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 Frelinghuysen, Ranking Member Visclosky and members of the Subcommittee, thank you for the opportunity to present the Department of Defense request for fiscal year 2015 health programs funding.

Over the past thirteen years of war, our ability to deliver highly integrated combat casualty care has demonstrated a clear benefit to wounded, ill or injured Service members and provided timely support for combatant commanders. This success was built on a solid foundation of research, clinical experience, and hardworking professionals, both military and civilian, funded by the American taxpayer.

Looking forward, our national security and defense strategies must be supported by a strong, relevant, agile and forward-leaning MHS. The American public and our national leaders expect excellent care delivered reliably and compassionately anywhere our Service members are stationed or deployed. Furthermore, after thirteen years of war, they expect that the current level of support and care will be efficient and enhanced to meet future demands.

Secretary Hagel has outlined his priorities for managing the significant change the Department will experience in the coming years: institutional reform; re-evaluating our military force planning construct; preparing for a prolonged readiness challenge; protecting investments in emerging military capabilities; balancing forces between active and reserves; and reforming personnel and compensation policies.

In support of the Secretary's priorities, I have outlined six lines of efforts for the MHS. These include: (1) modernize MHS management with an enterprise focus; (2) define and deliver the medical capabilities and manpower needed in the 21st century; (3) invest in and expand strategic partnerships; (4) assess the balance of our medical force structure; (5) modernize the

TRICARE health program and (6) define the MHS' global health engagement requirements. Nested under each of these lines of effort are a variety of initiatives for the MHS designed to improve our ability to deliver quality healthcare wherever and whenever called upon to do so.

For this hearing, I would like to focus on two of these efforts that directly relate to our budget requests for this year.

Modernize MHS Management with an Enterprise Focus

The Defense Health Agency, a designated Combat Support Agency, is an important first step in modernizing our common business and clinical practices with accountability for performance to both the ASD(HA) and the Chairman. We have incorporated five of the ten targeted initial shared services into the DHA (listed below) and, over time, will look for other areas where we can be more efficient as a single entity in supporting the Services.

The TRICARE Health Plan
Pharmacy programs
Medical education and training
Medical research and development
Health information technology
Facility planning
Public health
Medical logistics
Procurement/contracting
Budget and resource management

In determining which common business and clinical practices become incorporated into the DHA for management, we follow a disciplined analytic approach and medical logistics provides a good example of our process. It was evident early in the process that the MHS needed to increase the proportion of purchasing from government-negotiated contract schedules and reduce the amount of purchasing through government purchase cards. The value stream analysis quickly highlighted this opportunity; the Services' medical logistics leaders communicated this

opportunity to the field and established draft measures to monitor performance. DoD has already witnessed a significant decrease in the use of government purchase cards and has increased the anticipated cost savings. In our initial business process reengineering analysis, we did not project any savings in FY2014. However, as a result of this change in buying behavior, we are on a path toward saving over $10 million in this FY and will also be accelerating our savings in the out years.

Another example is Health Information Technology, where multiple value streams have been developed and refined, to include the rationalization and consolidation of contracts, infrastructure, and systems to support our Health IT portfolio. Our original projections for Health IT, captured in our reports to Congress, anticipated additional costs in FY14 that would set the stage for savings in FY15 and beyond. Aggressive consolidation of IT management, progress toward establishing a single medical network infrastructure, and efforts to rationalize Service-specific systems, however, have cumulatively allowed us to introduce savings of $24.7 million in the first year of this shared service.

We have made significant progress since the DHA was established 150 days ago and are on track with most major milestones. In some instances, we have accelerated timelines for implementation and achieved savings earlier than initially projected. We are committed to ensuring our reforms work as planned and are confident in our approach; we remain appreciative of the support the Congress has provided over the last year.

In addition to the DHA, we have reformed our governance or decision-making process to drive performance and system improvement. We have engaged the Services more directly and explicitly into the governance process – both for policy-making and enterprise-wide operational decision-making. We have established, by charter, a number of integrated governing bodies to

accomplish this reform.

Another effort is the implementation of enhanced Multi-Service Market authorities and a structured process for monitoring and improving performance. We have established core measures of performance for the enterprise along with supporting measures linked to each of our objectives. These measures will be used to track performance through our governance structure that will hold all accountable for results.

We are investing in enterprise information systems that will help us do our work better and more efficiently. A good example of this effort is the implementation of a new Electronic Health Record (EHR). Our strategic objectives in regards to how we will ensure the interoperability of medical records of service members between DoD and the VA remain the same. We will: (1) provide seamless, integrated sharing of standardized health data among DoD, VA, and private sector providers; and (2) modernize the Electronic software and systems supporting DoD and VA clinicians.

Over the last ten months, we have made tactical changes in how we will work with the Department of Veterans Affairs (VA) on this effort, but achieve these same ends. We continue to work closely with our VA partners to achieve these objectives. By replacing our legacy systems with a single enterprise solution, we can enhance the delivery of care, improve the experience of care for our beneficiaries and better manage the health of our population. I am responsible for ensuring that the requirements for the new EHR meet the needs of our health system and the people we serve. I am working closely with Mr. Frank Kendall, the Under Secretary for Acquisition, Technology and Logistics, and Mr. Chris Miller, the Director of the Defense Healthcare Management Systems, that includes both the Interagency Program Office (IPO) and the DoD Healthcare Management System Modernization office. Mr. Miller is leading the

acquisition effort for the EHR.

Modernize the TRICARE Health Program

Health care costs continue to rise and economists project the current lower rate of growth will accelerate again in the future. In order to prepare the MHS and the Department, we are taking a number of steps to ensure the long term viability of the TRICARE Program. To that end, we are taking an aggressive approach to health promotion and prevention. Operation Live Well is the overarching framework for a set of programs and services we are offering to our military community. In addition, we 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 are participating in highly customized local efforts to improve health and well-being. 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.

Over the last four years, the Department has identified a number of initiatives focused on the purchased care sector – to include the implementation of outpatient prospective payment, reimbursement changes for Sole Community Hospitals, and changes in how we reimburse our Uniformed Services Family Health Plan providers for our dual-eligible Medicare/TRICARE beneficiaries. Cumulatively, these changes have led to impressive cost savings in our purchased care accounts, but now we must take a more comprehensive perspective in managing military health care costs.

Efforts to improve the execution of the TRICARE Health Plan are focused on how we better integrate our direct care and private sector health services delivery. As this generation of TRICARE contracts nears the end of its contract term, the Department is looking to reshape our

contracts in ways that can improve integration with military medical facilities, reduce unnecessary overhead and achieve greater simplicity for the beneficiary and the government. We have begun this work under the DHA and will be communicating with industry later in 2014 about our plans.

Our proposal for the FY15 budget also includes efforts to modernize the TRICARE program in terms of beneficiary engagement. The FY 2015 President's Budget proposal would simplify and modernize the existing TRICARE program in ways that provide incentives for wellness, decrease overutilization of health services, and allow beneficiaries to choose their providers. This proposal includes modest increases in beneficiary out-of-pockets costs for active duty families, retirees and their families, and Reserve Component members and their families, although some families may actually see a decrease.

The TRICARE benefit remains one of the most comprehensive benefits in the country, as it should be. Service members on active duty would have no out-of-pocket expense regardless of the point of delivery (MTF, network, or out-of-network) and the highest priority for access to MTF care.

In terms of simplification, the proposal would consolidate the various TRICARE options – TRICARE Prime, Extra, Standard, and other TRICARE Plans – into one plan. This model would make it easier to obtain care and provide greater freedom of choice by eliminating the requirement for beneficiaries to require authorizations when seeking civilian care. This approach would greatly simplify the administrative burden for beneficiaries and government and reduce unnecessary administrative costs.

This proposal would fully modernize our health plan for the first time since it was created twenty years ago with more contemporary benefit design and patient choice. Preventive services

would be covered at no cost to beneficiaries, regardless of where they receive their care – MTF, network or out-of-network. The cumulative effect of the proposed TRICARE fee increases still ensures beneficiary out-of-pocket costs (a) remain far below costs experienced by military beneficiaries in 1994, and (b) remain far better than virtually every comparable employer in the US today.

The ensuing tables provide specific information on the proposals we have included in this year's proposal.

Cost Sharing by Beneficiary Tier

Tier 1 is comprised of the following beneficiaries
(who would also continue to have priority MTF access *as they do now*):

- Service members on active duty (greater than 30 days)
- Reserve Component (RC) members for the treatment of a line of duty (LOD) condition

Tier 2 Beneficiaries **No participation fee**	**Tier 3 Participants** **Pay participation fee**
eligible active duty family members	
retirees (medically retired) and their eligible family members (new)	retirees (not medically retired) and their eligible family members
members of the US Family Health Plan (USFHP) with an active duty or Tier 2 sponsor	members of USFHP with a Tier 3 sponsor
survivors of service members who died on active duty (improved)	survivors of retirees
individuals covered under the Transitional Assistance Management Program (TAMP)	

Note. Tier 3 participants eligible for premium-free Medicare Part A would be required to pay Part B premiums to Medicare *as they do now,* in addition to the TRICARE participation fee.

By law, TRICARE for Life (TFL) beneficiaries would continue to have zero out-of-pocket expenses *as they do now* for services that are covered by both TRICARE and Medicare. If a service is covered by TRICARE, but not Medicare, TRICARE cost sharing rules would apply *as they do now*. If a service is covered by Medicare, but not TRICARE, Medicare cost sharing rules would apply *as they do now*. MTFs would not collect copayments from any TFL beneficiaries.

Table 1 – Annual TRICARE Participation Fee Rates (Calendar Year 2016)

TRICARE Participation Fee (inflated annually by cost of living adjustment (COLA) percentage)	
Tier 1	$0
Tier 2	$0
Tier 3, non-Medicare eligible	$286 individual/ $572 family
Tier 3, Medicare eligible	1% of gross retired pay/individual, max $300 ($400 for sponsor O7 or above)

Note. Individuals (other than ADFMs) eligible for premium-free Medicare Part A would be required to pay Part B premiums to Medicare *as they do now*.

Table 2 – Annual Deductible and Catastrophic Cap (Calendar Year 2016)

General Deductible (out-of-network care)	
Tier 1	$0
Tier 2, E1–E4 sponsor	$150 individual/$300 family
all other Tier 2 and Tier 3	$300 individual/$600 family
Catastrophic Cap (per fiscal year)	
Tier 1	$0
Tier 2 family	$1,500 network/$2,500 combined
Tier 3 family	$3,000 network/$5,000 combined

Table 3 – Outpatient Cost Sharing (Calendar Year 2016)

Services	TRICARE Network and Military Treatment Facility		Out-of-Network	
	Tier 2 with sponsor E4 & below/ E5 & above	Tier 3	Tier 2	Tier 3
Clinical preventive services [a]	$0	$0	$0	$0
Primary care visit	$0/0 MTF visit $10/15 network visit	$10 MTF visit **$20 network visit**	20% [b]	25% [b]
Specialty care visit (including behavioral health, PT, OT, speech)	$0/0 MTF visit or network BH group visit $20/25 network visit	$20 MTF visit or network BH group visit **$30 network visit**	20% [b]	25% [b]
Urgent care facility	$0/0 MTF visit $25/40 network visit	$30 MTF visit $50 network visit	20% [b]	25% [b]
Emergency department	$0/0 MTF visit $30/50 network visit	$50 MTF visit $75 network visit	20% [b]	25% [b]
Ambulance	$0/0 MTF trip, $10/15 network trip	$20 per trip, MTF or network	20% [b]	25% [b]
DME, prosthetics, orthotics, & supplies	10% of negotiated network fee	20% of MTF cost or network negotiated fee	20% [b]	25% [b]
Ambulatory surgery	$0/0 MTF $25/50 network	$50 MTF $100 network	20% [b]	25% [b]

a. No cost for clinical preventive services as selected by the Affordable Care Act

b. Percentage of TRICARE maximum allowable charge after deductible is met

Note: MTF – military treatment facility; BH – behavioral health, PT – physical therapy; OT – occupational therapy; DME – durable medical equipment

Table 4 – Inpatient Cost Sharing (Calendar Year 2016)

Services	TRICARE Network and Military Treatment Facility				Out-of-Network	
	Tier 2 with sponsor E4 & below/ E5 & above		Tier 3		Tier 2 with sponsor E4 & below/ E5 & above	Tier 3
Hospitalization	$17.35 $50/80	MTF per day network per admission	$17.35 $200	MTF per day network per admission	20% [a]	25% [a]
Inpatient skilled nursing/ rehabilitation [b]	$17/25	network per day	$25	day	$25/35 day	$250 per day or 20% [a] of billed charges for institutional services, whichever is less, plus 20% for separately billed services

a. Percentage of TRICARE maximum allowable charge after deductible is met

b. Inpatient skilled nursing / rehabilitation is generally not offered in MTFs for anyone other than service members

Table 5 – Cost-Sharing Impact on Beneficiary Families (Calendar Year 2016)

		Current TRICARE Triple Option		Consolidated TRICARE Health Plan	
		Annually	**Monthly**	**Annually**	**Monthly**
Tier 2 Family [a] (3 ADFMs not including service member)	DoD cost	$ 11,301		$ 10,588	
	Family cost sharing (no fee)	**$ 158**	**$ 13.17**	**$ 364**	**$ 30.33**
	Total	$ 11,549		$ 10,952	
	% borne by family	1.4%		3.3%	
Tier 3 Family [a] (3 members, all under age 65)	DoD cost	$ 13,435		$ 12,626	
	Family cost sharing & fee	**$ 1,378**	**$ 114.83**	**$ 1,526**	**$ 127.17**
	Total	$ 14,813		$ 14,152	
	% borne by family	9.3%		10.8%	

a. Not Medicare eligible

Note. The analysis assumes an average mix of MTF and civilian care within each beneficiary tier, and a weighted average of Prime and Non-Prime users for the current TRICARE triple option.

TRICARE would still offer a significant value compared to commercial insurance plans. The annual employer health benefits survey published by Kaiser Family Foundation (KFF)/ Health Research & Educational Trust [1] offers a useful benchmark for comparison. For instance, the 2013 average annual total premiums for employer-sponsored health plans were $5,884 for single coverage and $16,351 for family coverage.

The average employee contributions to the premium cost in 2013 were:

$ 999 ($ 83.25/month) for single coverage

$ 4,565 ($ 380.42/month) for family coverage

[1] http://kff.org/health-costs/

By comparison, the TRICARE participation fee (premium) would be $572 (calendar year 2016). Care at the MTFs would be very inexpensive with low copayments for Tier 3 participants and free of cost sharing for Tier 2 beneficiaries. TRICARE pharmacy copayments would remain significantly lower than other pharmacy benefit programs.

Table 6 - Health Plan Comparison

	TRICARE Standard Retiree family	FEHB Kaiser High	FEHB BC/BS Standard	TRICARE Consolidated Tier 3
family premium	$ 0	$ 5,055	$ 5,329	$ 572
family deductible	$ 300	$ 0	$ 700	$ 600
network specialty care visit	25%	$ 20	$ 30	$ 30
network pharmacy	$ 17	$ 30	30%	$ 28
(brand/non-formulary)	$ 44	$ 50	30%	limited availability
family catastrophic cap	$ 3,000	$ 4,500	network $ 6,000 combined $ 8,000	network $ 3,000 combined $ 5,000

Note. TRICARE Standard and FEHB are 2014 figures. TRICARE consolidated are 2016 figures.

Budget Request

Our FY2015 budget supports these efforts and our Quadruple Aim of increased readiness, better health, better care, at lower cost. We are committed to sustaining the medical readiness of our forces, the clinical skills of our medical forces, and the world-class treatment and rehabilitation for those who fight the battles of today, yesterday and tomorrow, and their families. This budget also sustains our long-term medical research and development portfolio allowing us to continually improve care for the warfighter.

For Fiscal Year 2015, we are requesting $32 billion for the Defense Health Program (DHP) Appropriation. Of this request, nearly $24.2 billion will support direct patient care in our military hospitals and clinics, as well as, care purchased from the civilian sector. This budget request will adequately fund our daily operations and our research programs; and it provides

sufficient resources to purchase needed medical equipment. Compared to last year's budget, this request represents a decrease of approximately 2 percent from our FY2014 appropriated funding.

Mr. Chairman, we understand the Department of Defense must do its part in addressing the nation's budget concerns and that it must be done in a responsible and judicious manner. I believe this proposed budget meets this test, and I am hopeful that in working collaboratively with our military service member and veteran organizations, we can reach agreement on our budget proposals.

I also appreciate the carryover authority Congress has granted 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.

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.