to do so; and (3) accept TRICARE (or network) reimbursement as payment in full for services rendered.

Taken together, we think the data reflect excellent access for South Region TRICARE beneficiaries. We are very especially pleased by the degree of acceptance of TRICARE by the medical community.

We also note that there are some areas within our Region that are medically underserved. As a result, access to medical services is very limited for TRICARE beneficiaries and for others residing in those areas. These areas are very challenging for us, and they sometimes lead to a perception of poorer than expected access for our beneficiaries.

Notwithstanding the excellent access for TRICARE beneficiaries, we do hear from South Region providers on a regular basis. Very often the comments involve TRICARE rates, and express the concern that they are too low. When our provider representatives explain the general congruence with Medicare rates, they often hear the opinion that, “Medicare rates are too low too.”

Other provider feedback generally cites a “hassle factor” perceived to exist with the TRICARE program. In particular, we hear that the requirements for the approval of referrals and authorizations – and especially the process of allowing military treatment facilities the “Right of First Refusal” for certain cases – are inappropriate and cumbersome. We’ve worked hard to mitigate these dissatisfiers by providing on-line tools and responsive telephone inquiry support, but they continue to surface in our provider contacts.

The new TRICARE contracts introduced unprecedented new provisions for our network providers: (1) all must agree to submit all claims to us in an electronic format; and (2) all are

required to furnish clear, legible consultation reports under very strict timelines for beneficiaries referred from military facilities. Enforcement of these rules has not been totally successful, and they are often seen as “more TRICARE hassles” by many in the provider community. The long term effect on network retention is unknown at this time.

In summary, all indicators provide evidence of excellent beneficiary access to health care services in the South, though there are problems – particularly for those who reside in medically underserved locales. Our expanding network is large and stable, and TRICARE participation by non-network providers reflects a commitment to supporting the military community. When we receive complaints, providers generally cite reimbursement rates and non-standard TRICARE performance requirements.

Sharing and Coordination between the Departments of Defense and Veterans Affairs

Humana Military Healthcare Services is aware of several initiatives undertaken by the Department of Veterans Affairs and the Department of Defense to share resources and to coordinate the delivery of health services. In the TRICARE arena, I recently became aware of two examples of creativity in this regard, and I would like to share them with you.

- The first involves the Navy’s Branch Medical Clinic in Key West, Florida. At that location, VA primary care and physical therapy professionals furnish care to TRICARE beneficiaries. What makes the arrangement so unusual is that the services are provided by the VA staff inside the Navy medical facility.

- The second example is a reverse scenario at the Veterans Affairs hospital in Montgomery, Alabama. Inside the VA hospital, the Air Force operates a podiatry clinic with providers from Maxwell Air Force Base – a very unique approach.

I applaud the Government's innovative actions at both locations, and I am confident there are many other examples of such creative solutions that have not come to my personal attention.

At Humana, we believe we have taken advantage of our unique role as a TRICARE contractor to fully utilize available Veterans Affairs assets in the delivery of health services to DoD beneficiaries. Today, our TRICARE network includes agreements with eight separate Veterans Integrated Service Networks (VISNs) located throughout the South. These agreements offer TRICARE beneficiaries access to 40 different VA medical centers and 137 other health care delivery sites. Taken together, our arrangement includes more than 6,000 VA health care professionals.

It is also worth noting that, where capacity exists, we have actually enrolled TRICARE Prime (HMO) beneficiaries to VA primary care managers (PCMs). This means that Veterans Affairs providers are managing the delivery of required medical/surgical care to Department of Defense patients. Included are PCMs located in Jackson, Mississippi; Fort Worth, Texas; Dallas, Texas; Key West Florida; and Key Largo, Florida.

Since August of 2004 (when we began our current contract), we have paid approximately \$1 million to Veterans Affairs facilities for care rendered to TRICARE beneficiaries. Clearly, this is a "win-win" outcome for all concerned:

- the VA employs underutilized resources to generate revenue
- TRICARE patients obtain access to high quality VA services at less cost than

would otherwise be required to obtain them from civilian sources

We are actively exploring additional partnering opportunities in the South. Our current deliberations involve Veterans Affairs facilities in Little Rock, Arkansas; Murfreesboro, Tennessee; Atlanta, Georgia; Shreveport, Louisiana; and Amarillo, Texas. We hope our preliminary discussions will yield tangible results in the relatively near future.

Recently, we were invited to share insights regarding TRICARE with VA business leaders. Together with Health Net Federal Services and the TRIWEST Healthcare Alliance, we provided perspectives and recommendations. We applaud the responsible VA officials for beginning to obtain insight on TRICARE “lessons learned” and for their focus on applying those lessons to the unique VA environment. Should specific commercial opportunities be developed, we would also welcome the chance to engage in free-and-open competition.

To summarize, we are aware of several sharing/coordination initiatives between the Department of Defense and the Department of Veterans Affairs. As TRICARE contractors, we have been very successful in utilizing available VA resources to support military beneficiaries. We look forward to doing even more in the future, and as opportunities arise, to competing for VA business as well.

Conclusion

In conclusion, Mr. Chairman, please allow me to thank the subcommittee for the opportunity to submit testimony for the record. The health and well-being of our military is essential to our nation. Humana Military Healthcare Services is committed to playing our role in ensuring the military community receives quality health care services. We are pleased with our performance over the years, and we believe that we have been a valuable TRICARE partner. We

look forward to working with Congress and the Department of Defense to achieve even greater success in the future.

¹ Staff Writer, “Wilson Health Information Finds TRICARE Members Most Satisfied With Their Health Insurance For Third Year In A Row. Kaiser Permanente Named Top Rated Health Maintenance Organization Nationally For Fifth Straight Year,” *PR Newswire Press Release*, September 27, 2005.



DAVID J. BAKER
President and Chief Executive Officer,
Humana Military Healthcare Services (HMHS)

Dave Baker serves as President and Chief Executive Officer of Humana Military Healthcare Services.

Following a distinguished active duty career of 27 years in the USAF Medical Service Corps, Dave joined HMHS as the Region 3 Executive Director in 1996. In this capacity, he was responsible for all HMHS field operations in Georgia, Florida, and South Carolina. In 1999, he became the Humana Military's Chief Operating Officer, and in January 2000, he assumed his current position.

Dave holds an MBA in Health and Hospital Administration from the University of Florida and BS degree in Business Administration from the University of Maryland. He is also a graduate of the Executive Program in Health Care Management of the Ohio State University. While on active duty, Dave completed the Interagency Institute for Federal Health Care Executives, Air War College, Air Command and Staff College and Squadron Officer School.

Raised in an Air Force family, he is the only TRICARE CEO who is a life-long beneficiary of the military health system.

**HUMANA MILITARY HEALTHCARE SERVICES – DISLOSURE STATEMENT
TESTIMONY BEFORE THE COMMITTEE ON ARMED SERVICES, U.S. HOUSE OF
REPRESENTATIVES**

**BY
DAVID J. BAKER, PRESIDENT & CEO
OCTOBER 19, 2005**

Contract (Contracting Office)	Contract Number	Amount of Contracts During the Last Three Fiscal Years
TRICARE Regions 3 & 4 (TRICARE Management Activity)	MDA906-96-C-0002	\$8,765,000,000
TRICARE Regions 2 & 5 (TRICARE Management Activity)	MDA906-97-C-0005	\$4,082,000,000
TRICARE Next Generation of Contracts, South Region (TRICARE Management Activity)	MDA906-03-C-0010	\$5,045,000,000
TRICARE Puerto Rico (TRICARE Management Activity)	H94002-04-D-0003	\$4,000,000
Patient Appointment Services - Bridge Contract for Tidewater Area (Army Medical Command Healthcare Acquisition Activity)	W81K04-04-P-0026	\$4,586,000
Patient Appointment Services - Bridge Contract for Wright Patterson Air Force Base – WPAFB (Army Medical Command Healthcare Acquisition Activity)	W81K04-04-P-0028	\$1,883,000
Patient Appointment Services - Bridge Contract for Keesler Air Force Base (Chief, Acquisition & Material Management, James A. Haley Veterans Hospital, Tampa FL)	V673(90F)P0010	\$747,000
Multiple Award Task Order (MATO) Indefinite Delivery Indefinite Quantity type (IDIQ) Contract for Patient Appointment Services (PAS) - Basic Contract & Task Orders (T.O.) for Fort Bragg & WPAFB (Army Medical Command Healthcare Acquisition Activity)	W81K04-05-D-7002	
	T.O. 0001 for Fort Bragg T.O. 0002 for WPAFB	\$2,477,000 \$4,048,000
MATO PAS Task Order (T.O.) for Keesler AFB (81 st Contracting Squadron, Keesler AFB)	W81K04-05-D-7002-RC01	\$4,837,000
MATO PAS Task Order (T.O.) for Colorado Springs Multi-Service Market Office (10 MSG/LGC – Multi-Service Market Office, Colorado Springs)	FA7000-05-F-0049	\$13,268,000
General Surgeon Services for Veterans Administration Outpatient Clinic, Austin, TX (Department of Veterans Affairs, Central Texas Veterans Health Care System)	V674P-3482	\$118,000