Prepared Statement

of

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REGARDING
DOD PERSONNEL PROGRAMS
BEFORE THE

SENATE ARMED SERVICES COMMITTEE
PERSONNEL SUBCOMMITTEE

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Mr. Chairman and distinguished members of the subcommittee, thank you for the opportunity to appear before you today on behalf of the men and women who comprise the Military Health System (MHS) and address our strategic priorities for the coming year.

We enter 2012 now having over ten years of experience in preparing for and responding to the consequences of war. We have seen the end of one major conflict and the implementation of a concrete timeline for the drawdown of the other. Yet, even with these milestones in our sights, we have many challenges to address in the coming year, both operational and fiscal.

I am proud of the performance of our military medical personnel on the battlefield and here at home. Last year, I provided this Committee with some of the accomplishments achieved in combat – the lowest levels of disease, non battle injury (DNBI) rates in warfare; the highest survival from wounds rate; the safety and speed of an aeromedical evacuation system that has no peer; and the treatment and rehabilitation of wounded warriors that is allowing ever greater numbers of our severely wounded to return to their units, or to pursue careers in the civilian sector.

These accomplishments bear repeating. I do this not simply to honor the men and women who made them happen, but also to point out that the actions and lessons that led to these outcomes are now being replicated in trauma centers, surgical suites, and rehabilitation centers around the country and around the world. The MHS is transferring our medical knowledge gained from battlefield medicine to the rest of society.

As we share our experiences with our colleagues in American medicine, we are also mindful of the need to look internally and assess what lessons we have learned – and consider how we should be organized to meet our future missions. In June 2011, the Deputy Secretary of Defense established an internal task force to study this issue. We have now also shared the task force report and the Deputy Secretary's planned reorganization with the Congress, consistent with Section 716 of the National Defense Authorization Act for fiscal year (FY) 2012. The plan we developed increases unity of effort, agility, and the opportunity for cost savings both through reduced overhead and, more importantly, through the implementation of common clinical and business practices across the enterprise. Our ability to implement this model will enhance virtually all of the programmatic issues we discuss in the MHS today.

The Department has proposed a $32.5 billion Defense Health Program (DHP) appropriation (Figure 1), reflecting a small increase from the FY2012 enacted budget.

Figure 1: FY2013 Defense Health Program (DHP) Summary

$ in Millions

Appropriation Summary	FY 2011[/1] Actual	Price Growth	Program Growth	FY 2012[/2] Enacted	Price Growth	Program Growth	FY 2013[/3] Estimate
Operation & Maintenance	29,953.5	721.7	-89.0	30,586.2	859.6	-96.6	31,349.3
RDT&E	1,205.8	22.9	38.1	1,266.8	22.8	-616.6	673.0
Procurement	546.7	12.4	73.4	632.5	14.2	-140.2	506.5
Total, DHP	**31,706.0**	**757.0**	**22.5**	**32,485.5**	**896.4**	**-853.4**	**32,528.7**
MERHCF Receipts[/4]	8,600.0			9,470.6			9,727.1
Total Health Care Costs	**40,306.0**			**41,956.1**			**42,255.8**
					Numbers may not add due to rounding		

[1] FY 2011 actuals include Operation and Maintenance (O&M) funding of $1,394.0M and Research and Development funding of $24.0M from the FY 2011 Overseas Contingency Operations (OCO), Title IX, Public Law 112-10.

[2] FY 2012 enacted (base), excludes O&M funding of $1,215.3M of OCO.
[3] FY 2013 estimate excludes O&M funding of $993.9M for OCO. The Department of Defense projects $135.6M O&M funding should transfer in FY 2012, and $139.2 million in FY 2013 to the Joint Department of Defense – Department of Veterans Affairs Medical Facility Demonstration Fund established by section 1704 of Public Law 111-84 (National Defense Authorization Act for Fiscal Year 2011).
[4] Reflects Departmental DoD Medicare-Eligible Retiree Health Care Fund (MERHCF) for FY 2011, FY 2012, and FY 2013 (O&M

Our proposal includes realistic cost growth for pharmacy, TRICARE contracts and other services provided both in our medical treatment facilities (MTFs) and care purchased from the private sector; as well as sustained investment in medical research and development.

I will outline the major elements of our strategy for 2013, using the Quadruple Aim -- the MHS strategic framework -- to discuss our initiatives. This framework captures the core mission requirements of the MHS: Assure Readiness; Improve Population Health; Enhance the Patient Experience of Care; and Responsibly Manage the Cost of Care.

Assuring Readiness

The MHS continues to closely monitor 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.

We have ensured that our medical forces are also ready through sustained investments in our enlisted and officer training programs, through our comprehensive Graduate Medical Education (GME) programs conducted at a number of our MTF training platforms throughout the MHS and with select civilian partners; at the Medical Education and Training Center

(METC) in San Antonio, Texas, in our military medical school, the Uniformed Services University of the Health Sciences.

We also assess the health of the force upon their return from deployment. 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. These person-to-person assessments are conducted by licensed mental health professionals or by designated individuals trained and certified to perform the assessments.

As part of our monitoring of the medical readiness of the force, we also assess our performance in ensuring that those service members who are identified as needing behavioral health services receive a referral and seek treatment. In this area, we have also witnessed improvement each year in both the referral for behavioral health services, and the rate at which service members seek ongoing treatment.

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 percent of Marines who agreed that seeking mental health care would harm their career dropped by more than fifty percent. Responses by the Marines on whether seeking mental

health care would cause members of their unit to have less confidence in them, cause unit leaders to treat them differently, cause unit leaders to blame them for the problem, or cause the Marine to be seen as weak, also saw similar statistically significant decreases.

Together with the Department of Veterans Affairs (VA), we have developed an integrated Mental Health Strategy that has 28 discrete strategic actions designed to strengthen access to clinical services, improve continuity of care across the Departments, streamline the adoption and implementation of evidence-based practices and ensure our mental health providers are delivering state-of-the-art care.

We have increased the number of behavioral health care providers over the past 3 years and embedded more in front line units. Along with providing care, we have undertaken the largest study of mental health risk and resilience ever conducted among military personnel. This study will identify risk and protective factors as well as moderators of suicide-related behaviors by 2014.

The Department continues to improve access to behavioral health services through a number of initiatives. In FY12, we have begun the process of embedding, over a four-year period, over 400 behavioral health providers into our patient-centered medical homes. We enhanced confidential, non-medical counseling through the Military Family Life Consultants (MFLC) and Military OneSource (MOS) programs, to include surge support – for both deployment/reintegration points in time, as well as other crises that emerge on a short-notice basis, such as the Ft Hood shooting and the Japanese earthquake/tsunami/nuclear incident.

Recent legislation now permits mobile VA Readjustment Counseling Services to provide outreach and readjustment counseling to active duty service members.

We have also made efforts to ensure continuity of behavioral health care for members in transition – to a new installation, from active to reserve status, or to the VA. We offer a diverse set of services to reach those military members seeking greater support. One notable program -- "*inTransition*" – was developed in response to the Mental Health Task Force recommendation to "maintain continuity of care across transitions for service members and veterans," and offers a voluntary telephonic coaching program designed to facilitate a smooth transition to a new source of care. *Afterdeployment.org* is another program, serving over 5,000 users monthly, that provides service members and their families with behavioral health information in a setting that preserves anonymity, and offers tools to help them recognize problematic behavioral health issues early and how to address these challenges. Recently, the VA has been using the site's interactive workshops in their walk-in clinics.

Just as the Department has established a comprehensive approach to its mental health destigmatization efforts, we have employed the same model for our suicide prevention programs. The Deputy Assistant Secretary of Defense for Readiness is standing up the Defense Suicide Prevention Office that will be staffed and resourced to develop, implement, integrate, and evaluate suicide prevention policies, procedures, and surveillance activities across the Department. This action specifically addresses a key recommendation contained in the DoD Task Force Report on Suicide Prevention and will greatly facilitate the timely implementation of additional recommendations contained in the report.

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 by providing clear and specific guidelines for the management of acute concussions. The Department's focus on TBI treatment has resulted in the standardization of 62 TBI programs at military treatment facilities (MTFs) in the non-deployed setting and the cultivation of 11 concussion restoration/care centers in the deployed setting. We have also helped update the behavioral health curriculum for all medical technicians and corpsmen at our Medical Education and Training Center (METC) to ensure our knowledge base is advanced throughout the MHS.

Our FY13 program sustains the significant investments we have made in all of our medical research and development programs, and in particular in the area of TBI and Post-Traumatic Stress (PTS). The Center for Neuroscience and Regenerative Medicine (CNRM) is a collaborative intramural federal program that bridges DoD and the National Institutes of Health (NIH) in order to catalyze innovative approaches to TBI research, and emphasizes research that is relevant to military populations. Our other focus areas for the Defense Medical Research and Development Program 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.

Within the readiness area, the health of our service members is also protected through sound occupational health practices. This past fall, the Institute of Medicine (IOM) concluded its independent study of the long-term health consequences of exposure to burn pits in Iraq and Afghanistan. The IOM was unable to identify any long-term health risks from these exposures. Nonetheless, DoD and the VA are continuing to monitor of the health of deployed Service members and veterans and provide for a longer period of post-exposure health assessments to ensure these initial findings are sustained over time.

Finally, at the core of our medical readiness posture is our people. Our recruitment of medical professionals – physicians, dentists, nurses, ancillary professionals and administrators – remains high. With the support of Congress, through the use of flexible bonuses and special salary rates, we have been able to meet most of our recruiting goals. Yet we recognize that competition for medical professionals will grow in the coming years, amidst a growing shortage of primary care providers and nurses. We will continue to work with Congress on potential new flexibilities to ensure we remain competitive in this environment.

Improving Population Health

Closely linked with our readiness mission are our efforts to improve the health of the entire MHS population. We are going to engage in a multi-year effort on two of the greatest contributors to ill health --- tobacco use and obesity in our population.

Our service members use tobacco and tobacco products at a much higher rate than their peers; we have started to reduce tobacco use, but we plan to do more. In addition to the existing suite of smoking cessation pharmaceuticals available at MTFs, and counseling services, we will soon offer the pharmaceutical benefit through our mail order program, and allow for a 24/7 smoking cessation line with counseling services over the phone.

In the area of obesity and overweight persons, in some circumstances we reflect what is occurring within the larger society. Our active-duty service members – as you would expect –do well in maintaining their weight and their fitness, and exceptionally well when compared to their peers. However, the influence of nutritional habits in the larger society is having effects on the military population and particularly on entry-level candidates. When those in uniform leave active service, too many reverse the physical fitness habits and discipline of military service. There is a financial cost to this; one DoD study found that $1.4 billion could be attributed to overweight and obesity-related medical problems and services. But, more importantly, the quality of life for our overweight and obese beneficiary population is often far worse than it should be as many are affected by obesity-related disease, such as diabetes and heart disease.

We have worked across the Services to develop and launch both adult and childhood obesity management and prevention guidelines, emphasizing the provider's role and positive steps to take in assisting and advising patients. We have also implemented a demonstration project to determine whether monetary incentives can be used to improve the overall health and wellness of the MHS population. We do not yet have the results of this demonstration project, but will report interim findings to the Congress this year. Finally, we have joined with a broader

set of partners in DoD, that includes bringing together everyone on a military installation – commanders, senior enlisted advisors, the military family program leaders and medical personnel – in a set of initiatives aimed at further improving the fitness of our entire community. Our military dining halls, schools and child development centers are offering healthier food choices – both here and in Afghanistan; our commissaries and exchanges will help identify better nutritional choices; and we're redesigning our military communities in ways that will increase exercise and fitness.

Enhancing the Patient Experience of Care

As the MHS moves into 2012, we will re-evaluate our efforts and mission through the lens of enhancing the patient experience of care by focusing on maximizing the value we provide to our beneficiaries.

The MHS is continuing the implementation of the Patient-Centered Medical Home (PCMH), a program with the principle focus of developing a cohesive relationship between the patient and the provider team. The PCMH is a transformative effort within our system, with the potential to positively affect all aspects of our strategic focus – readiness, population health, patient experience and per member cost. Begun in 2009 as a strategic initiative, the MHS has formalized through directive and accreditation our PCMH program. In 2011, 44 of our facilities were formally recognized by the National Committee on Quality Assurance (NCQA), with 93 percent recognized as Level 3 PCMHs (as compared to a private sector rate of 60 percent with Level 3 recognition). Our more mature PCMHs – at facilities throughout the Army, Navy and

Air Force, and representing more than 25% of our medical homes -- are achieving the outcomes we sought: improved access to care (increased percentage of the enrolled population getting an acute appointment within 24 hours, and a routine appointment in 72 hours); improved continuity with the same team of providers (increased percentage receiving care from their assigned primary care manager); and reduced emergency room utilization. In FY12, we will further augment our medical homes with a 24/7 nurse advice line to offer both enrollees (and all beneficiaries) access to essential health information. This nurse advice line will be linked with MTF appointing to further improve access to care, and reduce bureaucratic hurdles for our patients.

The Department has long been a national leader in developing and deploying a global, electronic health record (EHR). Our first EHR was put into the field in the late 1980s. We are now on the cusp of developing our third generation EHR – and the first to be co-developed with the Department of Veterans Affairs – the integrated Electronic Health Record (iEHR). Both DoD and the VA are encouraged by the progress that our interagency teams have made in refining or developing the IPO charter, and the principles, strategies and architectural framework for the iEHR as we embark upon this landmark effort.

The DoD/VA Interagency Program Office has been rechartered to give them more responsibility and authority as the program execution office for the iEHR. In addition, the VA has signed an agreement with the Defense Information Systems Agency to move the data centers for two of VA’s regions into DoD data centers. Most recently, this week we announced the selection for the Director of the Interagency Program Office.

As we expand the amount of health care information that we collect and share, we remain vigilant about the security of this sensitive health information. In the last year, a DoD contractor responsible for the maintenance of aspects of our electronic health record experienced a serious security breach in which 4.9 million medical records were potentially compromised. In the wake of that incident, we have conducted a critical review of the contractor's performance, as well as a review of our existing policies and procedures, and we have strengthened our guidance and future contract requirements for a number of security and encryption standards.

Our work with the VA on the iEHR is only one element of a comprehensive strategy to further partner with the Department of Veterans Affairs. We have successful joint ventures or fully integrated operations at ten locations in the United States, and, in addition, we are pursuing other opportunities for joint purchasing, shared education and training opportunities, and joint construction, where feasible.

The Military Construction (MILCON) program continues to recapitalize our inventory of MTFs. Our current investment program was substantially increased five years ago and has been essential in facilitating the BRAC transition and continued improvement of our MTFs. Both the Walter Reed National Military Medical Center in Bethesda, Maryland and the Fort Belvoir Community Hospital in Fort Belvoir, Virginia have opened their doors, showcasing the investments made, using evidence-based design standards. Construction and renovation of medical facilities in San Antonio is also complete. Along with other military medical facility projects in the U.S. over the last seven years, with the support of Congress we have just

completed one of the most transformative periods in the history of our military medicine infrastructure.

As budgets and force structure are reduced in the Department, we recognize that there is a need to reassess the size and scope of major construction projects, as we are currently doing with the Landstuhl Regional Medical Center in Germany. We will, however, sustain our commitment to the operational mission, patient-centered design and clinical quality, even if sizing issues are reconsidered. The recapitalization of military medical facilities is essential to our efforts to recapture health care that has migrated to the civilian sector.

Responsibly Managing Cost

We are proud of our achievements in combat and peacetime medicine. We offer a superb benefit to our 9.7 million beneficiaries, no matter where they live, through our direct health care system and through our managed care support contracts. This health care benefit is justifiably one of the finest and most generous in the county and is an appropriate benefit for those who serve our country. However, the costs of providing this care continue to increase more rapidly than overall inflation. For a number of years, and through several Administrations, there have been continuous, incremental steps taken to reduce the rate of growth in the costs of healthcare.

In addition, the requirements of the Budget Control Act of 2011 compelled the Department to identify $487 billion in budget reductions over the next ten years. The process of identifying these budget cuts was developed by the senior civilian, military officer and enlisted

leadership from throughout the Department. Difficult choices were made. Over ninety percent of the cost reductions were external to personnel compensation and benefits. Still, health care was not exempt from this process. The proposals being put forward in this budget appropriately balance the need for a superb benefit that assists with both recruitment and retention of an all-volunteer force with our need to sustain a cost-effective approach for the long-term.

This Administration is pursuing a four-pronged approach by which all stakeholders share responsibility for improving the health of our population and the financial stability of the system of care.

Our four approaches – moving from a system of healthcare to one of health; continuing to improve our internal efficiencies; implementing provider payment reform; and rebalancing cost-sharing – are further described below. In some instances, they reflect efforts already underway, or new initiatives that the Department is implementing within existing legislative and regulatory authorities.

Moving from Healthcare to Health

The Department of Defense's military medical leaders are leading a strategic effort to move our system to one that promotes and sustains the optimal health of those we serve, while providing world class healthcare when and where it is needed.

Central to this effort are the Department's investments in initiatives that keep our people well; that promote healthy lifestyles; and that reduce inappropriate emergency room visits and unnecessary hospitalizations. These initiatives have been addressed in earlier parts of my testimony and include the Patient-Centered Medical Home (PCMH) initiative; the embedding of behavioral health staff within these medical homes; the introduction of a 24/7 nurse advice line; and our many population health initiatives. We have also taken a number of steps to support preventive services. Our TRICARE beneficiaries – whether enrolled to TRICARE Prime or in TRICARE Standard – have no co-payments for recommended preventive services, such as influenza immunizations.

The "Healthcare to Health" element of our strategy will not produce immediate cost savings. Nonetheless, based on knowledge of well-constructed wellness programs in the private sector, we are confident that these, and other ongoing enhancements to the TRICARE program, will produce improvements to health that also "bend the cost curve." In the longer term, it is the strategy most likely to produce the greatest amount of savings to our system.

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.

I have also previously noted the proposed reorganization of the MHS, following the work of the Task Force on Military Health System (MHS) Governance, which evaluated options for the long-term governance of the MHS as a whole; governance in those areas where more than one Service operates medical treatment facilities – referred to as multi-Service markets, and governance for the National Capital Region (NCR).

Implementation of any organizational efficiencies resulting from this Task Force has been placed on hold at the direction of Congress, subject to a review by Congress and by the Comptroller General. We have provided Congressional Committees with the information requested regarding the Task Force work. The initial cost and savings estimates were necessarily preliminary, given the short duration of the task force. We will develop more detailed cost and savings estimates for any eventual governance model. The Deputy Secretary of Defense has also provided the planned "way ahead" for the governance of the MHS following congressional and GAO review. We believe that further integration of health services across the Services and with the TMA are needed in order to provide a continued high quality of care in an environment of diminishing resources while ensuring the preservation of the health benefit for future generations.

Provider Payment Reform

We are committed to identifying greater efficiencies and cost savings in all areas of our operations. In addition to internal efficiencies, we are also seeing significant savings through a number of provider payment reforms that we have introduced in the last several years. These

include the implementation of the outpatient prospective payment system; the policy changes we made for reimbursement to select hospitals and health plans in the TRICARE network; and further use of federal ceiling prices for acquisition of pharmaceuticals.

The Department has undertaken a broad-based, multi-year effort to ensure all aspects of our provider payments for care purchased from the civilian sector are aligned with best practices in Medicare and in private sector health plans. The most notable efforts have included implementation of changes to the outpatient prospective payment system (OPPS) and reform of payment to Sole Community Hospitals.

OPPS is modeled after the payment process that Medicare uses for similar health care services – setting a fixed fee per procedure, inclusive of provider and institutional charges for care. In order to allow medical facilities to transition to this new method of payment, TRICARE phased in the reimbursement levels over four years, with the full implementation of this policy set to occur in 2013. In FY 2012, we project $840 million in savings, and $5.5 billion over the fiscal years 2012-2017.

Our provider payment reform for Sole Community Hospitals (SCH) was also phased-in over time, and will provide a projected $31 million in savings in the first year, and will grow to about $100 million in savings through 2017.

In the area of purchasing prescription drugs, in 2009 we instituted a process for obtaining discounts on drugs distributed through retail network pharmacies, pursuant to authority provided

in the 2008 National Defense Authorization Act. Known as Federal Ceiling Prices (FCP), prescriptions purchased under FCP are at least 24 percent less than non-Federal Average Manufacturer prices. In 2012, the FCP program will save the Department over $1.6 billion, and will grow to over $2 billion in savings by 2017.

Beneficiary Cost-Shares

In addition to the focus on internal and external efficiencies, our proposed budget introduces changes to the health care out-of-pocket costs for our beneficiaries.

I want to make three critical points related to these proposals. First, even accounting for these proposed fee changes, the TRICARE benefit will remain one of the finest and most generous health benefits available in the country, with among the lowest beneficiary out-of-pocket costs available to anyone – and certainly lower than costs by other federal government employees. We believe that is appropriate and properly recognizes the special sacrifices of our men and women in uniform, past and present.

Second, as mentioned earlier in my testimony, these proposals were developed within the Department, and represent the input and consensus of our uniformed leadership, both officer and enlisted.

Third, we recognize that some beneficiary groups should be insulated from increases in out-of-pocket costs. We propose to exempt those service members, and their families, who were

medically retired from military service, as well as the families of service members who died on active duty. We also propose to establish cost-sharing tiers, with lower increases for retirees based on their military retirement pay. More junior enlisted retirees, for example, will experience the lowest dollar increases in out-of-pocket costs. Finally, we have also avoided any changes in cost-sharing for active duty families with the exception of prescription drug co-payments obtained outside of our MTFs. Prescription drugs distributed within MTFs will continue to be free of charge for all beneficiaries.

For over fifteen years, the Department had not increased patient out-of-pocket costs for any beneficiary. In fact, the TRICARE benefit was enhanced in many ways, and a number of out-of-pocket costs were decreased. A few of these enhancements include: active duty family members enrolled in TRICARE Prime had their co-pays eliminated; retirees and their families using TRICARE Prime had their catastrophic cap reduced from $7,500 to $3,000 per year; Medicare-eligible retirees and their families received TRICARE For Life coverage, and a TRICARE pharmacy benefit. Last year, we introduced very modest changes in one segment of our population – increasing TRICARE Prime enrollment fees for retiree families by $5/month, and indexed these fees so that future increases continue to be modest and beneficiaries can plan for them. We greatly appreciate the Congress' support for these proposals in the FY2012 budget, and have implemented those fee changes in the current year.

Although last year's changes were a necessary step, the Department has proposed further cost reduction efforts in 2013 as an element of our strategy to meet the requirements of the 2011 Budget Control Act. All of these 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. Retirees in TRICARE Prime, TRICARE Standard and TRICARE For Life each have a share of the increases; all beneficiaries (except uniformed personnel) have additional costs for prescription drugs outside of MTFs.

The following sections provide a high-level overview of the proposed changes in beneficiary out-of-pocket costs. Figure 2 summarizes the proposed fees:

- Fee increases for TRICARE programs. The following proposed changes represent increases from existing patient out-of-pocket costs.
    - TRICARE Prime Enrollment Fees. We propose to raise the enrollment fees in 2013 for retired service members and their families from between $80 – $300 per year, based on the retirement pay of the service member, and continue to provide similar increases through 2016.
    - TRICARE Deductibles. We propose to increase deductibles for the TRICARE Standard program for retired service members and their families beginning in FY13. TRICARE deductibles have not been changed since before the TRICARE program was introduced, having last been adjusted over 20 years ago.
    - TRICARE Pharmacy Co-Pays. We propose to increase pharmacy copayments for generic, brand name and non-formulary prescriptions in both the retail and mail order settings, although we will continue to offer significant incentives for beneficiaries to elect mail order over retail pharmacy networks. Additionally, non-formulary prescription drugs will no longer be available in the retail network.

These changes are proposed for all non-active duty beneficiaries, to include active duty family members. Prescription drugs obtained in military hospitals and clinics will continue to be provided without co-pay for any beneficiaries.

- New fees for TRICARE programs. Our proposed budget also calls for the introduction of new fees not previously part of the TRICARE program.
    - TRICARE Standard/Extra Enrollment Fee. We propose to introduce an annual enrollment fee in TRICARE Standard for retired service members and their families. The proposed fee for 2013 will be $70/ year for an individual retired beneficiary, or $140 per retired family.
    - TRICARE For Life (TFL) Enrollment Fee. When TFL was introduced in 2002, there was no enrollment fee in the program, only a requirement that beneficiaries be enrolled in Medicare Part B to enjoy their TFL benefit. Medicare Part B was always a step that we recommended our retirees elect, and prior to 2002, over 95% of eligible military retirees were enrolled in Medicare Part B. The TFL benefit has reduced beneficiary out-of-pocket costs by thousands of dollars per year in co-payments or Medicare supplemental health insurance plan payments. The proposed TFL enrollment fees, similar to the TRICARE Prime enrollment fees, are tiered, based on an individual's retirement pay – and range from $35 to $115 per beneficiary per year in FY2013.
    - Exclusion of Enrollment Fees from the Catastrophic Cap. We propose that enrollment fees, which had previously accumulated toward a retiree's catastrophic cap limit, will not be counted toward the cap beginning in 2013.

- In addition to the indexing of the TRICARE Prime enrollment fee, which is already indexed, we propose to index other beneficiary out-of-pocket costs identified in this set of proposals, to include the TRICARE Standard deductible, TRICARE Standard enrollment fee, TRICARE For Life enrollment fees, pharmacy co-payments, and catastrophic caps.

Figure 2. Summary of TRICARE Proposals

- **TRICARE Prime for Working Age Retirees (under Age 65)**
- As part of the FY 2013 President's Budget, the Department will seek additional increases in the **TRICARE Prime** (Health Maintenance Organization (HMO) type plan) enrollment fees in order to bring the beneficiary cost share closer to the original levels mandated by Congress when the program was established. These increases will be phased-in over a 4-year period and will be tiered based on the amount of the beneficiary's military retirement pay.

- Table 1 displays the proposed fees by fiscal year for the three tiers of retired pay. After FY 2016, the enrollment fees will be indexed to increases in National Health Expenditures (NHE). The retired pay tiers will also be indexed to ensure beneficiaries are not pushed into a higher tier as a result of annual cost-of-living (COLA) increases. The construct and tiering are generally based on recommendations of the 2007 *Task Force on the Future of Military Health Care*.

Table 1 – TRICARE Prime Annual Family Enrollment Fees (Individual Fees = 50%)

Retired Pay	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016*	FY 2017
Tier 1: $0 – $22,589	$460/$520	$600	$680	$760	$850	$893
Tier 2: $22,590 – $45,178	$460/$520	$720	$920	$1,185	$1,450	$1,523
Tier 3: $45,179 & above	$460/$520	$820	$1,120	$1,535	$1,950	$2,048

- * Indexed to medical inflation (National Health Expenditures) after FY 2016

- **TRICARE Standard and Extra for Working Age Retirees (under Age 65)**
- The **TRICARE Standard and Extra** (fee-for-service type) benefit programs currently have no enrollment fees and modest annual deductibles of $150 per individual and $300 per family. For FY 2013, the Department proposal will seek to implement an annual enrollment fee and increase deductibles. These increases displayed in Table 2 will be phased-in over a 5 year period and will then be indexed to increases in NHE.

Table 2 – TRICARE Standard/Extra Fees/Deductibles

Annual Enrollment Fees	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017*
Individual	$0	$70	$85	$100	$115	$130
Family	$0	$140	$170	$200	$230	$250
Annual Deductibles						
Individual	$150	$160	$200	$230	$260	$290
Family	$300	$320	$400	$460	$520	$580

- * Indexed to medical inflation (National Health Expenditures) after FY 2017

- **TRICARE-for-Life Benefit (TFL) Benefit Program for Retirees age 65 and Older**
- Like almost all Americans, upon reaching age 65, TRICARE beneficiaries must enroll in Medicare and begin paying Medicare Part B (outpatient care coverage) premiums. With Part B coverage, Medicare typically covers only 80 percent of eligible health care services and some people choose to be covered by "Medigap" or other private insurance policies to lower cost-sharing and receive additional coverage. Enacted in 2001, the TFL program acts as a second payer plan for

TRICARE beneficiaries covering the costs not paid by Medicare. While the average "Medigap" plan with comparable coverage carried premiums $2,100 per individual in 2009, there are currently no annual fees for TFL coverage. As part of the FY 2013, President's Budget, the Department is proposing to implement modest annual fees for TFL coverage. These fees will be phased in over a 4-year period and use the same tiering based on the beneficiary's retired pay along with the same indexing and exemptions as the proposed TRICARE Prime fees. Table 3 displays the proposed TFL fees by fiscal year for the three tiers of retired pay.

Table 3 – TRICARE-for-Life Annual Enrollment Fees – Per Individual

Retired Pay	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016*	FY 2017
Tier 1: $0 – $22,589	$0	$35	$75	$115	$150	$158
Tier 2: $22,590 – $45,178	$0	$75	$150	$225	$300	$317
Tier 3: $45,179 & above	$0	$115	$225	$335	$450	$475

- * Indexed to medical inflation (National Health Expenditures) after FY 2016

- **Pharmacy Co-Pays**
- This proposal will adjust pharmacy co-pay structure for retirees and active duty family members to incentivize the use of mail order and generic drugs. Prescriptions will continue to be filled at no cost to beneficiaries at Military Treatment Facilities (MTFs). No fees would continue to apply to prescriptions for active duty service members.

- Table 4 displays the proposed co-pays for prescriptions filled through the TRICARE retail and mail order pharmacy programs.

Table 4 – Pharmacy Co-Pays

Retail – 1 month fill	FY 2012	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Generic	$5	$5	$6	$7	$8	$9
Brand	$12	$26	$28	$30	$32	$34
Non-Formulary*	$25	N/A	N/A	N/A	N/A	N/A
Mail-Order – 3 month fill						
Generic	$0	$0	$0	$0	$0	$9
Brand	$9	$26	$28	$30	$32	$34
Non-Formulary*	$25	$51	$54	$58	$62	$66
Military Treatment Facilities	No Change – Still $0 Co-Pay					

- * Non-Formulary pharmaceuticals will have limited availability in retail pharmacies
- **Catastrophic Cap**
- In order to maintain the adjusted beneficiary cost share, the annual catastrophic cap $3,000 per family will also be indexed to NHE and exclude enrollment fees.

- Finally, to protect the most vulnerable, these proposals exempt survivors of members who die on active duty and medically retired and their family members from these increases. However, it should be noted that even once the proposal is fully implemented, the TRICARE Prime program remains a very generous benefit with the average beneficiary cost share well below the original 27 percent of health care costs when the program was fully implemented in 1996.

These proposed changes continue to be modest by historic standards of cost-sharing in the TRICARE program. In 1996, when TRICARE was implemented, a working age retiree's family of three contributed approximately 27% towards the total cost of their care; today that

percentage has dropped to just over 10 percent. Even with these proposed changes, the percentage would still remain below the percentage originally set by Congress, averaging approximately 14% of range of overall health care costs in 2017 – and stabilizing at that level for the out-years.

These adjustments are an important step to setting the TRICARE benefit on a more sustainable path that maintains the quality of the medical benefit for future generations. Moreover, the overwhelming majority of these adjustments will be phased in over a four to ten year period and will be appropriately indexed to ensure future sustainability and guarantee transparency. These proposals – one element of a four-pronged effort at cost control – will help shift us toward more effective and cost-efficient processes that will allow us to provide better care while meeting our obligations to help reduce our budgets.

We are cognizant of the strains placed on our economy and the government by federal budget deficits and long-term debt. We recognize that the Department of Defense must shoulder its share of responsibility and that we must tighten our belts just as so many Americans have been forced to do in recent years. We have not taken any proposed change lightly. The health benefit exemplifies the Department's gratitude to veterans for their service and acts as an integral part of recruiting, retaining, and maintaining a healthy force. We worked to ensure that cost changes would be minimized and that any reforms would not degrade the quality of the benefit. We are confident that this is the case.

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.