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Senate Armed Services Committee (SASC) Testimony
Executive Summary, March 14, 2012

The Department has proposed a Defense Health Program (DHP) budget of $32.5 billion for FY2013. The budget is aligned with the four major themes of the Military Health System (MHS) strategy, as follows.

Assuring Readiness. The MHS continues to closely monitor and assure the health and medical readiness of the military force. We have consistently witnessed improvements in the medical preparedness of our service members, both active and Reserve Component.

In our continued commitment to ensuring the mental health of our service-members, the Department has issued policy that Service members deployed in connection with a contingency operation receive a person-to-person, privately-administered mental health assessment before deployment, and three times after return from deployment. Senior leaders, both officer and enlisted, have led the effort to reduce the stigma associated with seeking mental health care. A DoD Mental Health Advisory Team (MHAT) survey from February 2011 showed that Marines who screened positive for mental health issues, had a substantial (and statistically significant) decrease in behavioral health stigma levels from 2006.

The Department of Defense has made great strides in implementing early identification and treatment programs for traumatic brain injuries (TBIs). Through the work of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), the DoD in-theater concussion policy has significantly improved the early detection of Service members with concussion; standardized 62 TBI programs at military treatment facilities (MTFs) in the non-deployed setting and established 11 concussion restoration/care centers in the deployed setting.

Our FY13 program sustains the significant investments made in all of our medical research and development programs, and in particular in the area of TBI and Post-Traumatic Stress (PTS). Our other focus areas include polytrauma and blast injury; operational health and performance; regenerative medicine; rehabilitation; psychological health and well-being for military personnel and families; and military medical training systems and health information technology applications.

Improving Population Health. Linked to our readiness mission, our efforts to improve the health of the entire MHS population is focus on two of the greatest contributors to ill health – tobacco use and obesity. We are launching a variety of programs, in close coordination with other military family and agency offices (e.g., Commissary and Exchange programs) across the Departments to incentivize healthier behaviors.

Enhancing the Patient Experience of Care. The Patient-Centered Medical Home (PCMH) is at the heart of our efforts to improve access to care and continuity of care, reduce unnecessary use of emergency rooms, and foster greater patient engagement in managing their

care. Our most mature DoD medical homes are realizing these outcomes, and we are receiving formal recognition of our medical home by the National Committee on Quality Assurance.

We are also continuing investments in our joint DoD/VA Integrated Electronic Health Record (iEHR) – a landmark effort that will improve the management of care for our service members and veterans who move between the two federal systems of care.

Responsibly Managing Cost. The Budget Control Act of 2011 compelled the Department to identify $487 billion in budget reductions over ten years. The Department is pursuing a four-pronged effort to reduce costs.

Healthcare to Health. Efforts are being refocused on maintaining population health, and reducing utilization of hospital services. There are no immediate cost-savings achieved through this initiative, but we believe that over the long-term, this strategy produces the greatest amount of savings.

Internal Efficiencies. The Department has instituted internal cost reduction efforts by decreasing headquarters administrative overhead; jointly purchasing medical supplies and equipment; and directing patients to lower cost venues for medications. The cumulative savings from all of these internal efforts for FY2013 are estimated at $259 million.

The Department has also proposed to consolidate activities, eliminating redundant functions while simultaneously improving joint integration of medically shared services, based on the recommendations of the Task Force on Military Health System (MHS) Governance. Implementation of these organizational efficiencies has been placed on hold at the direction of Congress, subject to a review by Congress and the Comptroller General.

Provider Payment Reform. We continue to expand the implementation of a number of provider payment reforms – outpatient prospective payment system (OPPS), payments for Sole Community Hospitals (SCH), and a discount model for prescription drugs, known as Federal Ceiling Prices (FCP) that cumulatively provide several billion dollars in projected savings in FY2013.

Beneficiary Cost Shares. All proposed changes are phased in over time. For select fees the Department has proposed "tiers" of co-pays based on the retirement pay of the beneficiary. Fee changes are distributed across the various TRICARE programs, so that no one beneficiary group bears the entire burden for these changes in cost-sharing. All beneficiaries (except uniformed personnel) have additional costs for prescription drugs outside of MTFs. These proposed changes continue to be modest by historic standards of cost-sharing in the TRICARE program. Even with these proposed changes, out-of-pocket costs will be approximately 14% of overall health care costs in 2017 – well-below the 27% level for retirees in 1996 when TRICARE began.