Prepared Statement

of

The Honorable Jonathan Woodson

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REGARDING

THE MILITARY HEALTH SYSTEM OVERVIEW

BEFORE THE

HOUSE APPROPRIATIONS COMMITTEE

DEFENSE SUBCOMMITTEE

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Chairman Young, Ranking Member Visclosky and members of the Subcommittee, thank you for the opportunity to present the Department of Defense request for funding of medical programs for fiscal year 2014 and especially for the honor of representing the dedicated military and civilian professionals who comprise the greatest military health system in the world.

The military health system remains strong and effective in meeting its missions of ensuring medical readiness and delivering quality health services for 9.6 million eligible beneficiaries worldwide. The budget we have put forward is fully aligned with the larger strategic objectives of the Department.

The military health system continues to provide high quality health care and an ever-improving health care experience for all beneficiaries -- active duty, those who have retired from a career of military service and all of their family members. This budget supports the core values of the military health system and the MHS strategic plan: improved readiness, better health, better health care, and lower cost. We are committed to sustaining the superb battlefield medical care we have provided to our warriors and the world-class treatment and rehabilitation for those who bear the wounds of military conflicts. This budget also sustains the long-term medical research and development portfolio allowing us to continually improve our capability to reduce mortality from wounds, injuries and illness sustained on the battlefield.

We also recognize that the Budget Control Act of 2011 presents unique challenges to the Department. Our budget proposes a series of modest efforts that aim to re-balance the health cost shares borne by the government and the beneficiaries we serve. These proposals are phased in over several years, protect the most vulnerable in our military community, and still allow the

Department to deliver one of the most comprehensive health benefits offered by any employer in this country.

Here are some of the highlights of the budget request:

For Fiscal Year 2014, we are requesting $33.1 billion for the Defense Health Appropriation. Of this request, nearly $24 billion will support direct patient care activities in our military hospitals and clinics, as well as, care purchased from our civilian sector partners. This budget request will adequately fund our daily operations plus our research programs; and it provides sufficient resources to procure needed medical equipment. Compared to last year's budget, this request represents an increase of less than 2 percent.

We not only owe a debt of gratitude to the men and women who have sacrificed so much as they supported conflicts around the world, we owe it to them to provide cutting edge treatment that improves the quality of their lives as much as possible. This request sustains medical research for wounded, ill and injured service members by requesting $363 million for continued support of cutting edge research projects. Access to mental health care has improved significantly with the addition of many qualified providers; and this budget targets $21 million to further "embedded" behavioral health support in primary care settings both at home and on the battlefield. The budget also expands our commitment to promoting preventive health care and preserving access to numerous clinical preventive services and screenings at no cost to our beneficiaries.

In partnership with the Department of Veterans Affairs (VA), we remain steadfast in our commitment to improving the DoD disability evaluation system and, in particular, the processing times for disability claims. This budget request includes $67.8 million in additional resources to

aid in reducing processing times and the backlog of service members transitioning through the Integrated Disability Evaluation System. We continue to strengthen our relationship with the Department of Veterans Affairs in other ways as well. This budget fully funds the DoD portion of operations of the joint DoD and VA federal health care center in Chicago, Illinois, and continues significant investments in the development of an interoperable health record that will facilitate more efficient sharing of health care data between the two departments.

Congress has been extremely generous in granting us carryover authority each year. This has been an invaluable tool that provides needed flexibility to manage issues that emerge during the year of budget execution. Given the size of our program and the inherent uncertainty in medical usage and costs, and especially medical claims costs related to our TRICARE program, carryover authority allows us to better manage the financial volatility within our program. . That authority has been helpful to the Department, and we request that it be continued in FY 2014.

We are intently focused on ensuring the behavioral health of our service members and their families remains a top priority. Over the last several years, we have hired more behavioral health specialists, brought on Public Health Service medical professionals, expanded our TRICARE network, and expanded the ways by which our beneficiaries can access mental health services. An important element of our strategy has been to embed mental health specialists directly within military units, and this approach has helped us identify and intervene earlier with service members, and has also encouraged our service members to seek assistance when they need it.

Over the past three years the MHS has reengineered primary care by implementing the patient centered medical home (PCMH) model. Over 2.5 million DoD beneficiaries are now receiving care from patient centered medical homes that have met criteria consistent with Level 2 or 3 National Committee on Quality Assurance recognition. A recent study of DoD PCMH performance identified significant improvements in ER utilization, quality indicators and patient satisfaction at the most mature PCMH sites. Lessons learned from first generation implementation of the medical home in the MHS have shown advances such as enhanced patient communication using secure messaging, improved access through alternatives to traditional visits, and standardized workflows and documentation for common medical problems. In addition, the expansion of behavioral health, pharmacy and other services within the PCMH and the incorporation of on-site real time specialty consultation has enabled more and more comprehensive care to be done in primary care, reducing the need for external consultations and improving continuity of care.

A critical force multiplier to our health care delivery system is a robust and modern electronic health record (EHR). The Department has long been a national leader in developing and deploying a global, electronic health record. And, for the last three years, DoD and the Department of Veterans Affairs have been working closely to deliver on two fundamental tasks in the health care arena: One, integrate health data for an individual into a seamless, interoperable electronic health record, and two, simultaneously modernize both Departments' legacy health information systems.

We have made tangible progress on a number of critical elements necessary to achieve our vision of an integrated record. The most notable efforts include the following: (1) Beginning to create a joint health data dictionary – ensuring that we are using the same, precise language to

describe the health data elements and fields in our health record system; (2) moving VA data centers to the Defense Information System Agency, or DISA – an important step for efficiency in operations; (3) Selecting a single DoD-VA joint Single Sign On / Content Management solutions; (4) Implementing a joint Graphical User Interface – or GUI – that displays information from both DoD and VA systems. Initially rolled out in North Chicago, San Antonio and Hawaii health systems, this is an important interim step to make it easier for our staffs to view patient information no matter which health system a patient used.

These are important achievements that are necessary for the seamless sharing of information. The work that has already been accomplished is money well-spent. In February, the DoD and VA Secretaries approved the following actions:

1. Expand our existing "Blue Button" capability so that VA and DoD patients can securely download their medical record using industry standard formats by May 2013;
2. Ensure clinicians can see consolidated patient data through a common viewer at nine key sites by July 2013;
3. Complete the mapping of VA health data to the Health Data Dictionary by September 2013; and
4. Accelerate the "real-time" availability of VA data by December 2013.

We are also continuing our initiative to "move from healthcare to health." Operation Live Well is the overarching framework for a set of programs and services we are offering to our military community. Over the last year, I directed the convening of two "Deep Dive" initiatives where subject matter experts met and developed innovative approaches to address weight management and tobacco utilization. We are implementing small pilot programs, developed by our own people, in military communities around the country.

And, we are working closely with the Military Community and Family Policy Office on the Healthy Base Initiative – in which fourteen military installations and defense agency offices around the world will participate in highly customized local efforts to improve health and well-being. The specific initiatives will get underway in summer of this year. Although there are many actions we can take to improve readiness, health and cost control, no single item can have as broad an effect across all of our strategic aims as a measurable change in individual and community health behaviors.

The budget request also reflects our commitment to achieving greater efficiency in the operation of the military health system. You have asked that efficiency be a top priority for the military health system; I believe that we are achieving this goal.

Over the past several years we have introduced a series of measures that have cumulatively reduced government expenditures by billions of dollars. We have decreased administrative overhead at our headquarters (and will further streamline our headquarters operations in the coming years); we are increasing our joint purchasing of medical supplies and equipment; the establishment of federal ceiling prices for drugs has saved almost $800 million annually as well as encouraging the use of the less costly mail order pharmacy. We have aligned our payments to hospitals for outpatient services with Medicare, which when fully implemented in FY 2014 will yield annual savings of over $900 million. And, our ongoing efforts to combat fraud will continue to yield savings based on targeting improper billings by civilian providers.

Within military communities where we have existing military medical capacity, the Department has established an MHS modernization study – a collaborative effort of OSD/Health

Affairs and the Service Medical Departments -- to assess our current portfolio of hospitals and clinics and determine if infrastructure changes should be considered. We are also looking at ways to more fully utilize the available capacity of our larger hospitals and medical centers. We have begun work on better defining and measuring the readiness of the health care so that we can both maintain the capability that has been developed over the last ten years of war and tailor the number and composition of the team as the requirements for the health force change in response to the evolving national security environment. We expect to conclude our work in October 2013 in order to inform our FY2015 strategic effort and budget submission.

Along with the significant cumulative effects of these efficiencies, the Department will establish a Defense Health Agency to unify our governance procedures across the Office of the Secretary of Defense and the three military departments. These long sought changes, which have the full support of the civilian and military leadership of the Department, will produce a more integrated health system and establish more common clinical and business practices across the enterprise. The centerpiece of this reform is the establishment of shared services for ten, high profile and high cost components of our system: the TRICARE health plan, health facilities, health information technology, medical logistics, pharmacy, medical education and training, medical research and development, public health, resource management, and contracting.

We will also introduce a more integrated approach to health services delivery in our local health care markets. In those military communities served by more than one Service branch, we are providing enhanced authorities for designated senior military medical officials to direct resources and establishing unified business performance plans to ensure we further improve access, service and avoid unnecessary duplication.

In the National Capital Region, we will sustain and institutionalize the tremendous accomplishments that have produced a model for joint service excellence and teamwork, not only for our wounded warriors and their families, but for our nation. The Joint Task Force National Capital Medical Region (JTF CAPMED) will transition to a medical directorate within the Defense Health Agency, and we will similarly direct the development of a single, 5-year business plan encompassing all medical facilities in the NCR.

We are excited by the opportunity that these reforms provide us to continuously improve how we ensure readiness, sustain health, improve health care, and lower costs.

But in an era of declining resources, today's military health care system cannot be sustained for future generations without further reform. The budget before you includes proposals aimed at re-balancing beneficiary cost shares that have been largely untouched for almost two decades. The overwhelming majority of our proposals are targeted at modest and phased-in increases in cost shares for military retirees and their families.

According to the Defense Business Board, 17% of those who serve in the military complete a 20 year career of service. The average retirement age from military service is approximately 43 years. Some members may retire as young as 38 years of age, following 20 years of military service. We refer to retirees under the age of 65 as "working age retirees" because second careers are the norm for most retirees in their 40's or 50's. Prior to the significant rise of health care costs in the private sector, most retirees obtained health insurance from their post-military service employers. However, because TRICARE fees were shielded from the effects of health care inflation, many retirees relinquished employer provided insurance which has grown more expensive in recent years and chose TRICARE as their primary insurer

instead. This is one of many factors contributing to the growth in costs for health care in the Department of Defense.

Our proposal protects the most vulnerable in our military populations – survivors of service members who died on active duty, and medically retired individuals and their families – so they would see no increase in fees.

We must – and do -- sustain a robust health care benefit for retirees, which they have earned as a consequence of a career of service to our nation. These reforms, which have the full support of civilian and military leadership in the Department, are a means to achieve that goal. They would slow the growth in retiree health benefit costs to the Department over time, without compromising the robust medical benefits that retirees receive, and yield more than $9 billion in health care savings over the next five years to contribute to the readiness of our military forces.

The features of our proposals are as follows:

- TRICARE Prime enrollment fees. About half of military retirees elect to use TRICARE Prime – our model that closely manages care within a closed military and private sector network. In recent years, Congress allowed the Department to slightly raise the TRICARE Prime enrollment fee from $460 per year for a family (a level established in 1994) to its current level of $539 per year. Under the Administration's proposal, beginning in 2014 and phased-in through 2018, retirees under the age of 65 would experience an increase in the TRICARE Prime enrollment fee based on a percentage of his or her gross military retirement pay. These fees would include both floors, starting with the current fee for FY 2013 of $539 dollars per year for a family, and ceilings, which would raise enrollments fees to just $1226 per year for family coverage by 2018. A separate ceiling for flag officers would increase from the current fee for family coverage to $1,840 per year. After 2017 enrollment fees for retirees would be indexed to annual cost of living increases applied to military retired pay – a request that has been

made by the military and veteran organizations who represent many of our beneficiaries. Copayments for outpatient doctor visits would rise to $16, except for mental health services, which would remain at the current level of $12. All the other characteristics of TRICARE Prime would remain unchanged, including assignment of a primary care manager, free access to clinical preventive services and automatic claims filing by our contractors. Total out of pocket expenses would remain far below average civilian health care expenditures of nearly $6,000 per year.

- TRICARE Standard. The TRICARE Standard option is the Department's fee for service type plan, under which beneficiaries chose to pay higher out of pocket costs, including annual deductibles of $150 per individual and $300 per family, in return for maximum flexibility in the choice of their health care providers. TRICARE Extra provides Standard users with additional discounts if they chose a provider within our contractor networks. Currently, TRICARE Standard beneficiaries pay no premium or enrollment fee for health care. Beginning in 2014, the Department proposes to implement an annual enrollment fee beginning at $140 and rising incrementally to $250 by 2018; TRICARE's current annual deductibles would increase from $300 for a family to $580 for a family in FY 2018, still well below the average deductible in most health insurance plans.

- Catastrophic Cap. Retirees in TRICARE have an annual catastrophic cap on out of pocket medical expenses of $3,000, after which the Departments pays 100% of the allowable costs. We are proposing that beginning in FY 2014, that cap would be indexed to increases in the cost of living increase applied to military retired pay, and exclude enrollment fees.

- TRICARE For Life. TRICARE for Life is the benefit added by Congress in 2001 which provides wrap around supplemental coverage for our military/Medicare-eligible beneficiaries at no cost to military retirees who also and enroll in Medicare Part B. Comparable Medicare supplemental coverage for civilians costs about $2,100 per year per person. We propose implementation of modest annual enrollment fees for TRICARE for Life <u>for new enrollees only</u> beginning in 2014. TRICARE for Life enrollment fees would also be phased-in for individuals and families over a 4-year period, and will be based on a percentage of the beneficiary's military gross retired pay up to an annual fee

ceiling, with a separate, higher ceiling specifically for flag officers. Under this proposal, the ceiling cost would be $613 by 2018 for most families, and $818 for flag officers. After 2017, the ceilings would be indexed to the amount of the cost of living adjustment on military retired pay.

TRICARE Prime Fees – Linked to Gross Retired Pay, No Impact to ADFMs											
Annual Enrollment Fees	**FY 13**	**FY 14***	**FY 15**	**FY 16**	**FY 17**	**FY 18**	**FY 19**	**FY 20**	**FY 21**	**FY 22**	**FY 23**
Prime Annual Enrollment Fees											
Floor -- Current Fee inflated by COLA	$539	$548	$558	$569	$581	$594	$607	$620	$634	$648	$662
% of Gross Retired Pay -- 4% FY 2017	$539	2.95%	3.30%	3.65%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Ceiling -- After FY 2017 inflated by COLA)	$539	$750	$900	$1,050	$1,200	$1,226	$1,253	$1,281	$1,309	$1,338	$1,367
Flag Officer Ceiling -- $1,800	$539	$900	$1,200	$1,500	$1,800	$1,840	$1,880	$1,921	$1,964	$2,007	$2,051
TRICARE Standard/Extra Fees/Deductibles – Under 65 Retirees, No ADFM impact											
Annual Enrollment Fees	**Current**	**FY 14**	**FY 15**	**FY 16**	**FY 17**	**FY 18***	**FY 19**	**FY 20**	**FY 21**	**FY 22**	**FY 23**
Individual	**$0**	$70	$85	$100	$115	$125	$128	$131	$133	$136	$139
Family	**$0**	$140	$170	$200	$230	$250	$256	$261	$267	$273	$279
Annual Deductibles											
Individual	$150	$160	$200	$230	$260	$290	$296	$303	$310	$316	$323
Family	$300	$320	$400	$460	$520	$580	$593	$606	$619	$633	$647
TRICARE-for-Life (TFL) Fees – 65+ Retirees, Tiered, No Impact to ADFMs											
Annual Fee - Per Individual	**Current**	**FY 14**	**FY 15**	**FY 16**	**FY 17***	**FY 18**	**FY 19**	**FY 20**	**FY 21**	**FY 22**	**FY 23**
% of Gross Retired Pay -- 1% FY 2017	**$0**	0.25%	0.50%	0.75%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Ceiling -- After FY 2017 inflated by COLA	**$0**	$75	$150	$225	$300	$307	$313	$320	$327	$334	$342
Flag Officer Ceiling -- $400	**$0**	$100	$200	$300	$400	$409	$418	$427	$436	$446	$456
TRICARE Prime Visits Fee – No Legislation Required, No ADFM impact											
Outpatient Visit Fee	**FY 13**	**FY 14***	**FY 15**	**FY 16**	**FY 17**	**FY 18**	**FY 19**	**FY 20**	**FY 21**	**FY 22**	**FY 23**
Prime Annual Enrollment Fees											
Non-Mental Health Office Visit Copay	$12	$16	$16	$16	$17	$17	$18	$18	$18	$19	$19
Pharmacy Co-Pays (Includes ADFMs)											
Retail Rx (1 month fill)	**Current Fee**	**FY 14**	**FY 15**	**FY 16**	**FY 17**	**FY 18**	**FY 19**	**FY 20**	**FY 21**	**FY 22**	**FY 23**
Generic	$5	$5	$6	$7	$8	$9	$10	$11	$12	$13	$14
Brand	$17	$26	$28	$30	$32	$34	$36	$38	$40	$43	$45
Non-Formulary*	$44	Available only on a limited basis									
Mail-Order Rx (3 month fill)											
Generic	$0	$0	$0	$0	$0	$9	$10	$11	$12	$13	$14
Brand	$13	$26	$28	$30	$32	$34	$36	$38	$40	$43	$45
Non-Formulary	$43	$51	$54	$58	$62	$66	$70	$75	$80	$85	$90
Military Treatment Facilities	**No change -- still $0 co-pay**										
**N/A = Not available at retail after FY 13, except under limited circumstances*											
Note: All proposals exempt service members (and their families) medically retired from active duty and families of service members who died on active duty .											

DoD also provides pharmaceuticals to all beneficiaries in three ways: in military hospitals and clinics at no cost to the beneficiary; from more than 57,000 retail drug stores throughout the country; and through a single national mail order program. All categories of beneficiaries except active duty members share in the cost of drugs obtained from retail and mail

order sources. While Congress has recently authorized increases in these cost shares, and supported our efforts to encourage the use of the less costly mail order program, we are seeking further reform to aid in controlling the fast growing pharmacy portion of our budget – through increased copayments and limited availability of high cost non-formulary drugs in retail pharmacies. Additionally, we would build on Congressional action in the National Defense Authorization Act for 2013 which required beneficiaries over age 65 to obtain refills of certain drugs from the national mail order program and extend that requirement to all beneficiaries, requiring that all prescriptions for long term maintenance medications be filled through either military treatment facilities or the national mail order pharmacy program. These actions will ensure savings in excess of $5 billion over the next five years.

Even with these reforms retirees would pay less as a percentage of total costs than they paid for care from civilian providers nearly two decades ago. In 1996, retirees paid roughly 27% of the total health care costs. In 2012, that figure had dropped only 10.3%. With these proposals, the retire cost-share will continue to be less than 15%. Retirees would continue to receive health care benefits that are more generous than most private sector plans, at far lower costs than those paid by most private sector workers.

We estimate that the cumulative savings to the defense health program resulting from proposed increases in enrollment fees, deductibles and catastrophic caps would exceed $9 billion over the next 5 years. A word about savings to the Department: I have spoken about savings to the defense health program which is based on annual appropriations by this Committee. But slowing the growth of government costs of retiree health care will also result in savings in the mandatory account for retiree health care, the Medicare Eligible Retiree Health Care Fund. That fund will expend $9.5 billion for retiree health care in FY 2014.

The proposals will not affect most active duty military families. Active duty families enrolled in TRICARE Prime pay no fees (no enrollment fees or cost-shares) other than pharmacy copayments – and they only pay these fees when they obtain prescriptions outside of a military hospital or clinic.

We consider the comprehensive benefits we offer to be an important tool in the recruitment and retention of a skilled volunteer force. And we fervently believe that the changes we recommend uphold our commitment to all military beneficiaries, and to the readiness of our armed forces – a commitment to maintain one of the best health care benefits in the country, to protect the most vulnerable members of our population from cost increases, to invest in both health care and health, for the greatest military force in the world, both now and for generations to come.

In addition to presenting you with next year's budget and proposals, before I conclude I also want to acknowledge the challenges of operating this year under budget sequestration.

As the chief advisor to the Secretary of Defense, I want to highlight what cannot and will not be compromised.

First, our commitment to quality of care is sacrosanct. We will not allow quality to suffer or place any patient at risk. Period.

The Department will also ensure that the care provided to our wounded warriors is maintained. Our continued focus on their medical treatment and rehabilitation will continue. It is our goal to make sure that from the wounded warrior's perspective, they should see no difference in the care they receive before, during or after sequestration. And we will sustain our close

collaboration with other federal and private sector partners, including the Department of Veterans Affairs.

Finally, to the greatest extent possible, we will work to sustain access to our military hospitals and clinics for our service members, their families, retirees and their families.

But sustaining patient care during sequestration comes at a cost. The Department is reducing funding from a wide range of other essential investments. This will produce significant, negative long-term effects on the overall Military Health System.

By directing all resources to the provision of patient care under a sequestration, we will have less funding to address medical facility maintenance and the needed restoration and modernization projects. This will negatively affect the healthcare environment and potentially drive substantial bills for facility maintenance in the future. While we will continue to fund projects that directly affect patient safety or that are emergent in nature, we will see a degradation in the aesthetic quality and functionality of our medical facilities. This can impact the morale of both the medical staff and the patients and can greatly degrade the patient's experience of healthcare within the military health system. Many of our facilities are older and require substantial upkeep. To delay these medical facility projects only exacerbates the problem and ultimately the medical staff and more concerning, the patients, suffer the consequences. This is not a sustainable strategy.

In order to continue our health care operations, we will dramatically reduce our investment in equipment. This means equipment will be used longer and will require more maintenance – increasing the potential for equipment breakdowns and increasing maintenance costs. At some point, equipment becomes obsolete and cannot be repaired any longer.

Research and Development projects will also suffer. Congressionally directed research projects are not protected under sequestration and will be reduced by approximately 8%, but no more. We will protect our core research projects that are directed towards wounded warrior issues. Other core research projects may need to be reduced by more than 8% so that we can "make ends meet" in the delivery of health care. This means that important, promising research projects could be slowed or stopped altogether.

In patient care areas, nearly 40% of our medical staff in military hospitals and clinics is civilian. With some exceptions, these civilians are facing a potential furlough. We can expect the furlough of medical staff will impact access to care – perhaps causing inconvenience and dissatisfaction among those patients accustomed to getting their care in military treatment facilities. Furthermore, patients who formerly received care in a military treatment facility may need to obtain care in the private sector at an increased cost to the Department and the American taxpayer.

The long-term effects on our ability to recruit and retain the best military and civilian medical experts this country can offer is also at risk. The combined military and civilian workforce that has been instrumental in saving lives on the battlefield is watching these proceedings closely. Like public servants everywhere, they are sitting down at their kitchen tables with their families – looking at the family budget, guessing at the continued uncertainty in their professional endeavors, and weighing alternatives to their current career choices. I want them to remain with us.

Sustaining a high quality military health system for all of our beneficiaries is our mission and a personal, moral obligation.

We understand the Department of Defense must do its part in addressing the nation's budget concerns; however, it must be done in a responsible and judicious manner. The path forced upon us through sequestration is neither. I remain hopeful that the Congress can still reach agreement that will allow us to shape our future in a more careful, deliberate and rationale manner.

I am honored to represent the men and women of the Military Health System before you today, and I look forward to answering any questions you may have.