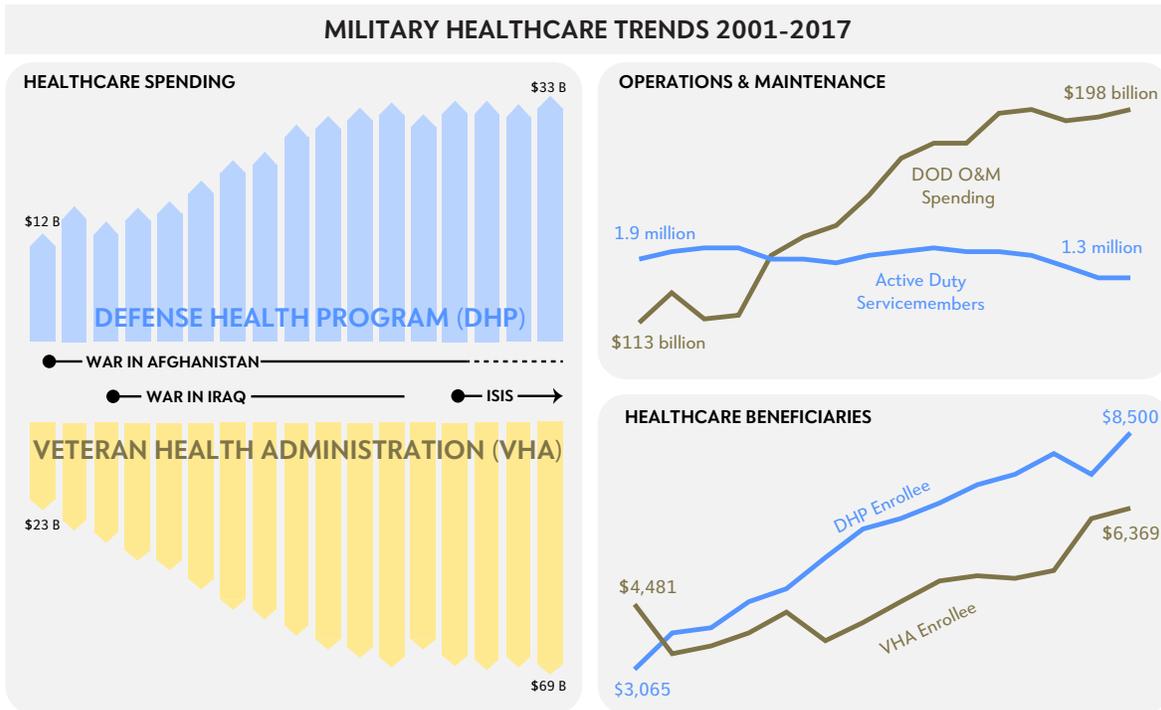


MILITARY HEALTHCARE RISING COSTS AND DECREASING RETURNS

JANUARY 2017

Bottom Line Up Front

Military “readiness” is frequently used as a bottom line metric for evaluating the return on investment for defense spending. This report confronts the conventional definition of readiness, arguing that it should include health, wellness, and performance related metrics. Whether a readiness ‘crisis’ exists, as argued by some, the costs of maintaining and supporting the health and wellness of the armed forces are clearly increasing. At best, the return in terms of readiness is not commensurate with the level of investment. At worst, readiness is declining even as costs rise.



Source: Department of Defense, Department of Veteran Affairs

Human capital is integral to operational capabilities and is therefore the most important asset for Department of Defense (DOD) investment. Yet, DOD’s conventional definition of readiness revolves around macroscopic considerations such as budgets, equipment, end strengths, and a projected ability to conduct specific mission-types; it does not adequately account for nearly two decades of continuous combat and the associated strain on the human capital of the armed forces. Absent a holistic approach that addresses not only the health and wellness of individual service members — active duty, guard, and reserves — but also their families, communities and support networks, the ability of our armed forces to prevail in an increasingly dangerous and complex world remains in jeopardy. Continuing to throw money at the problem — without developing new approaches to address the human dimension — is not an effective solution.

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Issues

This report clarifies ambiguities and articulates concerns with the conventional approach to readiness by addressing the following four components:

-) **DEFINING READINESS** While the level of military readiness continues to be debated, readiness itself remains poorly defined. Despite reform in recent decades, the prevailing definition undervalues the essential human dimension.
-) **REASSESSING READINESS** The readiness of the force should not be limited to equipment and mission sets but should also include the health and emotional wellbeing of individuals, which varies across a spectrum throughout their career.
-) **COSTS OF READINESS** The current prescription to address the decline in human capital readiness is to increase spending without addressing underlying structural problems. DOD focuses primarily on ensuring service members meet “medical readiness” requirements while the VA faces the long-term economic consequences of rising healthcare costs. Moreover, unchecked growth in spending is unsustainable and adversely impacts other spending accounts.
-) **NEW APPROACH** The existing “one size fits all”, facilities-based model for military healthcare burdens the individual seeking treatment. The episodic nature of individual engagements fails to address the full complexity and comorbidity of issues facing the military community. A complementary alternative approach would be to promote self-awareness and health literacy, so that service members, veterans, their families, and support communities attend to issues before a more acute or serious condition emerges.

Discussion

) **DEFINING READINESS**

The “readiness” of our military forces has been the subject of public debate in recent months. A central question in the debate revolves around whether or not there is a legitimate crisis in military readiness. In August 2016, David Petraeus and Michael O’Hanlon wrote in the Wall Street Journal that the “crisis” of military readiness was a “myth.” They argued that the defense budget was adequate in normalized terms; the military had a wealth of combat experience; and, the boon in technology would be favorable to the United States. Their claims generated counter-arguments that the American military lags behind in its equipment modernization; finds itself ill-prepared to operate in non-counterinsurgency conflicts against a near-peer; and, holds a poor track record in its engagements since 9/11.

The debate raised concerns about whether DOD adequately defines the concept of military readiness and, more importantly, whether an adequate, associated set of metrics exists to assess the state

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of readiness. DOD has two major methods for evaluating readiness: DRRS (Defense Readiness Reporting System) for unit-level readiness and PULHES (Physical Profile Serial System) for individual medical readiness. Both systems are antiquated and need reform.

“We are unable to generate readiness for unknown contingencies, and under our current budget Army readiness will at best flatline over the next three to four years.

- Ray Odierno
Army Chief of Staff
2015

DOD uses DRRS to measure readiness at the unit level by allowing commanders to capture qualitative self-assessments based on prescribed mission sets. DRSS was borne out of a 1999 effort by the Pentagon to reform an older model called SORTs (Status of Readiness and Training). SORTs was criticized for its dependency on simple input metrics, such as the percentages of required personnel or equipment and supplies on-hand. While the goal of DRRS was to capture the less tangible, more qualitative aspects of assessing readiness, it ended up disappointing critics. Rather than effectively overhauling SORTs, DRRS ended up simply refining the existing model. Moreover, the categories of DRRS-assigned mission sets do not capture the post-9/11 environment. At the

very least, this suggests a need for revised metrics beyond the traditional paradigm of readiness, one that is more applicable across a range of possible mission-types.

PULHES evaluates physical capacity/stamina, upper extremities, lower extremities, hearing, vision, and psychiatric fitness. PULHES was initially implemented in 1944 to streamline and standardize medical screening to meet the rising WWII manpower demand. While useful, PULHES is criticized for a number of deficiencies, most notably for its psychiatric evaluations. Studies show that one-time psychiatric screenings are unreliable in predicting future human performance. To be effective, such evaluations must be conducted on a persistent basis under military conditions, instead of in a medical setting, to sufficiently diagnose or treat any underlying conditions or issues. Despite noted deficiencies, the half-century old PULHES continues to be the bedrock of DOD assessments for a service member’s “medical readiness” for deployment today.

Readiness remains a poorly understood and ill-defined concept. The recently departed Undersecretary of Defense for Personnel and Readiness, Brad Carson, wrote publicly that current Pentagon processes are “broken,” and that the development of an improved readiness reporting system was high on the list of needed reforms. At the unit and individual-level, the services employ antiquated tools based on requirements and assumptions of bygone eras. The DRRS model fails to account for the changing nature of mission requirements of today’s security environment, while PULHES fails to account for the impact of modern day warfare on the individual and the overall wellness of the members of the military and their support networks.

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) REASSESSING READINESS

For policy-makers and military commanders, military readiness is generally considered on two levels. The first is a strategic debate that poses budgetary and end-strength numbers against the ability to meet requirements. The second is a static assessment of medical readiness based on the PULHES methodology, a process that fails to effectively measure today's combat requirements or essential components of human wellness. Moreover, both categories suffer from subjectivity and narrowness; they ignore the less tangible human dimension of readiness and the fact that the health and wellness of individual service members can vary along a spectrum throughout their military career.

A September 2016 Government Accountability Office assessment of military readiness concluded that the steady pace of combat deployments has stressed the force. However, the much-cited "stress" generally refers more to equipment than personnel. Further, when personnel factors are considered, they are generally limited to end-strength and quantitative effects of the high pace of deployments, such as "gaps in the number of unit leaders with the right grade, experience, and technical and leadership qualifications." The GAO report makes no mention of psychological effects as a factor in overall readiness. Similarly, of the 26 congressionally-mandated reporting requirements on readiness, only seven pertain to personnel and, except for "morale," none of the criteria reflect the health of the individuals composing the force. While the "health of the force" is a frequently-used term, it has come to be taken figuratively, not literally.

The challenge of accounting for the health and wellness dimension of readiness is particularly acute given the possibility that a decade of continuous combat has compromised the armed forces. Overall end strengths are comparable to the force of 2001 but data suggest some underlying elements have changed.

- More than 5,000 service members died from hostile action in the decade ending in 2015 compared to 13 in the decade ending in 2001.
- 265 military suicides were reported in 2015, compared to the peak of 321 in 2012, and 141 in 2001.
- Active duty forces have had a 61% increase in obesity since 2002, equating to \$1.5 billion in annual spending to treat obesity-related health problems.

Underscoring this data is the growing percentage of veterans who encounter behavioral problems, at rates exceeding that of the general population. A 2016 VA study made headlines when it reported that approximately 20 veterans per day committed suicide in 2014. At the time, this figure comprised approximately 18% of the national total despite the fact that veterans made up only 9% of the U.S. population. Of note, the average age of veteran suicide victims studied in this report was over 50, suggesting that the problem predates the post-9/11 generation.

When medical and health readiness is measured by DOD, as with PULHES, it relies on a minimalistic and piecemeal definition of medical/health readiness. For example, it considers

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variables that include physical tests, “class 1” dental status, vision or eyeglasses status, and immunization status. The system does not capture crucial health and wellness factors that contribute significantly to the ability of an individual to perform his or her job. It ignores the causal chain between gaps in individual performance and the subsequent impact on the success or failure of military operations.

The basic medical health of military forces has been highlighted by recent media attention, particularly on obesity. Eight percent of U.S. military personnel are clinically overweight today compared to 1.5% before 9/11. Obesity is also now the number one reason for disqualification in the military recruiting process. One-third of the target young adult population (age 17 to 24) in the United States is ineligible due to obesity, a trend that is getting worse. Gregory Poland, a doctor at the Mayo Clinic who advises DOD on health issues, estimated that by 2020 only 20% of the recruiting population will be eligible based on current weight and fitness qualifications.

In addition, physiological health, mental health and emotional wellbeing are neglected in defining military readiness. The PULHES model evaluates mental conditions on a one-time basis rather than on an ongoing engagement that anticipates the potential for changes throughout an individual’s military service. Furthermore, current procedures inadequately address borderline conditions or those that cannot be diagnosed within established guidelines.

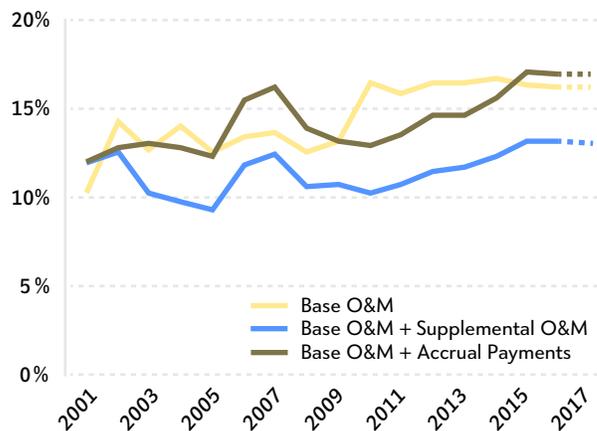
The impacts of physical and mental health on readiness are difficult to assess, in part due to a lack of coordination and collaboration between the services, DOD, and the VA. Within DOD, each service has its own service-specific database for medical records with no practical interface across branches. Similarly, DOD and VA abandoned plans to integrate electronic health records that would have allowed a service member to retain career health data through the transition to civilian life. Stove-piped systems mean that episodic health assessments are made without the crucial context of past medical and health history.

) COSTS OF READINESS

In addition to the direct operational impacts of a force that is not at optimal health, runaway healthcare costs for the military community over the past fifteen years is a worrying trend with implications for other, non-healthcare-related investments, to include spending for equipment and training, the traditional drivers of readiness.

The number of veterans receiving disability compensation increased from 2.3 million in 2001 to around 4.2 million in 2015. While this delta partially reflects the growing set of injuries and illnesses eligible for compensation, it also reflects a deterioration in the underlying health of individuals that compose the force.

PERCENT OF DHP FUNDING OF O&M SPENDING



Source: Department of Defense

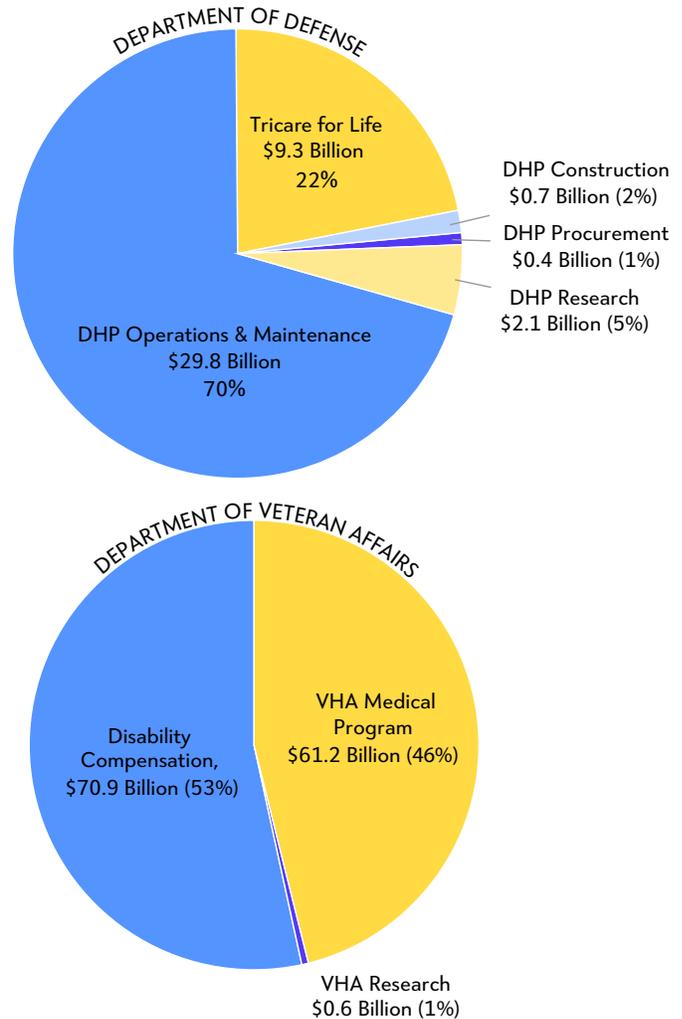
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Moreover, per capita healthcare costs for active duty and veterans have ballooned over the last 15 years, while the number of beneficiaries remained relatively stable. This increase is driven by a combination of expanded benefits, increased utilization, and increased prescription use. From 2001-2015, the annual cost per beneficiary of DOD's Defense Health Program and the VA's Veterans Health Administration rose 6.0% and 6.5% respectively, rates that outpaced inflation and private sector healthcare cost increases.

The Defense Health Program continues to become an increasingly larger portion of the Operations & Maintenance account, accounting for 40% of the FY 2017 O&M budget request. The O&M account funds a range of activities including training, maintenance, and repair, elements that are conventional metrics for readiness. According to the Center for Strategic and International Studies, in 2016 alone, DHP cost increases accounted for 33% of the rise in O&M costs. The overall trends in defense healthcare spending indicate they are potentially unsustainable and will impact other DOD investments.

Most notably, in 2016 the Congressional Budget Office noted that reining in rises in health-related O&M costs would benefit DOD. Slowing the growth of healthcare costs would allow DOD to preserve its force structure (number of combat units) and offset the costs of modernization. Currently, DOD projects a large modernization and procurement funding gap in 2022 and has not identified how it will be filled.

BREAKDOWN OF HEALTHCARE SPENDING



Source: Department of Defense, Department of Veteran Affairs

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) NEW APPROACH

Trends in military suicide and spending are only the most overt signals that point to a systemic failure in our assessment methodology and perhaps in our conceptualization of human capital. The episodic nature of engagements between service members, veterans, and the military healthcare system remains a persistent problem as patients are not tracked and care is often not connected. At the same time, facility-based programs, while necessary and useful, suffer from poor scalability, limited access, and significant infrastructure costs that prevent them from addressing the full scale and complexity of the growing health and wellness problem. Meanwhile, service members and families are discouraged from reaching out for help, fearing reprisals or a perceived stigma regarding mental and emotional health issues.

Although awareness of the issue within Congress is growing, it still is not clear what is and is not working. Mental and behavioral health efforts, like those promulgated by the FY16 and FY17 NDAs, have been applied piecemeal and do not address structural problems like interagency and interservice coordination. The proliferation of non-profit and non-governmental organizations (e.g. veteran service organizations) covers some of the shortcomings of the military healthcare system. These organizations, however, focus on small sections of the larger problem; they cannot fully correct for the dysfunction across national institutions that should be working together to identify and execute a system-level solution.

The combination of increasing healthcare costs and neglect of the human dimension of readiness is a long-term structural problem that is unlikely to fix itself. Despite readiness metrics failing to account for essential human dimensions of health and wellness, data collected outside of the traditional scope of readiness suggest there are shortcomings in existing institutions' ability to support the individuals composing the force. In addition to recommending that these dimensions become a permanent component of readiness accounting, an alternative approach to military healthcare is needed, one that focuses on personal empowerment and health literacy so that individuals can identify and bring attention to issues before a more acute and serious condition emerges. Offering personalized solutions and information instead of a "one-size fits all" approach can increase self-awareness and improve participation in care and wellness initiatives.

At the same time, the alternative approach must recognize that the health and wellbeing of the service member and veteran involves their families, friends, and support networks. Fortunately, this approach becomes possible by leveraging existing technologies that are transportable, scalable, and capable of overcoming the limitations of traditional facilities-based engagements. In particular, using such technology can replace episodic engagements with persistent care through baseline assessments that individuals can update and share with different caregivers during and after their military service.

Finally, the alternative is not to characterize the military community as "broken" and in need of "fixing." Rather, it is to change how health and readiness issues are viewed, placing increased emphasis on personalized solutions, persistent engagement, and reporting standards that more

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accurately represent the mental and physical readiness of the force.

“Humans are more important than hardware.” USSOCOM’s first SOF Truth serves as a great reminder that people are truly the most important asset our military has to preserve and protect.

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