Prepared Statement

of

The Honorable Jonathan Woodson, M.D.,
Assistant Secretary of Defense (Health Affairs)

VADM Raquel C. Bono
Director, Defense Health Agency

BEFORE THE

SENATE ARMED SERVICES COMMITTEE
SUBCOMMITTEE ON PERSONNEL

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Chairman Graham, Ranking Member Gillibrand and members of the Committee, I am pleased to discuss the Department of Defense's multi-year plan for modernizing military medicine in service to the 9.4 million Americans who rely on DoD for the delivery and coordination of healthcare around the world. I am honored to have Vice Admiral Raquel Bono, Director of the Defense Health Agency (DHA), join me in presenting this plan. And, I am proud to have the Surgeons General of the Army, Navy, and Air Force also accompany us at today's hearing and speak to the Service-specific issues for which they are responsible.

I want to thank the leadership of the Committee for placing military health care reform high on the agenda for action this year. There are a number of interconnected features of the Military Health System (MHS) that influence how we are organized, how we deliver and coordinate care, and how we interact with the broader American health system.

Over the last two and half years, the MHS has fully embraced an enterprise management approach to our work. Together with the Service Medical Departments and the Defense Health Agency, we have crafted strategies, policies, enterprise support activities, and leadership development programs that benefit the system as a whole. Our approaches to access, quality and safety are executed in a collaborative, interdependent manner. Operationally, where we work together in deployed environments or in multi-service markets, we increasingly ensure there is an integrated operating model that facilitates support to line commanders, to service members and to our patients.

For our beneficiaries, we recognize TRICARE is an essential and valued piece of that health system. Both military medicine and the US health system are in a period of profound change driven by new discoveries, technological advances, and integrated delivery models aimed at increasing quality and controlling costs. Our proposals for modernization include both

operational actions that we are undertaking right now, as well as legislative proposals that we have included in the President's budget.

TRICARE is essential to recruiting and retention and is an integral part of our overarching strategy for the MHS – the Quadruple Aim: Ensure Readiness, Improve Health, Improve Healthcare, and Lower Cost.

As we institutionalize the lessons learned from fourteen years of conflict, and as we implement a series of actions emerging from the Secretary's Review of the MHS, we must modernize our TRICARE program to better align with how medicine is delivered in 2016, and how patients expect to receive timely and high quality care.

DoD is taking a new approach to our reform efforts in 2016 and 2017. We are focused on defining value from the perspective of the patient. Emerging from the internal MHS Review, we have invested a great deal of time in understanding and evaluating our performance in access to care, clinical quality, and efficiency from our perspective as provider, insurer, and employer. In 2016, we are looking at healthcare delivery through the patient's lens, and developing systems and processes that are responsive to their needs.

Our starting point in our modernization plan is the recognition that TRICARE is a good health benefit that supports an exceptional group of Americans. Recent testimony by beneficiary organizations to Congress reinforced the view that TRICARE is one of the most comprehensive health benefits offered by any employer in the United States. While valuing the TRICARE benefit, beneficiaries voiced to Congress and to DoD that they particularly want to see improvements in access to care. We have heard their concerns – and our reform strategy upholds the sacred promise we make to those who serve their country and to their families.

Congress and DoD have expanded eligibility, benefits and services under TRICARE over the 22 years it has been in existence. The most notable expansions include: TRICARE For Life – extending TRICARE benefits as second payer to Medicare for dual-eligible beneficiaries, TRICARE Prime Remote – offering Prime-like benefits to active duty families when they are stationed far from military installations; and TRICARE Reserve Select – offering certain Reservists with the opportunity to enroll in TRICARE with a modest premium payment.

We have tied our MHS modernization plan to our overarching strategic plan. Our MHS strategy continues to use the Quadruple Aim as our north star – Improved Readiness, Better Health, Better Care, Lower Cost. This is the framework I will use to describe the actions underway and those we have proposed.

The Military Health System: Readiness at the Center of our Strategy

Over the last decade, the MHS performed superbly in providing combat casualty care and life-saving treatment, achieving historic outcomes in saving lives and preventing injuries and illnesses. Lessons from fourteen years of battlefield medicine, along with transformative changes in the practice of medicine in the United States, require new approaches to how we ensure medical readiness and how we best meet the expectations of our beneficiaries. We are continuously reevaluating and improving our approach to maintaining the health of the force, sustaining a ready medical force, and delivering quality healthcare to our beneficiaries –on the battlefield, on military installations, or in civilian healthcare settings

The MHS is unique in our national health system. DoD operates a global system of hospitals, clinics, and health team – both fixed and deployable – to meet the health needs of our military force, and to maintain the ability of ***our MSH to meet the readiness needs of the***

force as we continue to assess reform strategies to improve this primary mission.

When we say "readiness" is at the center of our strategy – we mean: the medical readiness of individual service members, the readiness of medical forces – and the need to build and sustain the clinical skills of the entire medical team so they are best prepared for whatever mission they are called to perform. Readiness also ***refers to family readiness***. The health and wellness of our military families affects service member readiness in direct and indirect ways. In 2016, we look at readiness from this broader perspective -- with consideration for the family members' viewpoint of whether our health system supports their own health goals.

TRICARE directly supports this readiness mission. In 2015, the Military Compensation and Retirement Modernization Commission (MCRMC) acknowledged the important role that MTFs have in sustaining the readiness of our medical forces. We have accepted a number of recommendations from the MCRMC and have launched a process to identify the essential medical capabilities needed to support the full spectrum of military operations.

One of the most important actions that we undertook during the Iraq and Afghanistan conflicts was the establishment of the Joint Trauma System (JTS). This system contributed significantly to the MHS' ability to produce historic survivability rates for those wounded in action, and accelerated our ability to continuously improve combat casualty care research, training and practice. JTS will be embedded as an enterprise-wide system that provides essential support to our combatant commanders around the world.

Of course, not all MTFs include the full spectrum of medical or surgical capabilities. This requires that we augment MTF-provided care by purchasing health services from civilian healthcare networks managed though the TRICARE program.

In 2016, we plan to expand choices for our beneficiaries – allowing them the opportunity to more freely seek care from either military or civilian providers. There are a number of ways by which we can expand our service offerings. For example, retirees who are Medicare eligible can receive care in MTFs. Caring for these types of patients helps ensure military medical provider readiness. Likewise, resource sharing agreements with the Department of Veterans Affairs allow Veterans to receive care within MTFs, giving our military medical providers exposure to a more complex set of patient health needs. Other unique arrangements, such as civilian access to our Level I Trauma System and burn center at San Antonio Military Medical Center, ensure that our providers remain current with best practices in trauma and burn care – important skills to maintain for military operations. In other external resource sharing arrangements, military providers obtain admitting privileges at nearby civilian institutions, where they can provide a wider range of care for our beneficiaries, also allowing for clinical skills maintenance.

Although the MHS is an indispensable element of national security, the TRICARE feature of beneficiary choice also includes the choice of beneficiaries to receive all of their care from civilian providers. In some circumstances, this choice is driven by necessity – where beneficiaries reside in areas not near a military installation. In other circumstances, beneficiaries simply elect to receive civilian care even when military medical facilities are nearby. Some military retirees use other systems of care beyond TRICARE: the health care afforded to Veterans through the VA, the health insurance product provided through their employer, or the Medicare program. For those beneficiaries who elect to receive all of their care from civilian sources, whether by choice or circumstance, we are interested in exploring ways to direct beneficiaries to accessible, high quality providers.

The MHS is a complex web of relationships that extend beyond DoD to include other federal health partners as well as the civilian community. This integrated system of care requires relentless attention to the development of leaders with skills to operate in the joint environment. We recently reviewed our leadership development programs and identified the need to better integrate and sequence these programs. I have directed our leadership team to put together a revised curriculum for leadership development in the joint environment that focuses on the development of management skills that further ensure readiness, improve health, access, and quality and responsibly manage cost.

MHS Modernization: Better Health

MHS modernization recognizes that our health system can be made even better; and that the delivery of accessible, high quality care, matched with exceptional customer service, is part of our mission, not secondary to it.

Our multi-year modernization plan offers a significant advancement in how the MHS will be a leader in healthcare delivery and customer service in the country. Our modernization plan raises customer service performance levels; improves health; further expands choice; simplifies the process of getting care and offers additional new ways to access care; ensures access to the latest healthy technology; helps direct patients to the highest quality of care; and continues to offer value at an out-of-pocket cost to our people that is lower than virtually any health plan in the country.

DoD has already begun its multi-year modernization of the TRICARE program. First, we will continue our efforts to prioritize health ahead of healthcare.

TRICARE has always had excellent coverage of important preventive services – and we're making it better. Most of our preventive services are available without any cost share. For example, any beneficiary (Prime / Extra / Standard / TRICARE For Life) can get required immunizations from any provider, to include retail clinics. We are going to expand the ease and coverage of even more services in the coming year, and ensure our preventive services plan is fully aligned with the Affordable Care Act provisions.

TRICARE Modernization: Better Care

There are a number of components of health care delivery that are focused on better care. Access, quality and safety are among the predominant components in which we will dedicate our energy and resources in the coming year.

Access – Easier, Patient-Centered. We are overhauling every aspect of our how our patients get care – whether primary or specialty care.

Our patients deserve high quality care delivered safely and expeditiously. Yet, we frequently hear about problems accessing health care within the MHS. In our internal review, we heard that patients are concerned about being told to call back for an appointment, and dissatisfied with delays in getting care because of a cumbersome pre-authorization and referral system.

During the MHS Review, we found that MTFs generally meet defined access to care standards on average. However, there was a great deal of variation – there were MTFs that did not meet these standards and others who consistently performed better than the standard. In 2015, we incorporated two measures of access into an enterprise-wide, "Partnership for

Improvement" dashboard, which is reviewed monthly by me and the other MHS leaders present today.

The same access standards apply to both MTF provided care and TRICARE Prime care delivered in the private sector. Assessment of purchased private sector primary care access is largely determined from patient experience surveys. According to survey data, individuals who use TRICARE Standard or Extra are more satisfied with the care provided when compared to those who use TRICARE Prime. In 2016, we will be exploring beneficiary concerns more deeply by engaging focus groups on specific subjects.

Recent Congressional testimony from beneficiary groups suggests that the lower satisfaction with TRICARE Prime is related to the inability to get an appointment at an MTF and to the associated referral and authorization processes. NDAA 2016 called for improving access in the following ways: 1) make it easier for beneficiaries to move among the identified TRICARE managed care support contract regions; 2) allow TRICARE Prime *beneficiaries access to urgent care centers without a preauthorization* requirement under a pilot project; and 3) expand the public transparency of quality, safety and satisfaction information.

We have taken a number of steps to improve access to care. We implemented "first call resolution" policies ensuring that the appointment or referral will be completed during the initial call for beneficiaries enrolled to our patient-centered medical homes. I issued initial guidance for simplified appointing and first call resolution on June 2, 2015. We have already begun to see the positive effect of these changes from the patients' perspective. Performance monitoring will ensure compliance and survey data is letting us know if our beneficiaries are satisfied with the results.

We are not simply monitoring our performance from this one action. We have put a number of policy and operational actions into motion already this year,

The Services and DHA undertook a listening tour to MTFs and with beneficiaries around the country. We learned a great deal from these visits. The Services and DHA have identified that peak hours of physician supply do not always match patient demand. In response, we are extending hours to evenings and *weekends in a number* of our MTFs. We have increased the number of urgent appointment by 32% since May 2015, and we have expanded the overall number of appointments by more than 11%.

Part of our enterprise approach is to effectively use the demonstration authority that Congress has provided us and pilot new approaches to patient care delivery. We recognize that patients, particularly those with complex or chronic medical conditions, require ongoing services from a mix of primary care and specialty providers. I am directing demonstration projects in which we evaluate the use of "integrated practice units (IPUs)" into our medical homes. The most important feature of the IPU is that it organizes medical services around the patient's needs and medical condition rather than organizing medical services from the health system's perspective.

Contemporary access to healthcare is no longer confined to the four walls of a doctor's office or dictated by drive time standards. Instead, information technology offers a variety of opportunities for patients to engage the medical system. Providers can extend their reach to treat or advise their patients beyond the clinic's open hours or without requiring distant travel. Furthermore, many of these modalities offer new opportunities to support the warfighter wherever they are deployed. In January 2016, I expanded our policies to encourage greater use of

telehealth, and permit its connection to the patient's home. The new policy will enhance our abilities to provide telemedicine services and expand access for our beneficiaries.

In 2014, we established a Nurse Advice Line (NAL) for all of our beneficiaries. This new capability now fields 1,800 calls per day (significantly higher than we projected, and higher than most commercial health plans). Call volumes are increasing each month. Many patients, after engaging with the NAL, do not subsequently seek emergency care, but wait to be seen at their Primary Care Medical Home at the MTF. For those whose symptoms suggest a true emergency, the NAL activates the emergency medical system and stays on the phone until help arrives. Additionally, the 24/7 NAL is integrated with our appointing and referral systems, ensuring beneficiary have round-the-clock access to healthcare advice and appointing services. We plan to expand the services offered by the NAL in the next year to increase convenient access.

The TRICARE program has leveraged web-based technologies to provide beneficiaries with information, secure ways to enroll for health care services, review claims, pay bills, and even make appointments. Patients can communicate with their providers using secure messaging services and download their medical records using Blue Button technology. We are ensuring that all primary care providers and most specialists use and promote the secure messaging capability with their patients. The new electronic medical record will add even more functionality for patients.

In 2016, the MHS will begin to deploy smart phone applications that will make it easy for our patients to contact their providers, access all of the TRICARE Online capabilities, and find useful information about the nearest MTF. We will also launch new telehealth capabilities that will allow providers to consult with their patients using video technology, along with capabilities

for providers to securely monitor their patients' health remotely (e.g. blood pressure monitoring or other biometric data).

DoD will also implement a pilot program that allows enrollees to access urgent care centers without requiring a preauthorization, consistent with NDAA 2016. I am confident that these additional means of access – both virtual and physical – will have a significant, positive affect on satisfaction with accessibility and customer service among our Prime population.

For patients who receive referrals from their primary care providers, we are also streamlining referral processes so that patients will be advised of referral approval in a more timely way.

We are also proposing to allow beneficiaries who live more than one hour away from an MTF to enroll for care at those facilities. While we believe that patients should live in close proximity to their primary care provider, we also believe that patients should be able to choose their provider, even if the provider is more than an hour's drive away. However, we will retain contract provisions that require the civilian network to be constructed in such a way as to ensure easy geographical access, to the extent possible, for our beneficiaries, using existing drive time standards.

In our FY17 proposed budget, we introduce a new approach to the DoD health benefit that further simplifies the program for beneficiaries. Patients would be able to choose between a managed benefit that prioritizes care in the MTFs (and continues to offer MTF care at no cost to beneficiaries), and an unmanaged option that sustains the freedom of choice for beneficiaries to seek civilian care without restriction.

Our initiatives are intended to ensure retention of our existing enrollees as well as increase use of military treatment facilities for all beneficiaries. Our customer service

enhancements are intended to encourage our beneficiaries who live near a military hospital or clinic to come back to the MTF.

Finally, in 2016, we will also award the TRICARE-2017 (T-2017) contracts, with healthcare delivery slated to begin in 2017, allowing for a 12-month transition period between contractors. T-2017 is another element in our efforts to simply program management, reduce administrative costs, incentivize value and ensure quality with our network providers. We have also streamlined processes for portability, helping ease beneficiary transition as they move from installation to installation. We will reduce TRICARE regions from three to two, eliminating unnecessary administrative overhead for both the government and contractors.

Quality of Care. The MHS is *proud of the quality of care we deliver*. The MHS Review found that the MHS performed well along the quality and safety parameters studied. However, similar to our findings on access, we found wide variation across MTFs and across safety and quality measures. Like health systems everywhere, we know we can improve further. And we will.

We have implemented a number of important measures to achieve that objective. In 2015, we standardized quality and safety measures across the enterprise and can now compare performance across all MTFs. We are now amending our TRICARE contracts to establish similar reporting for private sector care. Senior leaders monitor performance on a monthly basis.

MTF commanders are being provided with tools to both educate their staffs and monitor their performance. We are expanding participation in the American College of Surgeons (ACS) National Surgical Quality Improvement Program (NSQIP) to all MTFs with surgical capabilities. This partnership provides these MTFs with insights into improving surgical mortality and morbidity. In the coming months, we will provide the Institute for Healthcare Improvement's

(IHI) Global Trigger Tool (GTT) to all MTFs to proactively assist in identifying potential safety concerns.

When serious chronic illness, medical conditions, special needs or injuries require a comprehensive coordination of care across multiple providers, beneficiaries will be assured of a personal case manager who will assist with coordinating care wherever it is provided – with other military hospitals, in the civilian sector, or with the VA.

The Department is going to adopt or introduce value-based payment demonstration projects in 2016. In 2015, we opened discussions with the Centers for Medicare and Medicaid Services (CMS) to explore how we can participate in several of the innovative payment reform initiatives that CMS has introduced over the past several years. By aligning efforts with other federal initiatives focused on value-based payment, we can leverage the extensive research that led to these demonstrations. And, the complex rules related to payment formulas have been incorporated into contractor-operated, federal claims processing systems. Several of the bundled payment demonstration projects – such as the recent CMS demonstration around bundled payments for joint replacements -- hold the most promise for the populations that we serve. We will provide the Committee with regular updates on our progress in this area.

Comprehensive information on service delivery – access, quality, safety and satisfaction – is available online to the public for the military health system as a whole with some limited information visible at the MTF level. Additional information will soon be available at the MTF, consistent with the direction from the Secretary of Defense and the NDAA 2016. We have engaged and will continue to engage our military and veteran beneficiary organizations in how we might present this information in ways that make the information more relevant and easier to understand. And, we encourage our patients to ask us questions about our quality and safety

record, and to engage in questions about their own plan for health. And, the DHA is working with CMS to place MHS performance information on Hospital Compare to provide another outlet where our performance information will be publicly shared. We are incorporating beneficiaries into our quality management activities.

The MHS has identified six communities where there is a significant military medical presence by more than one Service Medical Department. We refer to these communities as "multi-service markets." Collectively, over 40% of all care we deliver in DoD medical facilities occurs in these markets and an equally significant amount of care is purchased from the private sector in these markets. We have provided senior medical leaders in these markets with enhanced authorities to coordinate service delivery; standardize appointing and referral policies; and reallocate local resources to best meet beneficiary needs. We have achieved some early successes in these markets relative to access to care and patient satisfaction.

These multi-service markets are major deployment platforms, and we similarly plan to use them as platforms for innovation. They reach across Service-specific populations and the lessons we learn from innovating in these markets can be more rapidly shared across the enterprise.

Health Benefits and Technological Advances – Leaning Forward. Healthcare is changing fast. And, with the generous support of Congress, TRICARE has been made more flexible and more adaptive to the changes in technology to advance health. DoD now has greater authorities to approve emerging technologies for coverage. We have already started this process – for laboratory-developed tests and for other promising medical procedures. Where the medical evidence is present, we will look to do more.

We are ensuring that TRICARE's mental health and substance use disorder benefit meets current standards of care and – like our preventive services benefits -- align with the Affordable Care Act, Mental Health Parity Act and other federal health legislation. We have already eliminated the limit on inpatient behavioral health bed days, and we will finalize policies to ensure parity in other areas in 2016.

One of the most important advances we will introduce in 2016 is the first phase of deployment of our new Electronic Health Record (EHR) in the Pacific Northwest. This multi-billion acquisition represents a major milestone for the Department. Our decision to purchase a commercial, off-the-shelf product provides DoD with a system that will support our journey to high reliability, allow ongoing private sector innovation to be incorporated into future releases, and support our interoperability objectives in sharing information with both the VA and with private sector providers. The EHR will also feature an advanced patient portal, providing our patients with easier access to their own health data – and improve their ability to manage their care.

Support for Children with Special Needs. Over the last several years, we have modernized TRICARE and the Extended Care Health Options (ECHO) program, expanding services to retiree families and eliminating financial caps on services. We are continuing to improve our complex case management services, with a particular focus on the unique needs of military families and frequent relocations.

TRICARE for Reservists. Issues regarding continuity of care, and continuity of coverage, for Reserve Component families have been raised by both the Reserve community and in the Military Compensation and Retirement Modernization Commission report in 2015. Although the TRICARE Reserve Select program has been well received and offers an excellent

health benefit, the Department continues to explore opportunities that can accommodate those Reserve members and families who would prefer to retain their existing provider relationships.

TRICARE Support. In October 2015, the DHA reached Full Operating Capability. The TRICARE Health Plan is one of the principal enterprise support activities – or shared services – for which the DHA is responsible. Working closely with the Service Medical Departments, we are better able to coordinate policy and operational decisions in support of TRICARE changes in a more agile and transparent manner. Our other enterprise support activities – pharmacy operations, health information technology, medical logistics, health facilities, public health, medical research and development, medical education and training, contracting, and budget & resource management – also provide essential support services to both combatant commanders and the Services.

I would like to highlight just one element of how this enterprise support better enabled critical support in a crisis. In 2015, the MHS witnessed an alarming escalation in prescription drug costs, largely related to increased utilization of compound medications. The DHA monitoring system identified potential fraudulent activity; recommended and concurrently implemented a series of enterprise-wide screening procedures in our military pharmacies, mail order and retail network that precipitously and safely reduced inappropriate fills of compound drug prescriptions; and coordinated with the Department of Justice in the prosecution of fraudulent actors and the recovery of funds.

Cost -- Responsible, Moderate Changes in Beneficiary Cost-Sharing. The full complement of improvements and services that we have put forward also requires investment. Most of these additional costs will be borne by the Department. For example, the implementation

of shared services led the Department to reduce defense health costs by $3.5 billion over five years, savings that have already been decremented from our proposed budget.

Since TRICARE and then TRICARE For Life were introduced, the percentage of care delivered in the private sector rather than in DoD medical facilities has grown. Today, over 60% of all DoD-funded health care is delivered in civilian settings through TRICARE. The integration of care delivered in military and civilian settings is – and will remain -- a necessary feature of military medicine. We will continue to assess our partnership with our civilian network and the impact of its prominence upon our direct care facilities, recognizing cost efficiencies where possible. Over the last several years, overall defense health program costs have been well managed, with actual costs coming in less than projected at the beginning of the year.

Although costs have stabilized in recent years through both management actions on the part of the Department and a general slowdown in US healthcare inflation, National Health Expenditure projections, a product of the Centers for Medicare and Medicaid Services, anticipate a gradual increase in per capita health care costs to roughly 5 percent in coming years.

The Department has submitted several reform plans since 2005, largely to control health care costs. Last year, the submission of the President's Budget (PB) 2016 benefit reform proposal was relatively well received. The PB 2017 health benefit reform proposal leverages the PB 2016 proposal but makes some important adjustments. Following are the attributes of the PB 2017 proposal.

- A simpler system — provides beneficiaries with two care alternatives and overall less complexity in their health plan. TRICARE Select is an HMO-like (managed) option that is MTF-centric and TRICARE Choice is a PPO-like (unmanaged) option offering greater

choice at a modestly higher cost.

- Economically emphasizes TRICARE Select leveraging MTFs as the lowest cost option for care to make full use of Direct Care capacity and also provides needed workload for military providers for readiness training.
- No change for active duty — who would maintain priority access to health care without any cost sharing but would still require authorization for civilian care.
- Copays — will depend on beneficiary category (excluding active duty) and care venue; it is designed to minimize overutilization of costly care venues. There would be no copays in MTFs to facilitate the effective use of military clinics and hospitals and thereby improve the efficiency of DoD's fixed facility cost structure. There would be fixed network copays for the TRICARE Choice option without a deductible.
- Participation fee — for retirees (not medically retired), their families, and survivors of retirees (except survivors of those who died on active duty). They would pay an annual participation fee or forfeit coverage for the plan year. There is no participation fee for active duty members or their family members. There is a higher participation fee for those retirees choosing the TRICARE Choice option ($200 higher).
- Open season enrollment — similar to most commercial plans, participants must enroll for a 1-year period of coverage or lose the opportunity.
- Catastrophic caps — which have not gone up in 10 years would increase slightly but still remain sufficiently low to protect beneficiaries from financial hardship. The participation fee would no longer count towards the cap.
- Medically retired members and their families and survivors of those who died on active duty would be treated the same as Active Duty family members (ADFMs), with no

participation fee and lower cost shares.

- To ensure equity among ADFMs, the proposal offers all ADFMs a no cost medical/surgical care option regardless of assignment location and zero copays for ADFM emergency room use, including in the network.
- The Department will offer a second payer option with a lower fee for those with other health insurance.
- Fees and copays will be indexed at the National Health Expenditures (NHE) per capita.

There have been no changes to most cost-sharing elements of the TRICARE Program since it was established in 1994. At the time TRICARE was introduced, retiree family beneficiary out-of-pocket payments accounted for approximately 27% of total TRICARE health care costs. Today, retirees and their families only bear 8% of the costs, and our proposal raises that share to 10.5% of total costs. For active duty families, the changes are even smaller, moving out-of-pocket costs from 1.4% of total costs to 1.6%. By any measure, these changes are modest, responsible adjustments that place the Department's health program on a stable, long-term financial footing and preserve the foundation of the health system and its platforms for ensuring a medically ready and ready medical force.

We enter 2016 confident that an excellent health benefit can be further strengthened through a combination of legislative, policy, and operational reforms. Our health benefit plays an important role in readiness as well as recruiting and retaining the men and women in uniform who serve this nation.

The MHS continues to *serve as a unique and indispensable national security asset. It supports our active duty force and it retains its clinical skills through an active clinical practice in both peace and war*. It offers a ready asset to respond to humanitarian assistance needs and

disaster response. The full complement of preventive, public health, primary care, specialty and specialty care services that we offer are necessary components for meeting the national security obligations of the United States.

Our *health benefit must continue* to ensure a ready medical force of military providers and support staff able to deploy anywhere, anytime with skills that support combatant commander requirements; provide access, choice and value of the health care benefit, and be fiscally sustainable for the Department.

The MHS reforms we have outlined today will help us meet the appropriately high expectations that beneficiaries have for us. Service members, military retirees and their families are right to expect affordable, accessible quality health care is available to them from both military or civilian providers, wherever they reside. We are committed to increasing value from their vantage point.

Our proposal represents a balanced, comprehensive package of reforms that are directly aligned with and address each element of our Quadruple Aim. We have initiatives that will improve readiness, improve health, improve care, and lower cost. We look forward to working with you over the coming months to further refine and articulate our objectives in a manner that improves value for everyone – our warfighters, our combatant commanders, our patients, our medical force, and the American taxpayer.

Thank you for inviting the Surgeons General, Admiral Bono and me here today to speak with you about the essential linkage between our readiness mission and our health benefit, and about our plans to further improve benefits and services for the long term.