[H.A.S.C. No. 110–16]

# HEARING

ON

# NATIONAL DEFENSE AUTHORIZATION ACT FOR FISCAL YEAR 2008

AND

# OVERSIGHT OF PREVIOUSLY AUTHORIZED PROGRAMS

BEFORE THE

## COMMITTEE ON ARMED SERVICES
## HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

FIRST SESSION

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MILITARY PERSONNEL SUBCOMMITTEE HEARING

ON

# MILITARY HEALTH-CARE BUDGET AND THE CHALLENGES FACING THE MILITARY HEALTH-CARE SYSTEM

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HEARING HELD
FEBRUARY 13, 2007

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# CONTENTS

## CHRONOLOGICAL LIST OF HEARINGS

2007


Page

HEARING:

Tuesday, February 13, 2007, Fiscal Year 2008 National Defense Authorization Act—Military Health-Care Budget and the Challenges Facing the Military Health-Care System ..... 1

APPENDIX:

Tuesday, February 13, 2007 ..... 33


**TUESDAY, FEBRUARY 13, 2007**

**FISCAL YEAR 2008 NATIONAL DEFENSE AUTHORIZATION ACT—MILITARY HEALTH-CARE BUDGET AND THE CHALLENGES FACING THE MILITARY HEALTH-CARE SYSTEM**

STATEMENTS PRESENTED BY MEMBERS OF CONGRESS


McHugh, Hon. John M., a Representative from New York, Ranking Member, Military Personnel Subcommittee ..... 1

Snyder, Hon. Vic, a Representative from Arkansas, Chairman, Military Personnel Subcommittee ..... 1


WITNESSES


Winkenwerder, Hon. William, Jr., MD, MBA, Assistant Secretary of Defense for Health Affairs, Department of Defense ..... 2


APPENDIX


PREPARED STATEMENTS:

McHugh, Hon. John M. ..... 39

Snyder, Hon. Vic ..... 37

Winkenwerder, Dr. William, Jr. ..... 42

DOCUMENTS SUBMITTED FOR THE RECORD:

[There were no Documents submitted.]

QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD:

Mrs. Drake ..... 67

Mr. McHugh ..... 66

Dr. Snyder ..... 59

# FISCAL YEAR 2008 NATIONAL DEFENSE AUTHORIZATION ACT—MILITARY HEALTH-CARE BUDGET AND THE CHALLENGES FACING THE MILITARY HEALTH-CARE SYSTEM

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HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
MILITARY PERSONNEL SUBCOMMITTEE,
*Washington, DC, Tuesday, February 13, 2007.*

The subcommittee met, pursuant to call, at 2:04 p.m., in room 2212, Rayburn House Office Building, Hon. Vic Snyder (chairman of the subcommittee) presiding.

## OPENING STATEMENT OF HON. VIC SNYDER, A REPRESENTATIVE FROM ARKANSAS, CHAIRMAN, MILITARY PERSONNEL SUBCOMMITTEE

Dr. SNYDER. The committee will come to order.

We are pleased today to have as our guest Dr. Winkenwerder, who is—we are all familiar with him and he is familiar with us after almost six years of time in this position.

We certainly appreciate your service, Dr. Winkenwerder.

I just want to be real brief and not read a formal opening statement before I yield to Mr. McHugh, but the issues that we continue to address as a committee and as a Congress and as the American people is how do we maintain the quality of care for our men and women in uniform and their families and retirees and how we pay for it.

And we are looking for your guidance and advice and thoughts on that, Dr. Winkenwerder, and I look forward to your testimony and the questions and answers we have.

As I mentioned before, we have three members of this committee that have never served on the Armed Services Committee before and are new to this Congress, and we have some veterans, but we all benefit from as complete an explanation as you want to give as to any of the issues coming forth.

And, with that, I will yield to Mr. McHugh.

[The prepared statement Dr. Snyder can be found in the Appendix on page 37.]

## STATEMENT OF HON. JOHN M. MCHUGH, A REPRESENTATIVE FROM NEW YORK, RANKING MEMBER, MILITARY PERSONNEL SUBCOMMITTEE

Mr. MCHUGH. Thank you, Mr. Chairman.

Doctor, welcome. I echo the chairman's comments and deeply appreciate, as well, your leadership over the years. It is always a

pleasure to have you with us. And, as Chairman Snyder said, we look forward to your comments.

I, too, will ask for unanimous consent to have my statement placed in the record.

Dr. SNYDER. Without objection.

Mr. MCHUGH. But I have just a couple of comments.

Obviously, as the chairman and I have discussed, there is, as there was last year, some considerable imputed savings and components of this budget proposal placed in predicated upon congressional action, about $2.1 billion, which also has to do with expected so-called savings and other kinds of fiscal advances by the upcoming Task Force on Military Health Care that is looking at these kinds of issues.

That was a proposal that was not well-received last year—is that a fair way to say that? I think it is—in the Congress, and that is a lot of money. And we would like to hear from you, of course, as to how you came to that point again. I am kind of troubled by it.

Also, with about $157 million, I believe the figure is, in requested increases to fund a continuation of the military to civilian transformation, about 2,700 positions—we have gone through a big chunk of that, over 5,500. We have to begin to become somewhat concerned that we are not reaching too far on that. So I look forward to your comments on that, as well.

But, beyond that, as the chairman said, we look forward to your comments.

And with that, Mr. Chairman, I yield back to you.

[The prepared statement of Mr. McHugh can be found in the Appendix on page 39.]

Dr. SNYDER. Thank you, Mr. McHugh.

One little bookkeeping—no, "bookkeeping" is not the word—etiquette thing. We had a question last time about how members are recognized for questions. And traditionally on this committee, you know, comes down the gavel, we go back and forth by party. But then from there on, it is whoever shows up in the order in which they come in, regardless of party affiliation—has been the way this committee has conducted its business.

And that is the way we will do it, if that is all right with Mr. McHugh.

Mr. MCHUGH. Absolutely. It is tradition.

Dr. SNYDER. Dr. Winkenwerder, take as much time as you need.

## STATEMENT OF HON. WILLIAM WINKENWERDER, JR., MD, MBA, ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE

Dr. WINKENWERDER. Thank you. And I can hear that my microphone is on, so, Mr. Chairman, thank you, and thank you to all the members of this committee for the opportunity to discuss the nation's military health system now and in the future.

And thank you for your tremendous support and steady support over the years that I have been in the fortunate position to be able to lead this system and to serve all the great Americans that we serve.

Today, we serve and protect more than 2.2 million service members in the active, reserve and national guard components, including more than 250,000 who are deployed overseas.

America's military health system is unquestionably the finest in the world. Our medical professionals have performed superbly on the battlefield. I want to just recount a few facts for you in that regard.

We have the lowest death-to-wounded ratio and the lowest disease-and-non-battle-injury rate witnessed in the history of warfare. Once we put that dedicated, trained, professional on the scene, a remarkable 97 percent to 98 percent survive.

Also, remarkably, among the approximate, at this point in time, 23,000, give or take, service members in Iraq to date who have been wounded, over 70 percent have returned to duty within 72 hours—that is, within three days.

My priority remains to provide life-enhancing, life-sustaining care to America's service men and women, both deployed and here at home, and to simultaneously sustain the high-quality health-care system that we offer to more than nine million Americans.

Today, what I would like to do is briefly touch on three items of concern to me and our leadership: first, our fiscal year 2008 budget and critical near-term financial issues; second, the long-term plans to strengthen our health system; and third, our efforts to provide an even more integrated joint health-care delivery system.

With our fiscal 2008 health-care budget estimate of about $40 billion, we have submitted legislation, as you know, to assist in bringing our rapidly growing costs under better control. It is best to view this proposal as a placeholder. It reflects the magnitude of the department's growing health-care problem.

We believe that the members of the recently established Task Force on the Future of Military Health Care should have a completely free hand in making their recommendations that address the sustainability of military health care and the TRICARE benefit. The thinking of these military and civilian experts brings, in our view, a welcome and fresh perspective to the potential solutions for our cost-growth issues.

As they have begun their work, the task force members now realize that the majority of Department of Defense (DOD) health spending is for retirees and their family members, who make up more than half of our eligible beneficiary population. By 2011, retiree health spending will dominate DOD health spending, with 65 percent of all dollars going for retirees.

We need help in addressing this problem and help in educating our beneficiaries and advocacy groups with a fresh and welcome look.

You, America's representatives, have heard these numbers before, but let me restate them. Left unchanged, our program will cost taxpayers $64 billion by 2015. Health-care costs will continue to consume a growing slice of the department's budget, reaching 12 percent of the DOD budget, versus 6 percent in 2001.

Without relief, spending for health care will, in my judgment, divert critical funds needed for war-fighters, their readiness and for critical equipment.

I hope you are as eager as I am to see how the experts of the task force, with their original and their earnest views on the issue, how they assess our situation and what they will recommend. Again, we are very open to whatever it is that they recommend and trust the good judgment that they are bringing to the task.

In the meantime, we are doing everything we can to control our cost growth. We are also executing our new TRICARE regional contracts more efficiently, saving dollars, and we are demanding greater efficiency within our own military medical facilities.

However, there is one area, pharmacy, that is particularly noteworthy. Nearly 6.7 million beneficiaries use our pharmacy benefit, and in fiscal 2006, our total pharmacy cost was more than $6 billion for that year alone. If we did nothing to control our pharmacy cost growth, we project pharmacy costs alone would reach $15 billion by 2015.

We are taking every action for which we have authority: promoting our mandatory generic substitution policy, joint contracting with the Veterans Administration, launching a mail-order promotion campaign, and making voluntary agreements with pharmaceutical manufacturers to lower the cost.

These efforts are working, but recent legislation passed by Congress and other regulations limit our ability to control costs in the fastest area of pharmacy, and that is the retail sector. In retail, products cost us 50 percent more than the same drugs dispensed through our military treatment facility or through mail-order. That is 50 percent more.

You can help us, we believe, by allowing the department to make appropriate changes in the structure of our pharmacy benefit. These changes will clearly accelerate use of our new mail-order and, we are calling it, our home-delivery pharmacy program, enhance the use of generics, and it will also give us greater leverage when negotiating with the pharmaceutical manufacturers.

Another area on which I want to update you is our effort to better integrate our health-care delivery system. Our line leaders, the Joint Chiefs of Staff and our customers world-wide expect that we will operate in a more joint manner throughout the world.

We are doing that in combat theaters today, and we are doing it in the seamless transfer of our wounded or ill service members from the jointly staffed medical center in Landstuhl, Germany. You have heard about these efforts.

We are now preparing to bring the advantages of joint operations to our medical facilities in the United States.

Based on the decisions made by the previous Congress to accept the Base Realignment and Closure Commission recommendations, the BRAC recommendations, we are moving forward with the consolidation of medical facilities here in the national capital area and in San Antonio. We are also consolidating operations in medical research and development and in education and training.

The medical infrastructure we are creating will better serve our beneficiaries through improved access to care, by locating primary care services closer to our patient population, through enhanced graduate medical education, through joint military medical enlistee training, and through the creation of, in our judgment, the world's

best military medical facility, the new Walter Reed National Military Medical Center on the Bethesda campus.

I remain deeply honored to work with the military medical officers, civilians and enlisted personnel and our support contractors, who provide exceptionally high-quality medical care to our service members while our nation is at war.

We are giving our best effort to care for both the physical and the mental wounds that war produces. And we are succeeding in saving lives while helping many of our wounded warriors to be able to continue their careers in the military and continuing on active duty.

I look forward to building upon many successes, to creating an even better, more efficient health-care system for the future.

I know that you, Mr. Chairman, and other members of this committee have a similar vision. Working together with us and carefully considering the recommendations of the task force, I believe we can make military medicine stronger than ever for our deserving beneficiaries.

And let me say this: Decisions we must make may not always be easy or politically expedient. But they will be the right decisions if they create the solid fiscal foundation for the future that will allow our great and talented professionals to continue providing world-class care for today's and tomorrow's protectors of America.

Thank you again, Mr. Chairman and members of this committee, for your support for the men and women in uniform and for our military health system. We look forward to working with you in the coming year, and I look forward to answering your questions today. Thank you.

[The prepared statement of Dr. Winkenwerder can be found in the Appendix on page 42.]

Dr. SNYDER. Thank you, Dr. Winkenwerder, for your statement.

Debra is going to put the five-minute clock on me, and then we will go to Mr. McHugh for as much time as he will take, and then we will go around. And almost for sure, we will come back around.

We don't have any more votes today, Dr. Winkenwerder, so we may have you until the thaw, until the spring thaw. [Laughter.]

Dr. Winkenwerder, you have been outspoken in your views about how we need to pay for this. And you have run into both the realities of how we pay for the system but also perhaps the political realities of grappling with those issues. And you talked about it again today, both in your written and your oral statement.

Last year when we had this discussion, you gave us a fair amount of written materials in terms of numbers and charts and graphs, and you haven't done that this year. And are you planning to provide us with that kind of numbers analysis so we know where you are at?

I mean, part of what you gave us, you know, last year and what your charts showed last year were that, for military care and direct care, the number was very reasonable, in terms of being not quite a flat line but almost a flat line.

Are you planning to provide us additional information on the status of your budget so that we might analyze that?

Dr. WINKENWERDER. Yes, we would be glad to provide any information that would be helpful to you.

Let me just say, in terms of what we are terming the "placeholder legislative proposal," to us it is not so important as to what the specifics of the solution or solutions are as it is the decision, and decisions, to move forward to make some necessary changes.

And we did not believe that it would be appropriate to come forward with a detailed, either, continuation of last year's proposal or a modification of that, because we felt that that would be, in fact, directing the task force to one solution or another.

And so, candidly, we just didn't want to try to say, "Here is the solution," or there it is——

[The information referred to can be found in the Appendix beginning on page 59.]

Dr. SNYDER. No, I understand.

Dr. WINKENWERDER [continuing]. And so we have been rather generic.

Dr. SNYDER. I understand. What I am——

Dr. WINKENWERDER. And that has been our approach.

Dr. SNYDER [continuing]. More concerned about is that if you can provide us with your analysis this year about where we are at.

Dr. WINKENWERDER. Yes.

Dr. SNYDER. And I understand what you are saying.

Dr. WINKENWERDER. Okay.

Dr. SNYDER. And you did that last year, but you haven't this year, and I think it is important to have that.

Dr. WINKENWERDER. We will do that.

Dr. SNYDER. The second question I want to ask you—and you have probably heard that I did this with Secretary Gates the other day. But in the President's budget, there was a reference made to the future military health-care task force.

And this is the line from the President's budget proposal: "In fiscal year 2008, this budget includes $1.862 million in proposed assumed savings, which assumes enactment of a $719 million legislative proposal and additional regulatory modification requiring further study and a recommendation be made by the Department of Defense Task Force on the Future of Military Health Care, established by Public Law 109–452, on benefit reform."

Mr. McHugh continues to ask the most insightful questions at the full committee and brought this up the other day, and I had the staff chase down this one and asked Secretary Gates about it, because there are two aspects of it.

Number one, the budget is saying flat-out a recommendation be made on a task force whose final report doesn't come out until December of this year. And some of us think that that is not very appropriate, to base a number or savings on a task force's opinions, its recommendations, that are not even expected to be out—now, they are going to do some preliminary stuff, but their final report doesn't come out until December.

Second, this statement has poisoned the water a bit for this task force. And there are folks in this community, you know, who care a great deal about military retirees and veterans and folks in the military that look on that language as a sign you have stacked the task force. And I am telling them, "Give it a chance."

And I have talked with some of the leadership of the task force who are very concerned, and I said, "Look, you just go on out there and do your business. It is not the expectation of Congress that somehow your goal is to provide a recommendation for this year. You do the work as you see it."

So would you respond to those concerns, please, about this language in the President's budget?

Dr. WINKENWERDER. Yes.

First of all, we have not, nor do we think it would make good sense, to "stack" the task force. That just is not in anybody's interest. It is a bipartisan group, for starters, and there was a special effort to ensure that. There was an effort to ensure that there was a variety of views.

I think we know, as you do, that the solution, or solutions, are ones that are going to have to result from agreement across the aisle. There is not going to be, you know, a Republican solution or a Democrat solution. It really is going to require coming together.

And so, that is the first point. And it is going to require even beyond the political spectrum to all the various different constituencies. That is the nature of our program. There are a lot of stakeholders in our program. We realize that. And so, the views and perspectives of all of those stakeholders need to be represented.

It was not our goal to poison the water in any way. I hope that is not the case. I believe it will not be the case, because we have been clear that, from the department's standpoint, we are only supporting the task force in terms of providing whatever data, whatever information, reports, studies, analysis, that they request. And that is it.

We are not, you know, behind the scenes trying to do anything other than that. I mean, the people that are on the group speak for themselves. They are strong-minded, strong-willed, very bright individuals, as you know. And I have full confidence they are going to say whatever they think.

Now, at this point, I think our task is to look at what they produce.

And to your question about the interim versus final, it is our understanding that they do intend to issue some sort of interim report in May. That would not be the final report.

But we also understand that they have prioritized the issues and that financial and funding and sustainability issues are at the top of their priority list. I understand they are probably going to take on some other things during this first three or four or six months.

But it is our hope, certainly, that they would be able to come forward with some ideas that we could talk about. And candidly, I think many of us know what the potential solution set is. The question is, can we gather around to make some decisions in a way that we can all stand behind?

Dr. SNYDER. I agree with your comment about the strong wills. They were pretty strong-willed in their expression about that language.

Dr. WINKENWERDER. Yes.

Dr. SNYDER. Mr. McHugh, for as much time as he needs.

Mr. MCHUGH. Put me on the clock, if I may, Mr. Chairman, too. If it is good enough for you, it is good enough for me, by golly.

I would say, Dr. Winkenwerder, with respect to the chairman's comments about you maybe being here to the spring thaw, you had better hope that doesn't apply to my district, because we have had 12 feet of snow in the last week. [Laughter.]

So I would take it a little bit easier on you than that.

I would like to pursue this a little bit further. I don't know if it has poisoned the well with respect to the task force, but, as I am sure you know, it has not made a number of them happy.

You have changed your testimony in the last few hours, at least as far as we know, and used an important word: "placeholder." It wasn't there originally. And that is an important change.

But despite that word change, the fact of the matter is the budget request assumes savings of $1.9 billion.

I appreciated your comments about—and there is over $240 million of other undefined initiatives, and if you want to share some information about what those might be, that would be helpful as well.

But your comments suggest that you are not just going to accept everything the task force says, I assume, number one.

And number two, what if they come back with no savings? I kind of doubt that is going to happen, but it is within their parameters. What do we do about the $1.9 billion? Do you have a backup plan to fully fund it, or do you have a cut list? That is a lot of money.

Dr. WINKENWERDER. It is. And, yes, we do have some approaches that we would and could take.

Mr. MCHUGH. Could you share those with us?

Dr. WINKENWERDER. Well, as you would guess, they are fairly dramatic in terms of their impact and what they would require. It is not our preference to move in those directions.

Our preference is to get the whole train moving forward—and the train with lots of cars being the Department of Defense, Congress, beneficiary advocacy groups, the task force—with the task force giving us, we hope, wise, informed, even-handed, prudent advice.

And I just have confidence that we will be able to stand behind and support their recommendations. And I will be very surprised if their recommendations are not recommendations that we can support.

I am confident, as well, that their recommendations are going to carry a lot of weight with all the audiences, because of the nature of the people that have been brought together. And they are not all of one mind. I am sure about that. There are a lot of different views there.

But I think whatever they come up with is something we are going to have to look at very, very carefully.

Mr. MCHUGH. Well, I agree. This is our one oversight hearing. And at the risk of sounding inhospitable, I think it is important for the committee members to hear and for the record to show if we don't come to that figure, what happens?

Dr. WINKENWERDER. The department, as it has in times past, will have to work within its own constituency to figure out how to solve these problems and issues——

Mr. MCHUGH. Will you agree it wouldn't be pretty?

Dr. WINKENWERDER. I am sorry?

Mr. MCHUGH. It would not be pretty. We are going to have to——

Dr. WINKENWERDER. It could be tough.

Mr. MCHUGH. I mean, the mathematics are pretty simple. I was not a math major, but you are either going to have to find a huge amount of cuts or some kind of rabbit out of a hat. True?

Dr. WINKENWERDER. It is going to be tough. It would be tough, there is no question. It would be very difficult.

But I will say this, and I think it is important for the committee to hear this: We looped back after last year's experience with our civilian leaders, with our military leaders—the vice chiefs, the chiefs, the vice chairmen, the chairmen—everybody. And I think what you are seeing is a statement of how convicted especially our military leaders are about this issue. And it is a statement about the degree to which they view the significance of the problem.

And that is not something I could have done, you know, on my own, or that Dr. Chu and I could have done. I mean, this had to be a department view, because people realize that it is a serious proposal that has been put forward.

Mr. MCHUGH. Absolutely. And let me just say, with the few seconds I have left, I do not mean to suggest for a moment that you, as an individual or your department in both the Pentagon and the individual services, are trying to do anything but what is absolutely right for these troops.

But I just think it is critical for all the members to understand you have the nearly $2 billion worth of—in fact, over $2 billion when you add in the other $248 million—of undefined savings. That is a huge number to come up to.

And if we don't come up to it through the task force or through something else that you or we or someone does, you are going to have to take $2 billion-plus out of the military health-care program. That is the reality. And that is a tough budget to bring to this Hill.

Dr. WINKENWERDER. You are right.

Mr. MCHUGH. Okay. Thank you, sir.

Thank you, Mr. Chairman.

Dr. SNYDER. Ms. Shea-Porter.

Ms. SHEA-PORTER. Thank you.

I have a couple of questions. I am new, and I am trying to determine the cost of soldiers in the field versus soldiers that are not being deployed, and wondered if you could first tell me that.

Dr. WINKENWERDER. If your question is about the cost of our ongoing operations in Iraq and Afghanistan——

Ms. SHEA-PORTER. Yes.

Dr. WINKENWERDER [continuing]. As a result of the global war, it is around $1 billion. It is a bit over $1 billion this year.

And let's see if I have the numbers here.

In 2007, it is $1.73 billion. That is this year. Last year was actually a bit more than that in the supplemental, $1.153 billion.

And that covers a number of things: health care for mobilized guard and reserve who have to come forward to perform duties; pre- and post-deployment health care; additional things we do for people before and after deployment; something we called medical backfill, in other words, when we deploy service medical profes-

sionals and we have to fill for them back here in the United States, typically through call-up of guard and reserve or by purchasing care in our network; other medical support; and then aeromedical evacuation.

Those are the main components, but that is roughly what the bill is in the aggregate.

Ms. SHEA-PORTER. Okay. And these are obviously huge numbers, but I wondered if you could tell me what the cost would be per soldier, the average soldier. I recognize that, you know, there are different levels of health care required, and some injuries and some not, but just in general.

Dr. WINKENWERDER. We don't actually keep track of our costs in that way. We do have a good idea, a very good idea, of what it costs per person, per month. That is typically our cost accounting structure here in the United States for an active-duty person, for a family member or for a retiree.

Of course, that amount tends to increase with age and illness and medical condition. And that number has grown. On average, in the early 2000 period it was growing in double-digit figures. More recently, it has grown at about seven percent or eight percent between last year and this year.

But that number is—I don't have it in the back of my head, but it is $200-plus per person, per month. That is roughly what it would be. It is probably somewhat less than that in theater because the folks are healthy, by and large, and therefore should be less expensive.

Ms. SHEA-PORTER. Then if we have an escalation, you would not be able to say how much more money would have to be allocated to cover the new troops.

Dr. WINKENWERDER. The additional troops that would result from any change in deployment strategy—whatever it is, I would wager an estimate that the cost of that would not be considerable, because we already have a fixed infrastructure there.

There would probably be some additional medical support that would be needed, but we already have a fixed infrastructure that has capacity.

Ms. SHEA-PORTER. I, too, am worried about this efficiency savings, et cetera. That doesn't look tangible to me right now.

I also wanted to ask you about the mental health part of your budget. I am actually quite surprised to see the number of soldiers who have already accessed health care for post-traumatic stress syndrome (PTSD). And if Vietnam is any indicator of what we can be looking at, this is a higher number that are seeking help already.

But taking this out a year, two years and five years hence, are you seeing a great surge in the cost to provide health care? That is the first question.

And the second question that I had was I have been told there are soldiers in theater who are being left behind on patrols because they have post-traumatic stress syndrome, and they are not receiving medical treatment for that. And I wanted to ask you if you could address that.

Dr. WINKENWERDER. Sure. The first part has to do with what we are seeing with respect to mental health trends and PTSD and other similar kinds of issues.

We are spending more money. Our systems and reports tell me that the number of visits on an outpatient basis, the number of hospitalizations, the amounts that we are spending on pharmaceuticals are all going up for mental health services.

Some of that is driven by the same kinds of things that are driving health-care trends upward more generally. Some is driven by the fact that we have a greater population that we are caring for today than we did in 2001 or 2002. I am comparing, let's say, 2002 versus 2006, the most recent year.

And what we find is that the rate of outpatient usage has gone up about 20 percent. The rate of inpatient usage is roughly the same. The rate of pharmaceuticals has gone up about 50 percent.

But if you look at our total expenditures and how much is going for mental health four years or five years ago versus today, it was about 8.6 percent four years or five years ago. Today it is like 9.5 percent. So it has gone up a little bit as a share of the aggregate.

And we are actively—that does not bother us. In fact, in my way of thinking, it is a good indicator because we are trying to reach out, expecting that people are going to have some mental health problems, and so we know we are actually promoting and incurring a certain higher use because of the things we are trying to do to help people. So that is a good thing, we believe.

If I might say one other thing in terms of the rates of PTSD, because there is a lot of discussion and, frankly, there are a lot of things that are said out in the public, in the airwaves and the media, that are inaccurate, at least based on all the good data that we have.

The best data are studies that have been published involving military research that have been published in the New England Journal and other very reputable medical journals that suggest that the rates are in the range of 10 percent, 12 percent among our redeployers coming home. It is not half of all the people that are coming back; it is a fraction. And those are the facts of what we are seeing.

Now, the other thing is that the way that most people respond who do have PTSD-type symptoms is they tend to have them for a period of time and, especially if they get some support and help and counseling, those symptoms resolve.

For many people, they will resolve even without that. But our effort is to identify people, to support them, to help them.

But the percentage of people who have chronic, debilitating symptoms and what you might call chronic post-traumatic stress disorder is really a pretty small number. I mean, it is in the low single digits based on the information I am familiar with.

But I believe that our goal, our objective, should be to help every single person who has—whether it is PTSD, anxiety, depression, or is having problems with relationships or substance abuse—to reach out and identify those people early and to get help for them before they do things that could be really damaging to themselves, to their loved ones or to their life in general.

Ms. SHEA-PORTER. I agree with you. I am just questioning about whether you are actually able to care for them with this budget. Thank you.

Dr. WINKENWERDER. Yes. The quick answer is yes, we have the sufficient funds and sufficient personnel to do a good job.

Dr. SNYDER. Thank you.

Mr. Wilson.

Mr. WILSON. Thank you, Mr. Chairman.

And thank you, Doctor. And I am particularly happy to be here with you in that my second son was graduated from Uniformed Services University Medical School, and you were the keynote speaker, graduation speaker. And I am very pleased that he is currently serving now in Connecticut and studying barometric medicine. So we are very proud.

I was very interested in seeing your report on partnership with the Department of Veterans Affairs (VA). And I have seen that firsthand in our state, how helpful that can be to veterans.

And can you explain how that is proceeding? And what can we do to help promote this?

Dr. WINKENWERDER. Thank you. And thank you for the service that your son is providing. It is a great thing that he is doing.

With respect to our work with the VA, in my humble judgment, I think that we have made tremendous progress working with the VA and cutting down or tearing down barriers and silos that would naturally exist with two large institutions, two large bureaucracies.

We have dedicated leadership on these issues between what we call a joint executive committee chaired by Dr. Chu on the Department of Defense side and Secretary Mansfield on the Department of Veterans Affairs side.

We have a health executive committee that I co-chair with the current acting undersecretary of the VA, Dr. Michael Kussman. We meet about every 3 months with both of these committees. We have a strategic plan. We have a series of things that we want to achieve, objectives. And we also measure, or we try to measure, what we do.

Have we been completely successful in everything we have tried to do? No. We have had failures. We have had things that we wish had, you know, worked better or more quickly. But I believe we have made a lot of progress, and let me highlight what I think the progress is.

First and foremost, I think the way in which we are communicating now for those who have serious and severe injuries, working between the DOD and the VA to transfer their care and to ensure that they get the care that they need when they move into the VA system from the DOD system—there are still some glitches, and there are still cases that come up. And when I hear about those cases, I am concerned and I wish I wouldn't hear about a case when it happens. But we try to jump on it and make the right thing happen.

In the area of information-sharing, we are really, I think, doing great things that are very difficult in terms of—because we are capturing today a lot of information on the battlefield and downrange, as we call it, electronically—medical information. We are now able to transfer a fair amount of that medical information to

the VA so that they have it within their system, so their doctors can access that information.

Clinical practice guidelines, things that we are using, the same clinical guidelines to take care of certain things like PTSD.

Sharing of facilities: A good example of that would be in the north Chicago area where we have one facility now that will be caring for both DOD beneficiaries and VA beneficiaries. And that is a model we would like to pursue and do in more places.

Rather than building a new DOD facility or a new VA facility, let's look at how we combine our efforts and work out of one facility and actually one team of people. It is a new way of doing business.

So those are a few of the things that we have done that we feel good about. But we are certainly open to ideas, suggestions and critique on the ways that we can do things better. Because it is going to be, in our judgment, an ongoing task, over who knows how long, that we are going to have to continue to work together closely.

Mr. WILSON. Well, I know, Mr. Chairman, that, seeing how successful this is for geographic access, particularly in Secretary Jones's community of Charleston that I grew up in, that has really been very, very helpful, and so veterans and active-duty can receive services without travel.

A final point: The Navy has directed cutting 901 billets in addition to the military-to-civilian conversion. How will this impact with the increase in the number of Marines that has been authorized?

Dr. WINKENWERDER. It is an issue that the Navy and the Marines will need to look at. Per the process in terms of the program of military positions being converted to civilian positions, it is a review by the service secretary at the end of everything cycle to certify that those transitions or those conversions do not cut into needed capability.

And so each service secretary, independent from my office or any office within the Office of the Secretary, makes that judgment. So I fully believe that the secretary of the Navy, in looking at what might be a growing number of Marines to care for, will incorporate that increase requirement into the current plans to convert those positions.

I wouldn't be surprised to see if the number of converted positions was reduced because of that. But that will be their decision, and we will be working with them to, you know, ensure that they conduct that analysis in an appropriate way.

Mr. WILSON. Thank you very much.

Dr. SNYDER. Ms. Sanchez.

Ms. SANCHEZ. Thank you, Mr. Chairman.

I just want to associate myself with the comments that both you and the ranking member, Ms. Shea-Porter, and I don't know if Mr. Wilson said it, but this whole issue of the $2 billion cost savings that we are going to see in this upcoming budget.

I mean, health costs, the way they are—I mean, we are lucky that you are saying that the increases are only 7 to 8 percent a year, but if we are looking at that $2 billion over—whether it is a $20 billion program or a $40 billion program, we are talking 5 percent to 10 percent, depending on how you cut it.

That is a lot of money missing that, if we take a look historically, probably should be money that should be missing at this point, the way we have seen things spent around here. So I would just like to associate myself with the concerns that we have over that.

I want to get back to this deployment post-traumatic stress disorder, because we are seeing it a lot in the soldiers who come back to California. And, as you know, it is not just in the active but in the national guard and the reservists that California has sent. We have the most members in the military coming out of California, so we have seen this quite a bit, in particular in the southern portion of our state.

It is my understanding that when a service member returns from deployment, they fill out a post-deployment health assessment, which has a four-item PTSD screening tool. And it is my understanding that if you say "yes" to three out of the four that that is considered a positive screening for that.

And in a Government Accountability Office (GAO) report from May of 2006, it reported that 22 percent of the service members who obtained a positive screening were referred for further mental health evaluation. And GAO recommended that the department identify which factors led to 22 percent of the positives being sent on to an additional screening versus 78 percent who weren't.

Can you tell us what you have determined, why 22 percent are being sent, 78 percent get to slide on this?

Dr. WINKENWERDER. Let me try to take everybody through this so that there is a clear understanding.

The first point is that checking off the boxes, three out of four, would be an indicator that that individual needs to be interviewed very carefully and needs to have a very careful discussion with a medical provider, a medical professional, to make a determination based on what they hear about those symptoms or those reports as to whether that individual, in the provider's judgment, does, in fact, have that clinical problem or is likely——

Ms. SANCHEZ. Does that happen——

Dr. WINKENWERDER. Yes. Yes. Everybody sees——

Ms. SANCHEZ. Somebody sees——

Dr. WINKENWERDER. Yes.

Ms. SANCHEZ. And in addition to that—you can answer this at this point—it says that providers are physicians, physician assistants, nurse practitioners, medical technicians with advanced training to provide treatment and administer medication.

I mean, what does "advanced training" mean? Are these really psychologists and psychiatrists looking at them? Who is looking at them if you test positively and then you go in front of somebody to have the questions so somebody can sense what is going on?

Dr. WINKENWERDER. Well, let me get to completing what I was about to say, because the GAO report, in our judgment, got it wrong in terms of drawing the proper conclusion about who got referred and what sort of follow-up happened.

What they failed to look at was the number of individuals who were referred back to their primary care physician, or who might have been referred to a chaplain, or who might have been referred to a group counseling session, or who might have been referred to

Military One Source, or who might have been referred, you know, into the TRICARE network.

Ms. SANCHEZ. So you are saying that the 22 percent didn't include any of these people?

Dr. WINKENWERDER. It did not. Their measurement did not incorporate all of that, so they pretty significantly undercounted the referrals. And that was a problem, and I am not sure they understood that completely when they did this study.

We talked to them about it. Unfortunately, when the study was published, it got leaked to the press before we had our comments to explain what had happened.

But that point aside, what we find from looking at service members again, not just when they come back on redeployment, but we have instituted a third evaluation that occurs in the three-month to six-month timeframe—we call it the post-deployment health reassessment. And it is a process that has been in place now for a couple of years, and we are catching up with a backlog from prior deployers. We have screened about 200,000 people.

What we find in that process is very interesting. We find higher rates of, actually, symptoms of physical and mental symptoms than immediately when people come back, confirming our suspicion that, many times, when people come back, they check the boxes because they want to get back to their family and they want to go on. We know that.

So this is an effort to reach out again, to really bring people in, to say, "How are you doing? How are things going with your family? Are you having physical or mental problems?" And what we find in that process is about 50 percent of people have either a physical or a mental concern.

But, like most of us, when we go to the doctor with a concern, it is most of the time not a diagnosable medical problem. And so, for example, in the area of physical health, what we find is about 53 percent express a concern about their physical health. But in terms of a provider, in this case a doctor, making a diagnosis, it is only about 10 percent. So most people need the reassurance that what they have is not, you know, a diagnosed condition. In the area of mental health, where about 34 percent had expressed a concern, only about 6 percent or 7 percent were a diagnosed condition.

Now, obviously, we are looking at all this. We are following a lot of data and a lot of trends. And there are other studies that are going on, so that we try to get it right and make sure that everybody who is seen who needs a referral gets a referral.

Everybody that goes through that process, almost one-third, about 30 percent, do get referred for either physical health follow-up or mental follow-up or some other kind of referral.

So that tells me that that is a pretty robust process. I mean, it is not as if people are just sort of cycling through and then they are being sent back to their unit. Many of them, almost one-third, are being referred on.

So we are going to continue to look at this. Many of these things we are doing for the first time. Nobody else has ever done this kind of work. And so we are learning as we go along. We think we are, you know, reaching out to most who need it.

Ms. SANCHEZ. Thank you, Mr. Chairman.

Dr. SNYDER. Ms. Drake.

Mrs. DRAKE. Thank you, Mr. Chairman.

Dr. Winkenwerder, it is nice to see you again.

Dr. WINKENWERDER. Good to see you.

Mrs. DRAKE. And it is really because of this committee that I learned about Health Net. And I know we have representatives out there today. And I want you to know they have been very helpful in the 2nd District of Virginia, working with our Portsmouth Naval Hospital, with our doctors. And they really are a resource for all of us, if you would want to follow through with that in your own districts.

I mean, they have really worked on things that—like ultrasounds for our military weren't automatically done, only if it was high-risk; other high-risk pregnancies; and just different issues we have worked on. And we have seen things working a little bit better.

It was also good to know that one of the things they are working on right now is payment to the doctors electronically, so they are paid very, very quickly, because we all know the challenges we have had of getting doctors to agree to participate in TRICARE. And it doesn't matter what your health system is if you can't get the doctors to provide the service. So I thought that was something that—I was very pleased to hear what they were doing.

We have all talked a lot about the task force. We have talked about the increase in end-strength. Can you tell me how those two mesh together? Is the task force using that increase in end-strength long-term in looking at the viability of our medical care system?

I mean, we are talking about it; you have put money in it. But is the task force also focusing on that? And how it will impact total cost?

Dr. WINKENWERDER. In my estimation, they will be looking at that. There are not a lot of data at this point that would tell us in a precise way what the additional cost burden will be because of this additional end-strength. I think we can probably impute what we think that might mean on the basis of our current experience with our current end-strength.

Mrs. DRAKE. I just want to make sure they factor it in, because when they were charged to do this, it was before the increase in end-strength——

Dr. WINKENWERDER. That is correct.

Mrs. DRAKE [continuing]. And to just make sure the information they have factors that in and that they get a good product in the end.

Dr. WINKENWERDER. That is correct.

And I think there is no question but that it will increase cost in the health-care system, because we will be supporting more active-duty and their families, and that will cost more money. I don't have a number to project.

And of course, this rolls in over a period of four years or five years, so we have to do some analysis. We have not done that yet, but we will do it.

Mrs. DRAKE. I just want to make sure they look at that——

Dr. WINKENWERDER. Yes.

Mrs. DRAKE [continuing]. Since it is not right now. It is not the present.

Dr. WINKENWERDER. Yes.

Mrs. DRAKE. The other question I have—because you did make the comment we all know what the answer is, and certainly we have struggled with this issue, and we are very concerned about the care provided to our military and our retirees and their families.

What are military members told in recent years when they sign up to join the military? Are they told, ''You are going to have affordable health care''? Are they told, ''You have health care''? What are they told, and what is their expectation?

I would just like to know that, moving forward to how do we deal with the amount of money that it takes and——

Dr. WINKENWERDER. Right.

Mrs. DRAKE [continuing]. Any proposals that you may make about prescription drugs. What are they expecting, based on what they have been told?

Dr. WINKENWERDER. I am going to be real honest. Since I don't work directly with our recruiting community, I don't know exactly what they are told.

My best guess is they are told that they would have, upon joining the military, access to an outstanding health-care benefit and health-care program, ability to see world-class doctors in world-class facilities, with essentially no cost-sharing as long as they are an active-duty service member, and for their families with, similarly, little to no cost-sharing, except that they use the TRICARE network.

And I expect that they are presented information about the TRICARE benefit. I would also expect that they would be told that, you know, if you serve 20 years, you will have access to a benefit that would be for life.

Mrs. DRAKE. I think that is important for us, in answering the question of what are we providing and how are we doing it, to know what their expectation is. And we know what our older veterans thought, that everything would be free the rest of their life. We know that is not said anymore.

But I just didn't know what is their expectation now. I mean, I would just like to get that. You can answer that later.

Dr. WINKENWERDER. It is a good question. We will get good information for you on exactly what people are being told.

But I endorse your implied message, that people ought to be told that they have a benefit and they have coverage for health care, but not necessarily that they have a free health care for a lifetime, because that is not true. That is not accurate.

[The information referred to can be found in the Appendix beginning on page 67.]

Mrs. DRAKE. Thank you.

My time is up, Mr. Chairman.

Dr. SNYDER. Dr. Winkenwerder, since on Thursday we are going to have our recruiting/retention hearing, you might want to pass on to Dr. Chu——

Dr. WINKENWERDER. We will pass that on.

Dr. SNYDER [continuing]. And the folks that Ms. Drake may have a question for them.

Dr. WINKENWERDER. We will do that.

Dr. SNYDER. Go ahead and start the clock again.

Mr. Jones has not returned?

I had several questions, not in any particular order, Dr. Winkenwerder. I want to ask you a question about autism. You all, I think, have a study going on about the services. Is that due in April?

Is that correct, Debra?

The study is due to come out from you all in April or somewhere in that timeframe?

Dr. WINKENWERDER. I think that is about right, yes.

Dr. SNYDER. Is that actively ongoing right now?

Dr. WINKENWERDER. Yes. We were directed by Congress to establish a task force, I believe, to look into the matter of applied behavioral analysis, a therapeutic approach to support children with autism.

Dr. SNYDER. And the whole issue of autism and how——

Dr. WINKENWERDER. Yes. Yes.

Dr. SNYDER. Yes, because in some ways that illustrates the challenges we have, because you want to have the best quality you can, and sometimes that means that you are going to—well, I think it does mean you all are going to be the leaders in an area.

And if you reach the conclusion—and I suspect that you probably will—that the evidence is there that that kind of therapy is effective, then that is a financial burden on the system.

Dr. WINKENWERDER. That is right.

Dr. SNYDER. And so I look forward to that, and I suspect it will be, you know, a fair-minded review of that whole issue.

And it becomes even more of an issue when we know that the diagnosis of autism continues, certainly has gone up over the last few years, and I believe a lot of our military kids are involved also.

One specific issue from your statement—I thought the satisfaction surveys that you all do seem to be good. And I asked my office, you know, how many complaints we hear about military medicine. We don't hear a whole lot in our office. And we do have both guard, reserve and an active base in my district.

But the satisfaction levels, by your own testimony, were slightly lower than civilian ones. It doesn't look to me like it is overwhelming, but I just wanted to ask, have you identified something—and maybe it is just the nature of moving around or something. What is your response to that?

Dr. WINKENWERDER. Yes. Again, that is compared to a high-level benchmark, not to an average.

Dr. SNYDER. That is good.

Dr. WINKENWERDER. And we know in the clinical areas in a number of different specialty components that our performance is very high, relative to any, you know, any civilian benchmark.

It would be my judgment that where we have satisfaction levels that are not at the top of the benchmark, what is driving that, I think it is probably mostly related to timely access and the availability to get in very quickly. Some of that is driven by people's expectations.

Interestingly, our retirees—and the older the retiree group, apparently, the more satisfied. Our retirees are the most satisfied.

Those that seem to be the least are the active-duty service members and their families, who you would think would have the most immediate access. But I think probably because of the hectic nature of their life and all their other duties and problems they, you know, are very much focused on getting in very quickly and getting out very quickly.

Now, the services and the surgeons general—you can ask them about this when they come testify—but they are working on trying to improve that access, timely access, and making it easier for people to get in and out.

Part of it is making sure that the provider's schedule is open to see patients. It is just the mechanics of getting people appointments. It is managing the staffing levels, having telephones that are always answered, all those things.

But they are applying, in some cases, really good Lean Six Sigma tools, for example, the Army is, to really hit on that very issue. And I think that is where most of it is.

People seem to give us very good ratings when it comes to the administrative part of, like, paying claims and getting claims paid, and that part seems to be working very well. But it is probably more in the access to care.

Dr. SNYDER. One of the questions that came up with Secretary Gates the other day that I wanted to ask about—and he was not aware of and was concerned about—and I will tell you exactly where it is. It is on page 53 of the analytical perspectives of the President's budget.

But it is where they compare research dollars per all the departments of government. In the Department of Defense budget, basic research had a cut of nine percent. Applied research had a cut of 18 percent.

And Secretary Gates was unaware of that and said it was something he was personally going to look at, and he related his experience as the head of a large research institute.

But that really concerns me as we are looking ahead in terms of the edge of our—you know, what is our technological edge in terms of war-fighting, and we are, you know, looking ahead a decade and two and three and four. That is really our seed corn.

I, frankly, don't know where your number is with research in your medical budget, but does that relate—are you all part of that cut, or how do you see the research number for——

Dr. WINKENWERDER. I don't know if we are part of that, so I don't have an answer for you on that. But I would share your concern about investment in research and the need to keep that number going up.

I don't know this for a fact, but I would suspect that it may be other competing priorities, bills that have to be paid, whether it is for repair of equipment and the like, or whether it is, in our case, again, paying for bills for everyday medical care in the TRICARE network and our cost-sharing structure that, you know, makes it difficult for us to increase that investment on the R&D side.

I believe we need to invest more dollars. That is critical. Where we have done that, there is no question but it is making a dif-

ference and saving lives today—the things that we have done, for example, in hemorrhage control.

We are gaining the fruit and the benefits of things that were done three, four, five, ten years ago, and then we see it, and we are able to apply it, sometimes bring forward those things very quickly.

But unless we keep the research going, we are not going to get those benefits. And so, we need to do that.

Dr. SNYDER. I shared my concern today with Mr. Spratt, the chairman of the Budget Committee, and he is concerned also.

Ms. Davis, did we ambush you?

Ms. DAVIS OF CALIFORNIA. You did ambush me, Mr. Chairman. That is all right.

I am sorry that I missed the beginning of the hearing and haven't had a chance to hear your remarks or the questions.

I think one of the things that particularly strikes me and I know that you have tried to address before is really our pipeline of physicians who will be available to care for our dependents, for our families, obviously, for our men and women in uniform, so that that benefit which we hold dear for those in uniform will always be there.

Perhaps you have already addressed that.

Dr. WINKENWERDER. No, I have not, actually.

Ms. DAVIS OF CALIFORNIA. If you could do that, that would be helpful.

I saw in the notes that bonuses are being increased.

Dr. WINKENWERDER. Yes.

Ms. DAVIS OF CALIFORNIA. Recruiting continues to be a concern. And what else can we do? And why do you think that is becoming such a problem? Is it partly the perception that our medical professionals will be brought into the war theater? Is that part of the difficulty?

Dr. WINKENWERDER. I don't think it is. I think it has more to do with our ability to compete on the basis of compensation. I really do.

And this is particularly true with the specialties that are more highly compensated. We have less challenge, candidly, for pediatricians and family practitioners and internists. We are, in some cases, overstaffed in those areas. But when it comes to orthopedic surgeons, radiologists, general surgeons, anesthesiologists, this is where we have trouble and a challenge.

Now, we are relatively well-staffed, but I am not as comfortable as I would like to be about the future, two, three, five, ten years down the line, because we do need that pipeline of people.

These new authorities that you in Congress granted us we very much appreciate. We believe it will be helpful.

However, one of our challenges is that, within our structure, the decisions about granting those bonuses and using those funds resides within the line of each service. And so, if there is a competition for dollars, let's say, for example, within the Army because of all the things the Army has to pay for, there may be—and I am not picking on the Army; I am just using that as an example. But there may be a reluctance to free up those dollars to be used for that purpose.

The flexibility is there. The authority is there. But people are not stepping forward to give the medical community the funds to recruit people. And we have a long tail of training.

So that is a concern I have, and we would appreciate any thoughts or suggestions you have on that front. We want to work with you on that.

I will say that one of our most solid sources of that pipeline for the future is the Uniformed Services University. It is really a key asset for us. Today, close to 25 percent of all military physicians are graduates of the Uniformed Services University. And when you go into the senior officer ranks, the proportion even goes higher: 30, 35 percent. And if you look at the current promotions to colonel today, a significant proportion come out of that program.

So the university is an important asset that we need to properly fund, nourish and continue into the future.

Ms. DAVIS OF CALIFORNIA. I appreciate that.

If I could just turn for a second to mental health coverage and the outreach.

And, Mr. Chairman, have you already discussed this a little bit?

Dr. SNYDER. He has talked about it quite a bit. I would like to hear—your perspective is an important one. Go ahead and wade on in.

Ms. DAVIS OF CALIFORNIA. Well, in the background I think it was mentioned that we offer an interview to people, we ask them, ''How are you feeling? How are you doing?''

We also know that, at least at one point, I think, people were told, ''Do you have any problems? If so, you know, come into treatment. If not, go home.'' And, you know, that is a tough choice, I think, for people to make.

Dr. WINKENWERDER. Right.

Ms. DAVIS OF CALIFORNIA. Can you give me a better sense? Out of the returning soldiers, men, women in uniform, what percentage of them actually—not necessarily are having adjustment problems but just are asking for interviews, are seeking help?

And what kind of follow-up do you have that would suggest that we either have the resources out there—and I know that in urban centers they may be there. They may not be there in rural counties.

What is the whole picture there? And what ought we be focusing on?

Dr. WINKENWERDER. The whole picture is, number one, we recognize that this is a top priority, and we have recognized it. Our efforts, if you look at where we are today, they are a reflection of the decisions we made two, three, four years ago in some cases.

Early on in this conflict, we recognized that we were going to have a mental health burden, and so we began to incorporate changes in our program. We have a much more robust in-theater mental health support today and mental health professionals embedded in our units, again, to deal with some issues that happen right then and there, not wait two months or six months or a year until people get back home. So that is one change, a much more aggressive approach in-theater.

Second is the post-deployment assessment, and then now a third leg, a reassessment, at three to six months after people get back,

where we reach out and bring them in to fill out questionnaires and with a face-to-face interview or session with a medical professional.

We have research that is going on to study that we didn't have 10, 15, 20 years ago, certainly not during Vietnam. We are more aggressive with the use of medications.

We have, I think, been more specific recently, in terms of guidance about who should be redeployed if they have certain kinds of symptoms or they require certain kinds of medications and they need to come home, or that they shouldn't redeploy or, you know, deploy for the first time if they have certain kinds of mental health problems.

There is a much higher recognition of all these issues. I think we are making real nice progress, cutting through some of the stigma.

And, again, we can stand up and talk about in the medical community these issues all day long, but ultimately it is whether our line leadership embraces this as a philosophy. And I actually will tell you I believe that they have at the highest levels.

Now, is it complete and across the board? No. I have no doubt that there are colonels and captains and sergeants in places who don't get it yet. And, you know, it is a balance, because clearly you do have to be tough, you have to be mentally tough, you have to be resilient to deal with the rigors of being a service member and going to war.

But that has to be balanced against when you are really having such difficulty that you can't perform your job or duty, or you are having huge relationship issues, or you are a risk to yourself or other people. So you have to be able to identify those issues and pull those people out, get them support, and help them so that they, you know, can either return to duty or that they can hopefully lead a normal life.

And that is our focus. We have a lot of programs. Do we know how they are all working? We are learning. But I think it is going to be some time before we know, you know, the impact of all of these things that we are doing, which are, in many cases, the first time that they have been done.

Dr. SNYDER. Mr. McHugh.

Mr. MCHUGH. Thank you, Mr. Chairman.

Let me blend two themes here. I heard, understandably, a number of members, Ms. Davis most recently, concerned about mental health. It is an issue. We know the suicide rates for the Army in Iraq, and we are all concerned. I know you are as well.

If you look at that issue in the context of the mention I made in my opening comments about military-civilian conversions, the schedule for those from 2006 to 2009 calls for 342 military mental health positions to become civilian positions over the total of that 4-year inclusive period.

There is obviously no guarantee those positions are going to be filled on a one-to-one or a two-to-one or whatever ratio it may be. But even if they are filled one-to-one, I think we can say with certainty the number of deployable mental health professionals will be depleted—or, not depleted, but reduced.

So I am just curious, has there been any re-evaluation on that? I mean, 2006 is not where we are in 2007. I understand times

change. But what kind of look-see is your office, your department, doing to make sure that we are going to not unnecessarily and very harmfully erode the ability and the availability of mental health positions, particularly in deployed areas, particularly given the surge that we have talked a little bit about here today?

So, your comments on that?

Dr. WINKENWERDER. Well, you raise a very good point and a very good concern. And I think we do need to take a look at that. We definitely don't want to go short or find ourselves in a position where we have insufficient military personnel, military-trained personnel, who can deploy or who can attend to the specific needs of military service members. And so, we need to look at that.

I would be happy to take that issue or that question and refer it back again to the Army. I don't know where the numbers came from, if there were more from one service or another. But we I will look into that——

[The information referred to can be found in the Appendix beginning on page 66.]

Mr. MCHUGH. That is fine.

Dr. WINKENWERDER [continuing]. Because I think you raise a very good point.

Mr. MCHUGH. That is fine. And I know we would all appreciate that, absolutely. And we don't want any guessing or such, because it is an important issue. I know you realize that most of all. So please do that.

And let me switch a little bit, if I might. We talked about the $1.8 billion in assumed savings because of the task force. You have almost $300 million in other undefined initiatives.

But the budget also includes nearly a quarter of a billion dollars, $248 million, in efficiencies from the military treatment facilities. Those are undefined. We had similar undefined efficiencies listed in the 2006 budget, as well as the 2007 budget. The year 2006 was $94 million. We are done with 2006.

And this is probably a tough question. You may have to take this for the record, as well. But can you give us an idea of how much of the $94 million, if any, did we achieve in efficiencies in the 2006 budget? What did you do to reach them? And what kind of efficiencies are we talking about when you are looking at $248 million for next year's budget?

Dr. WINKENWERDER. I am going to have to take that one for the record.

[The information referred to can be found in the Appendix beginning on page 66.]

Mr. MCHUGH. That is fair.

Dr. WINKENWERDER. But I will give you my best thought about that.

The way the numbers were developed for the efficiency goals and what we call the efficiency wedge, going out over several years, was to take a look at what it cost to purchase services in the network and then, if we were to purchase those same services, if you will, in our own facilities, how much would it cost.

And what we found was a gap. In other words, it cost more money to provide these services internally, or at least, maybe stat-

ed a better way, there was a proportion of the total dollars spent inside the system that could not be fully explained.

Some of that we know goes for things that are not compensated or billed for. They are things that relate to protecting our force, some of the public health issues, some of the force protection issues—lots of things that we do that you can't or don't bill for, so to speak.

And so we are trying to count, and we have had an ongoing process to better account for all of those things.

Having said that, our services looked at that issue two or three years ago and came up with what they believed were some efficiencies they could achieve either through increased productivity, through doing things more efficiently, delivering the care more efficiently. And the precise undergirding for those efficiencies is something that was developed by each of the services.

So we can try to obtain that information for you, but it was a commitment that they made to those targets based on productivity and efficiency targets that they believed that they could achieve.

Mr. MCHUGH. So they developed the targets. You did not dictate the targets.

Dr. WINKENWERDER. It was a process.

Mr. MCHUGH. You didn't say we——

Dr. WINKENWERDER. You know, it wasn't one or the other. It was a negotiated process.

Mr. MCHUGH. Democratic dictatorship.

Dr. WINKENWERDER. We are always democratic.

Mr. MCHUGH. Well, I appreciate that.

Just a final comment. If you could get the figures as to what we did save in 2006 and what we did to save them, and also what the target is, where the target areas lie with respect to the $248 million for next year.

Dr. WINKENWERDER. I would be glad to do that.

[The information referred to can be found in the Appendix beginning on page 66.]

Mr. MCHUGH. Thank you, sir.

Dr. WINKENWERDER. Thank you.

Mr. MCHUGH. Thank you, Mr. Chairman.

Dr. SNYDER. Ms. Drake.

Mrs. DRAKE. Thank you, Mr. Chairman.

I think it has been, what, about 1.5 years since we opened up TRICARE to reservists outside of their window of activation? Can you give us an update? Is that widely used or is it very little?

Dr. WINKENWERDER. It is being used, and it is growing. We have, I believe, about 34,000 or 35,000 beneficiaries in the new TRICARE Reserve Select program. And so, people are joining.

My recollection, however, is that the rate of growth of that program is not as great as we thought that it might be. But we are clearly reaching out to people in a very systematic way, particularly when they return home and for guard and reserve who might go back into the civilian sector, to make them aware that this is a benefit that they have, if they choose it.

What we find, however, is that most people seem to prefer their civilian health-care benefit program. And I am not sure we know exactly why that is, but it is not to say that people don't like the

TRICARE program. They do. I think we hear good comments on that as well.

But that is about where it is right now. And we think it is working well.

Obviously, Congress passed some additional changes last year that changed the cost-sharing structure on that so that it is 28 percent of the premium overall for all guard and reserve who might choose to join TRICARE Reserve benefit.

Mrs. DRAKE. So that may increase as they——

Dr. WINKENWERDER. My guess is that it definitely would, yes.

Mrs. DRAKE. All right. Well, thank you very much.

Thank you, Mr. Chairman.

Dr. WINKENWERDER. Thank you.

Dr. SNYDER. Ms. Davis, your number has come up again.

Ms. DAVIS OF CALIFORNIA. I am going to pass right now, Mr. Chairman. Do you want to go ahead and——

Dr. SNYDER. Yes.

Dr. Winkenwerder, Mr. Wilson asked you about the DOD–VA interface, and this is a topic that has been important to Mr. McHugh and others. And you said that if anyone has suggestions on how to look at that—I appreciate that openness.

But as you look ahead now—you gave a list of things that you would like. As you look ahead, what are things on a to-do list with regard to improving things at the DOD–VA interface? And how much impact do you think those particular things on your list will have on either quality or seamlessness or cost savings?

Dr. WINKENWERDER. I would outline for you four areas.

The first is in the area of joint markets and the opportunity for joint facilities.

So what we have in Chicago, for example, I think is a model that could potentially be duplicated in other places like southern Mississippi, the Biloxi-Gulfport area, the VA facility there. There is a Keesler Air Force facility there.

The same thing is true in Denver, Las Vegas. There are several other locations we are looking at and developing a priority list of places that we really ought to get serious about accelerating that effort and that model.

The second area would relate to our joint efforts in the electronic health record system. Secretary Nicholson and I made an announcement the week before last that we are going to pursue jointly developing a new inpatient module for our electronic health records system.

In our case, we have a limited capability on the inpatient side. Our system is primarily an outpatient records system. It is doing a great job for us. We have it deployed world-wide. But what is before us is the need to develop the in-patient side.

The VA, on the other hand, has a great system. They are needing to modify, update, as I understand it, their platform. And rather than us doing that separately, we want to pursue doing it together. We think we can save a lot of money and help set standards for electronic health records across the country by doing that. So that is another area.

Third, I would say, is our obligation to make further improvements in the way we take care of the severely injured and in the

area of traumatic brain injury, which is what we are just learning more about.

And in my judgment, we need to improve our screening process and our screening tools, and follow up and invest more in research on traumatic brain injury. And we are beginning to do that.

And then finally, I think, as we have talked about, in the area of mental health and our shared responsibility in the area of mental health to ensure that all those who have mental health problems or concerns or identified diagnosed conditions get the support that they need and that they be given the best possible chance for a full recovery from their mental problems.

So those are the—and we in the VA have talked about that, so what I am telling you, if you were to ask the same question to Dr. Kussman or even to Secretary Nicholson, I think you would hear the same shared agenda. We are going to be talking more about this in the very near future of our agenda to be more aggressive in these areas.

Dr. SNYDER. I think that is a—I know that, as I have mentioned, Mr. McHugh has a great interest in—I am on the VA Committee also, and we may well want to have our further formal discussions on that specific topic.

On another unrelated question, in your written statement, you used the phrase, talking about these changes of cost-sharing and all that, you used the word "aligned," I think was your word, "align" the premiums with private health insurance plan. How do you define "aligned"?

Dr. WINKENWERDER. Well, what that means to me is it means a relationship that is consistent over time.

And that does not mean the same level of cost-sharing. It just means that if, for example, what we ask of people today, as I think we talked about, is in the range of 10 percent to 12 percent of their cost, of the total cost of the program, is what they share in their—personally.

It had been around 25 percent, 26 percent. In our judgment, that needs to increase. But at some point, that increase ought to level off, and then it ought to stay leveled off.

In our judgment, the cost-sharing requirement for our military retirees ought to be less than it is for the best civilian programs. We believe that is what our retirees and those who have served this country deserve.

On the other hand, we don't believe we can afford the cost-sharing to continue to go down relative to the cost of the whole benefit.

So that is what I meant when I said "aligned." It means that the relationship is consistent over time and that it represents a consistent relationship between our cost structure and that that you would see in a civilian private-sector health plan.

Dr. SNYDER. Mr. McHugh.

Mr. MCHUGH. Thank you, Mr. Chairman.

Mr. Chairman, I appreciate your comment about the DOD and VA sharing initiative. And in fairness to Secretary Winkenwerder and Nicholson, they have stepped forward and are trying to do some things—and I know there was some very deeply ingrained and I would hope not insurmountable—although, after now, in my 15th year, having watched the struggle, they may be insurmount-

able differences—but there is so much that can be done, and I want to see that progress continue.

But you mentioned that feasibility study. Quick question: When will that be done? I know you have just announced it, but what is your timeframe on that?

Dr. WINKENWERDER. Not long. We think——

Mr. MCHUGH. Not another 15 years, then.

Dr. WINKENWERDER. No, no, no. Within the next 60 days. We really think that this is something that we ought to look at pretty quickly. It is really a study and look at our respective requirements.

And so we jointly are pushing the technical folks and the Information Technology (I.T.) communities of both the DOD and the VA to let a contract to do that work and to come back to us.

Our people and the people at the VA talk together all the time. They know each other. And we know that what is shared between us is far greater than what is different.

There is a lot of overlap in terms of what we expect the requirements to be. There are some differences. We have some things that we do that are out in the field that the VA providers just don't need to do. We know that. We have requirements for certain kinds of medical care, for example, for Obstetrics-Gynecology (OB–GYN) or for pediatrics, and that is not something that the VA does much of. And they have some issues, probably, on the chronic end of the field.

But there is, we think, probably a 90 percent overlap. But we want to define all those requirements and say, "Okay, how do we have it go forward?"

Mr. MCHUGH. And you do have a significant software—well, hardware challenge, too, on your databases, because you were kind about the VA's system, but, as I understand it, there is not a set of it off the shelf. I mean, they——

Dr. WINKENWERDER. That is right. And I don't want to speak for them, but I think they may be looking to make some changes in some of those approaches.

Mr. MCHUGH. Right. Yes, it wasn't a criticism, more of an observation. I mean, I was just——

Dr. WINKENWERDER. No, it works very well, I am told, for them. But we are both spending a fair amount of money, and so we think the taxpayers' money will be better spent if we do this jointly. And at the same time, we can help set standards for the rest of the country.

Mr. MCHUGH. Yes. We want quality of care and fewer medical errors, all that good stuff. Anyway, I will be looking forward to that report.

I mentioned concern about military-civilian conversions on mental health, but you have a pretty broad-range proposal, as I mentioned in my opening comments.

Does this budget assume any savings from the military-civilian conversions? If so, how much? If it does, we can't discern that.

Dr. WINKENWERDER. No.

Mr. MCHUGH. It does not.

Dr. WINKENWERDER. It does not.

Mr. MCHUGH. Thank you.

Mr. Chairman, that is it.

Dr. SNYDER. Ms. Davis.

Ms. DAVIS OF CALIFORNIA. Could you go back to that, then, in terms of those conversions? Were you anticipating that there would be savings, or may that shift?

Dr. WINKENWERDER. I think there are some savings.

Mr. Middleton.

We think there may be some cost savings, but we have not programmed that into the out-years. So right now it is cost-neutral.

Ms. DAVIS OF CALIFORNIA. But that wasn't the primary reason for making that shift.

Dr. WINKENWERDER. No. It really was not a budget-driven exercise. It was more to the question of, what is military-essential and what things can be done by civilians?

And it only makes sense to harvest all those things that could be done by civilians—to have civilians do them so that we can use military billets, military positions, for things that we really want the military to do. That was the driving thrust for it.

And of course, this military-civilian conversion effort does not apply just to the military health system. It applies across DOD.

I will say that I think we are one of the areas that has embraced this the most aggressively, because we do think that there is some significant opportunities——

Ms. DAVIS OF CALIFORNIA. Do you also see some down sides?

Dr. WINKENWERDER. Well, there is some risk, but what we have agreed to—and when I say "we," I mean myself, Dr. Chu, the service secretaries, our leadership—is that this needs to be done in a careful way. We need to look at it every year to see how we are coming on this pathway.

We need to look at the experience of the services with respect to whether they are able to hire the civilians, and how effectively are we executing, and are we harming or cutting into any of the things that Congressman McHugh talked about.

So I think we have set targets that we think are realistic, but we want to review them on an annual basis.

Ms. DAVIS OF CALIFORNIA. Thank you.

I guess my time is up, Mr. Chairman.

Dr. WINKENWERDER. If I might say one other thing, I wanted to bring up, because you talked about mental health, if I might, just to——

Dr. SNYDER. Yes. Go ahead.

Ms. DAVIS OF CALIFORNIA. Okay.

Dr. SNYDER. Mr. McHugh has no further questions.

Dr. WINKENWERDER [continuing]. To note that we do have, at Congress's direction, a mental health task force that is co-chaired by General Kiley, Army surgeon general, and—I am sorry, I can't recall the name of the other co-chair.

But it is a very robust effort to look at the totality of what we are doing in the mental health area. They have gone out and had sessions with the various communities around the country to get feedback. And so, it has been a very robust process.

They will be coming forward with recommendations later this year on any changes we should make, any additional things that we should be doing. I am sure they will look at everything.

Ms. DAVIS OF CALIFORNIA. Yes.

Dr. WINKENWERDER. And we look forward to that.

Ms. DAVIS OF CALIFORNIA. I am glad to hear that. And also I know to really tap the ideas and best practices that people are using at home——

Dr. WINKENWERDER. Sure.

Ms. DAVIS OF CALIFORNIA [continuing]. And how our spouses are able to work through many of those problems.

I think one of the other issues that has been raised, at least in San Diego and I am sure in other communities, is that rather than going even through the military system, people have sought outside help because they are not comfortable, they are afraid of word getting back to commanders, whatever that might be.

Dr. WINKENWERDER. Sure.

Ms. DAVIS OF CALIFORNIA. And so, how do you incorporate that into the thinking of what is really going on? And what kind of assistance do people need?

Dr. WINKENWERDER. Well, one common principle that we want to pursue—we believe we have—is that people ought to have access in as many different ways as we can devise or as are available to get the support and care they need.

Mental health is a—yes, it is a sensitive issue. And as much as we try to work through the stigma, I think most of us would not go around saying, you know, ''I have a mental health problem.'' You know, it is just not something most people are comfortable doing.

We have to work to try to remove that stigma. We are trying to do that. But we want to have the chance for people to access those services in a confidential way, if that is what they choose to do.

Ms. DAVIS OF CALIFORNIA. And are you comfortable that the budget that is proposed is——

Dr. WINKENWERDER. Yes, I am. I am comfortable. Right now, I have not gotten any feedback from our medical leadership that they don't have the resources they need to perform those functions.

Ms. DAVIS OF CALIFORNIA. Thank you.

Thank you, Mr. Chairman.

Dr. SNYDER. Dr. Winkenwerder, one specific question, if you could educate me on it, with regard to electronic medical records. This came up with Secretary Nicholson at the Veterans Committee last week, and he talked about their—an electronic record will be a prospective one, which—people come in with this thick of handwriting for the last 20 years or something. And I think I understood what he meant.

Is there anything inherently different in either the military health-care system or the VA system, to your knowledge, in terms of dealing with that issue, in terms of a transition from a handwritten inpatient or outpatient medical record to an electronically based medical record?

Dr. WINKENWERDER. Well, first of all, I can't answer exactly how they are dealing with that issue. But I will say that it is a big and difficult issue.

First, there is just the transition of providers and changing business process and changing culture for the doctors, nurses, technicians, everybody, to use and do things, everything, with a com-

puter, either a laptop or a handheld, so that changes the process of care.

But in addition to that, it just changes things for the patient, changes things for everybody.

And I have lost my train of thought here.

Dr. SNYDER. Well, that is understandable. You have been there by yourself for 1.5 hours. You are entitled to have one lost train of thought in an hour and 40 minutes. [Laughter.]

But the question I asked, is there anything inherently different? I mean, if I went to a hospital in Little Rock where I had been admitted, and have been, they would have a handwritten medical record. And when they made their conversion to electronic medical records, somebody would say, "Well, what do we do with all these doctors' scrawls?"

Is there anything inherently different between the medical care system and a private system in terms of making this transition to an electronic medical record? I would assume there is not, but I don't know that.

Dr. WINKENWERDER. Well, I don't know how the small doctor office or the two- or three-doctor group would do it. I suspect they would hold onto——

Dr. SNYDER. Still hand-write.

Dr. WINKENWERDER. But if they were converting to an electronic record system, they would hold onto their old paper records.

What we are trying to do—first of all, we have, as every difficult problem requires, a task force to work on this very issue within DOD. And it has to do with a number of things. One is how do you archive the old records, because we need them; there are certain legal requirements. There may be the need to refer back to them for clinical issues.

And then, of course, there is the issue of what do people do if the system goes down. Do they capture the information on paper and then transcribe it back in? I mean, so there is a lot of issues with doing this kind of conversion. Can you scan it in?

And so today, as we have stood up also, I am told that we have been able to go back and archive a couple of years' worth of encounter information, but we don't go back longer than that.

And so we are, to my knowledge—and my staff can correct me—we have paper records that we are going to have to hold onto for some period of time. And there is no simple, quick way to get all of this information into this central database.

Dr. SNYDER. I don't hear anything you are saying, though, that makes it sound like it is inherently different from any other organization.

Dr. WINKENWERDER. I think that is right.

Dr. SNYDER. Mr. McHugh, do you have any final questions or comments?

Mr. MCHUGH. No, Mr. Chairman. Thank you.

Dr. SNYDER. Dr. Winkenwerder, we appreciate you being here.

I did a radio interview live back home to a Little Rock station at 7:15 Central, and it was 55 degrees at 7 a.m., so I sense a thaw is in the air, and we will let you go. [Laughter.]

Just by a closing comment, you know, when we get the budget and we see things like, you know, 18 percent cut in applied re-

search and 9 percent cut in basic research, and somehow we are going to create almost $2 billion in this budget somewhere—it is, you know, the middle of February, and somehow we are going to do this in the next 3 or 4 months—it just creates a lot of, well, uncertainty, and at some level a little bit of anger, because, you know, a lot of members and the public out there think, "Well, wait a minute, this is going to be difficult."

And so we look forward to working with you. We appreciate your advocacy and your candor. But we obviously have some work to do on some aspects of this budget.

And I believe you promised me you were going to get me some nice charts and graphs about where we are at with the numbers——

Dr. WINKENWERDER. We will.

Dr. SNYDER [continuing]. In this year's presentation.

Dr. WINKENWERDER. We will.

Dr. SNYDER. Do you have any final closing comments?

Dr. WINKENWERDER. Just thank you for the opportunity to be here today and to have a very constructive dialogue, I think, on all of these issues. We want to work together with you.

I will say one final thing. With respect to these big challenges that we face, the only way—the only way—that we will solve them is if we in the department work together with you in the Congress, both sides of the aisle, and with our constituency and advocacy groups and all involved, and chart a path forward. And it is going to take some real leadership to do that, but I am confident it can be done.

Dr. SNYDER. I think Mr. McHugh and I are united in our concern about this number, so you have already got the bipartisanship going on there. Thank you.

Dr. WINKENWERDER. Thank you.

Dr. SNYDER. The hearing is adjourned.

Dr. WINKENWERDER. Thank you very much.

[Whereupon, at 3:44 p.m., the subcommittee was adjourned.]

# A P P E N D I X

FEBRUARY 13, 2007

## PREPARED STATEMENTS SUBMITTED FOR THE RECORD

FEBRUARY 13, 2007

Opening Statement Chairman Snyder
Hearing on the Review of the Military Health Care FY08 budget and challenges facing the Military Health Care System
February 13, 2007

Dr. Winkenwerder, welcome. We appreciate you being here to testify on the Defense Health Care System budget and the challenges that it faces.

As I have said in previous forums, rising health care costs is not something that is unique to the Department of Defense. Employers across the country are facing similar challenges in attempting to control the growth of health care costs for themselves and their employees. The question both the Department, Congress, and beneficiaries need to address is how do we approach this problem in a fair and equitable way that ensures we maintain a quality system that supports the military operational mission which is core to the system, while also continuing to provide quality care for DOD-eligible beneficiaries.

In order for us to have an open and honest dialogue, we need to understand the challenges that the system faces and the opportunities that are available to address those challenges. Let me assure my colleagues and other interested parties that this will not be the only health care hearing that the subcommittee will hold. I expect that we will have several more through out the year, because this and other health related issues are not going to be solved by one hearing.

There are enormous challenges facing the defense health care system—cost of health care is only one of many factors and increasing fees to beneficiaries may not necessarily be the most effective approach to solving this problem. I raise this issue because there are other factors in play here. For example, a recent national data collection by the Centers for

Disease Control and Prevention (CDC) determined that the U.S. rate for autism spectrum disorders among 8-year olds is approximately 1 in 150, compared to studies conducted several years ago which indicated that rates were somewhere between 1in 500 and 1 in 166 children, this is a significant growth. Just looking at the military dependent population would mean that there are thousands of military children who are suffering from autism and whose families will need help and services. Issues like these are not specifically factored into the budget but could have a significant impact on it. We will need to work together to address these issues.

Historically, our health care hearings on the subcommittee have been wide-ranging and included several panels of witnesses. Often Mr. McHugh and I ended up being the only ones left after several hours. I hope that having Dr. Winkenwerder as the only witness today will allow members the opportunity to delve deeper into these issues. We will continue to adhere to the 5 minute rule, which should allow us the opportunity for members to have another round of questions.

Mr. McHugh, did you have a statement you would like to make?

**Opening Remarks – Congressman McHugh**
**Military Personnel Subcommittee Hearing**
**Review of the Military Health Care FY 08 Budget and the Challenges facing the Military Health Care System**
**February 13, 2007**

**Thank you Dr. Snyder. Before I begin I'd like to thank you for holding this hearing. Although we routinely have an annual hearing on the Defense Health Program, there is nothing routine about the military health system and the extraordinary care it provides to our service members and their families.**

**The subcommittee remains committed to ensuring that the remarkable men and women who are entrusted with the lives of our troops have the resources to continue their work for future generations of our most deserving military beneficiaries. I would like to express my deep appreciation to Dr. Winkenwerder for his**

**leadership in delivering the highest quality healthcare during these most challenging times.**

**One of the most severe challenges is that for the second year in a row the budget for the Defense Health Program has been significantly reduced with the hope of Congressional support for changes to the benefit in the form of increased fees for TRICARE. The fiscal year 2008 budget reduction is $2.1 billion.**

**The overwhelming response from Congress last year to the Department's plan to raise fees should have sent a very clear message. Yet DOD continues to dig this budget hole.**

**Last year the John Warner National Defense Authorization Act for Fiscal Year 2007 restored $486 million to the DHP to cover the programmed decrease. It seems to me that overly optimistic assumptions and over-reliance on fee increases have once again put this subcommittee in the position of having to determine how much will have to be restored to the Defense Health**

**Program. I am concerned about how many more years the DOD plans to reduce the budget for the military health system.**

**The budget also includes an increase of $157 million dollars in civilian pay to fund an additional 2,712 positions planned for conversion from military to civilian positions in fiscal year 2008. In light of the 5,507 military positions that have already been converted since 2005, I can't help but wonder what effect this is having on the ability of the military health system to carry out its mission. We have not seen the certifications required by legislation Congress passed in 2005 and 2006. Those certifications are required to include an assessment of the effect of the conversions on cost, quality and access to care. Therefore it is difficult to determine whether the conversions included in this budget will have a negative effect on our military beneficiaries.**

**I look forward to Dr. Winkenwerder's testimony on these issues.**

# THE MILITARY HEALTH SYSTEM

OVERVIEW STATEMENT

BY THE HONORABLE WILLIAM WINKENWERDER, JR, MD, MBA

ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

BEFORE THE

SUBCOMMITTEE ON MILITARY PERSONNEL

ARMED SERVICES COMMITTEE

UNITED STATES HOUSE OF REPRESENTATIVES

FEBRUARY 13, 2007

**NOT FOR PUBLIC RELEASE UNTIL**

**RELEASED BY COMMITTEE**

Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System (MHS). The MHS serves more than 2.2 million members serving in the Active, Reserve, and Guard components with more than 251 thousand service members deployed overseas.

The Department is firmly committed to protecting the health of our service members and to providing world-class healthcare to more than 9 million beneficiaries. The Fiscal Year (FY) 2008 Defense Health Program funding request is $20.7 billion for Operation and Maintenance, Procurement and Research, and Development, Test and Evaluation Appropriations to finance the MHS mission. We project total military health expenditures, including personnel expenses, to be $40.5 billion for FY 2008. This includes payment of $10.9 billion to the Department of Defense Medicare Eligible Health Care Retiree Health Care Fund.

As you know, the Department faces a tremendous challenge with the growing costs and long-term sustainability of the Military Health System. We need important changes in our great health benefit program, TRICARE, to ensure a superior benefit for the long term. We need the help and support of Congress to achieve this goal. As a placeholder, our FY 2008 budget request assumes savings of $1.9 billion from reform proposals growing from those proposed in last year's President's budget. We await the interim report of the Department of Defense Task Force on the Future of Military Health Care as a basis for dialogue with the Congress on alternative savings.

**The MHS Strategic Plan – Keeping Warfighters Ready. For Life.**

In the past year, the MHS took several additional important steps in our multi-year transformation that will prepare our military forces and our military medical forces for the future. Our focus has been to develop greater joint capabilities and joint operations. I will outline a number of these initiatives today.

We guide all of our efforts through a vision of jointness, interoperability, greater efficiency, improved outcomes, and world-class education, research, and medical care. We have refined our MHS Strategic Plan, itself a superb road map, to provide a long-term perspective on the critical imperatives that will determine our success for the years ahead. We shaped our strategic plan with the recommendations contained in the 2006 Quadrennial Defense Review (QDR), Medical Readiness Review (MRR), and the Base Realignment and Closure Commission (BRAC) reports.

This plan – developed in concert with the Surgeons General, the Joint Staff and our line leaders – recognizes that our stakeholders, including this congressional body representing the American people, expect the following outcomes from the resources invested in military medicine:

- A fit, healthy and protected force

- Reduced death, injuries and diseases during military operations, and superior follow-up care and seamless transition with the VA
- Satisfied beneficiaries
- Creation of healthy communities
- Effective management of healthcare costs

Our internal measures and those of independent, external organizations show we are excelling in our mission. Yet, we are hardly complacent. We recognize that we must build upon our successes to sustain this global, unique military medical system.

**A Fit, Healthy and Protected Force**

Our primary objective is ensuring that every service member is medically protected and fit for duty. Together with the military commanders, we use a variety of tools to achieve this outcome.

Physical fitness and health promotion are critical elements in meeting the most basic health-preparedness expectations of our commanders. We instituted an Individual Medical Readiness (IMR) metric to assess each service member's preparedness for deployment. Current health assessments and dental examinations and up-to-date medical vaccination records comprise some of the measures we use to calculate the IMR of U.S. military forces.

The Department has programs to protect our service members against a variety of illnesses. The Department continues to view smallpox and anthrax as real threats that may be used as potential bioterrorism weapons against our soldiers, sailors, airmen and marines.

To date, with vaccines we have protected almost 1.5 million Department members against anthrax spores and more than 1.1 million against the smallpox virus. These vaccination programs have an unparalleled safety record and are setting the standard for others in the civilian sector. We are in the process of restarting the mandatory anthrax vaccination program, after the FDA published the Final Order confirming that the anthrax vaccine absorbed (AVA) is safe and effective for its labeled indication to protect individuals at high risk for anthrax disease.

We are also ensuring our service members are medically evaluated before deployments, upon return and then again 90–180 days after deployment. These health assessments provide a comprehensive picture of the fitness of our forces and highlight areas where intervention is indicated. For example, we have learned that service members do not always recognize or voice health concerns at the time they return from deployment. By reaching out to them three to six months later, we have found that approximately half of them report physical concerns, such as back or joint pain, and a third of them have mental-health concerns. This additional evaluation gives medical staff an opportunity to provide education, reassurance, or additional clinical evaluation and

treatment, as appropriate. Fortunately, as these clinical interactions occur, we have learned that only a fraction of those with concerns have diagnosed clinical conditions.

At the direction of Congress, we have implemented new health benefits that extend TRICARE coverage to members of the Guard and Reserve. We implemented the TRICARE Reserve Select (TRS) health plan for Reserve Component personnel and their families as mandated in the NDAA for FY 2005, and then amended in the NDAA for FY 2006. We are now working on the new program mandated by the NDAA for FY 2007. Today, more than 34,000 reservists and their families are paying the premiums and getting TRS coverage. We have made permanent their early access to TRICARE upon receipt of call-up orders and their continued access to TRICARE for six months following active duty service for both individuals and their families. Our FY 2008 budget request includes $381 million to cover the costs of this expanded benefit.

**Reduced Death, Injuries and Diseases during Military Operations**

Our military medical personnel have performed extraordinarily on the battlefield and in our medical facilities in the United States. Our investments in people, training, technology and equipment have paid major and historic dividends. We have established new standards in virtually every major category of wartime medicine:

- Lowest Disease, Non-Battle Injury (DNBI) Rate. As a testament to our medical readiness and preparedness, with our preventive-medicine approaches and our occupational-health capabilities, we are successfully addressing the single largest contributor to loss of forces – disease.

- Lowest Death-to-Wounded Ratio. Our agility in reaching wounded service members, and capability in treating them, has altered our perspective on what constitutes timeliness in life-saving care from the *golden hour* to the *platinum fifteen minutes*. We are saving service members with grievous wounds that were likely not survivable even 10 years ago.

- Reduced time to evacuation and definitive tertiary care. We now expedite the evacuation of Service members following forward-deployed surgery to stateside definitive care. We changed our evacuation paradigm to employ airborne intensive-care units. Wounded service members often arrive back in the United States within 3–4 days of initial injury.

Our successful efforts to prevent loss of life from battle injuries have consequences. Many of our wounded service members have worked heroically to regain their skills to the greatest extent possible. Of particular note, among the 563 individuals who have had major limb amputations, approximately six percent have returned to active duty.

We continue to focus on the need for mental-health counseling and family readjustment support for our service members after they return home. With this in mind, and in consideration of the potential for physical-health issues to arise once service members return, I directed a post-deployment health reassessment – a follow-up program

that expands upon our previous efforts. We recognize that everyone who goes to war changes. However, not everyone is affected in the same way, and not everyone has mental-health or readjustment issues. But some, a minority, do have health issues, and their health is our concern. This additional assessment includes a short questionnaire to be filled out by all service members – including Reservists and Guardsmen – three to six months after they have returned home. This assessment also includes a face-to-face visit in most cases. Service members with health concerns are referred to a healthcare provider for evaluation and assistance.

The intent of this program is to help determine the health status or personal situation of the service member through discovering any readjustment issues or problems. To get to the heart of issues, counselors ask such questions as: "How are you doing?" "How is your family?" If things are not well, we want our service members to know that help is available. We believe that with this new, disciplined and caring process, we can reach those who may need help and make a real difference in their recovery and reorientation to home life. As you know, some people in our country still stigmatize those who seek mental-health services. We believe that through this follow-on reassessment tool, we can reduce the stigma as a barrier to needed care. In fact, we have evidence that we are already reducing this stigma across the military.

We began small-scale implementation at high-deployment platforms in June 2005 to ensure program success and smooth integration into existing processes. Lessons learned from that small-scale implementation informed our program deployment, which began in January 2006. We are basing current implementation efforts on the Services' identification of those with highest needs and on units scheduled for return deployments. We are rolling out implementation across the military departments. As of January 29, 197,385 service members have completed a post-deployment health reassessment. Twenty-eight percent of these individuals received a referral for additional evaluation.

**Satisfied Beneficiaries**

Our beneficiaries continue to give the TRICARE program high marks in satisfaction. Overall satisfaction with the TRICARE health plan has risen significantly and consistently each year since 2001. Given the stresses of war during this time period, this is a remarkable achievement. The annual Outpatient Satisfaction Survey of military health system beneficiaries provides feedback that permits us to benchmark the satisfaction of beneficiaries with their outpatient experience at military treatment facilities against civilian health maintenance organizations. For the period of October 2005 through September 2006, military health system beneficiaries' overall satisfaction with medical care in the outpatient setting was 6.11 compared with the national civilian benchmark of 6.18 (on a seven-point scale where *7* is *completely satisfied*). For the same time period, military health system beneficiaries' overall satisfaction with the clinics at which outpatient services were provided was 6.02 compared with the national civilian benchmark of 6.13.

The military health system also administers the TRICARE Inpatient Satisfaction Survey to assess beneficiary satisfaction with inpatient care (military treatment facility

and network). For the period of July 1, 2005, to September 30, 2005, 79 percent of beneficiaries who received care from military treatment facilities were very satisfied with their care as compared with the civilian benchmark of 81 percent. Eighty-one percent of beneficiaries who received care from network facilities were very satisfied with their care.

We added financial incentives to improve beneficiary satisfaction from our contract partners and ensured our contractors are financially rewarded for care delivered in the private sector. Through our new MHS governance and strategic plan, we are focusing on the effectiveness and efficiencies of military treatment facilities and adding performance-based management and patient-centered care initiatives to transform our patients' experiences.

We have also enhanced our beneficiaries' online capabilities and unveiled a new TRICARE Online Web portal in November 2006. This online service allows beneficiaries to more easily enroll, make appointments, obtain pharmacy refills, check the status of their TRICARE claims, and perform online health assessment for specific disease risk and more. To our knowledge, there is no medical system in the world that arranges for a greater number, or percentage, of its appointments via the Internet than does ours.

**Creation of Healthy Communities**

We have the internal ability to expand upon two major initiatives in the coming years: increasing the use of evidence-based medicine, and increasing the patient-provider partnership in sustaining health.

We need to do more to make our patients partners in their healthcare. We are increasing the services available to specific populations – seeking to stem the adverse effects of alcohol abuse, tobacco usage, and obesity. The DoD has developed and implemented a series of demonstration and pilot projects to address the key health behaviors associated with premature and preventable death identified in the 2002 Health Related Behavior Survey.

Known as the "Health Lifestyles Initiatives," these projects address the increase in tobacco use, obesity, and alcohol misuse and abuse among beneficiaries, both active and non-active duty identified in the survey. We are primarily focusing these health-promotion activities on disease prevention and the adoption of healthy behaviors while testing the effectiveness of comprehensive benefits not currently covered by TRICARE.

The tobacco-cessation and weight-management demonstrations are comprehensive behavioral interventions. The tobacco-cessation demonstration provides pharmacotherapy in addition to a telephone quitline, a Web-based educational tool, and individualized quit kits. The weight-management demonstration provides health/weight loss coaching, as well as telephone and Web-based educational and motivational information.

The alcohol-abuse pilot project employs Web-based tools to educate and assess participants' knowledge of alcohol abuse, attitudes towards alcohol use and abuse, and current alcohol use. Preliminary results of the pilot study show that participants had a significant reduction in binge and heavy drinking, as well as real reductions in the number of drinks per occasion. We will conduct the more important, longer-term follow-up of these results in year two of the project.

The 2002 DoD Survey of Health Related Behaviors Among Military Personnel indicated that rates of cigarette use, heavy alcohol use, and overweight had all risen since 1998, and that these three health threats occur in our young enlisted population. To respond to these threats, TRICARE has undertaken counter-marketing campaigns to encourage quitting tobacco and reduction in binge drinking among the young enlisted population.

Both counter-marketing campaigns use themes developed from focus-group research among our young enlisted population. Since humor and emphasis on everyday negative consequences appealed to the target audience, we selected a popular icon who is out of control, "That Guy," as an effective mechanism and a campaign theme to reduce binge drinking. We chose the second campaign theme, "Quit Tobacco. Make Everyone Proud," because target-audience members had a favorable response to appeals that use their position as role models, particularly to children, as a motivation to quit using tobacco. The alcohol counter-marketing campaign is currently being tested at four military installations. The initial test rollout of the anti-tobacco campaign starts on February 20, 2007, in two media markets: Seattle (at McChord Air Force Base and Fort Lewis) and San Diego (at San Diego Naval Base and Camp Pendleton).

Recently, we announced the 2005 DoD Health Related Behaviors Survey. We added questions that addressed deployment issues and were pleased to find that the self-reported information indicated our military personnel are coping with the rigors of conflict and separation from family and home.

Although we found that most personnel use such positive coping mechanisms as talking to friends or exercising to cope with stress, we want to focus on those who report using unhealthy behaviors to help cope with their stress. We are quite concerned that of personnel who were deployed in the prior year 13.6 percent began using or increased their use of alcohol since being deployed; however, we are pleased that 17 percent stopped or decreased their alcohol use since deployment. We are also concerned that 10.3 percent began smoking or increased their cigarette smoking, 6.1 percent began using or used more smokeless tobacco, and 6.3 percent began or increased their cigar smoking.

However, 66.8 percent of all military personnel who were "smokers" in the past year made an attempt to quit during the last year. We are also pleased that 66.2 percent of military personnel indicated they were either "satisfied" or "very satisfied" overall with their current work assignment. Military personnel were notably and significantly less likely than civilians to use any illicit drugs in the past 30 days (4.6 percent versus 12.8 percent).

We will also be introducing targeted disease-management programs to engage our patients by offering tools and technologies that can reduce hospital admissions, visits to the emergency rooms, and poor quality of life. Our approach to disease management is twofold: 1) keep the well healthy, with a focus on healthy lifestyles, disease prevention, and health promotion and 2) maintain an active disease-management program for high-risk beneficiaries with specific chronic disease conditions. We are using evidence-based clinical-practice guidelines and educational resources developed jointly by the Departments of Defense and Veterans Affairs in both the military treatment facility and managed care support contractor disease-management programs.

On September 1, 2006, the MHS implemented a new disease-management initiative based on a consistent approach across all three managed care regions, focusing on asthma and congestive heart failure. The NDAA for fiscal year 2007 further mandates the MHS disease-management program to address, at a minimum: diabetes, cancer, heart disease, asthma, chronic obstructive pulmonary disorder, and depression and anxiety disorders. In the future we intend to expand our disease-management efforts to the four other mandated chronic diseases mentioned above.

High-quality care is safe care, and part of building healthy communities includes taking steps to minimize preventable harm as patients receive healthcare services. Both healthcare professionals and informed, prepared patients have roles to play in creating a safe patient experience. In a joint endeavor with the HHS Agency for Healthcare Research and Quality (AHRQ), the MHS has introduced TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) to improve quality and patient safety. TeamSTEPPS represents more than 20 years of research and evidence on teams and team performance in such diverse areas as aviation, nuclear power, business and healthcare. Ineffective, inadequate communication is a major contributing factor for medical errors. TeamSTEPPS provides the tools to counter this problem area. Our goal is to share this important tool with every healthcare facility in America to help them create and continue team training systems. Facilities that have implemented the program are already observing improvements in patient safety.

AHLTA – DoD's comprehensive, global electronic medical record and clinical data repository – significantly enhances our effort to create healthy communities and increase patients' personal engagement in their own healthcare. AHLTA creates a life-long, computer-based patient record for each and every military health beneficiary, regardless of their location, and provides seamless visibility of health information across our entire continuum of medical care. This gives our providers unprecedented access to critical health information whenever and wherever care is provided to our service members and beneficiaries.

The system is secure, standards based, and patient centric for use in our garrison-based medical facilities and our forward-deployed medical units. AHLTA provides our physicians with decision support and builds a single encounter document out of a team effort, linking diagnoses, procedures and orders into one record. In addition, AHLTA offers clinical reminders for preventive care and clinical-practice guidelines for those with chronic conditions.

In November 2006, we successfully completed worldwide deployment of AHLTA, which began in January 2004, at all 138 DoD Military Treatment Facilities. Our implementation-support activities spanned 11 time zones and included training for 55,242 users, including 18,065 healthcare providers. DoD's Clinical Data Repository is operational and contains electronic clinical records for more than 8.7 million beneficiaries. AHLTA use continues to grow at a significant pace. As of the end of January 2006, our providers had used AHLTA to process 38,647,198 outpatient encounters, and they currently process more than 113,400 patient visits per workday.

Additional components to AHLTA are yet to be unveiled, including a new inpatient module. Last month, at the American Health Information Community meeting, VA Secretary Nicholson and I announced that DoD and the Department of Veterans Affairs will collaborate to develop a joint inpatient electronic health record system for active duty military personnel and veterans. This is a groundbreaking decision.

The DoD and VA are a federal information-sharing success story. Because of our sharing of clinical data, we are already decreasing redundant tests and procedures for our patients, and reducing errors that are inherent to a paper records system.

AHLTA contains the largest computable and structured medical data repository in the world. As you know, we are leading the nation in standards adoption and interoperability.

Before the end of this decade we will be using AHLTA as a central research and planning tool, leveraging its computable health data to improve patient outcomes through prevention, early detection, and proper intervention.

Our accomplishments associated with the successful implementation of AHLTA are truly remarkable. It stands today as one of the most comprehensive, sophisticated, and promising electronic medical record systems in the world.

**Effective Management of Healthcare Costs**

Sustaining a medically ready military force and providing world-class health services for those injured and wounded in combat remains our primary mission. Yet, our resources are limited. Military commanders, defense leaders and our elected officials rightly expect us to simultaneously manage healthcare costs and provide outstanding healthcare to our beneficiaries. We are working hard to manage the MHS more efficiently and effectively with the resources we have. Let me highlight what we are doing.

The most comprehensive changes to our system in a generation will be brought about by the Base Realignment and Closure decisions. The BRAC recommendations will improve use and distribution of our facilities nationwide, and affect healthcare delivery and medical training across the MHS. The consolidation of medical centers in the National Capital Area and San Antonio will improve operations by reducing unnecessary infrastructure, rationalizing staff, and providing more robust environments to support Graduate Medical Education. In some areas, we expect to significantly enhance care by

providing services closer to where our beneficiaries reside, for example at Fort Belvoir, Virginia. By contrast, in smaller markets, MHS facilities will cease to provide inpatient services and instead focus on the delivery of high-quality ambulatory care. The BRAC recommendations will bring most medical enlisted training programs to Fort Sam Houston. As a result, the MHS will reduce its overall technical-training infrastructure while strengthening the consistency and quality of training across the Services.

Important activities are underway at all facilities affected by BRAC, and the key to our success in BRAC is the creation of sound planning principles to shape these new structures in ways that are joint, interoperable, non-redundant, and effective. In November 2006, following many months of work led by my office and the Joint Staff, the Deputy Secretary of Defense issued a policy that establishes new joint authority structures for a governance model that will serve our system well in aligning responsibility and authority throughout the military health system. We will consolidate and operate more jointly our large medical-delivery markets, education and training, medical research and development, and critical common-shared-service functions that support the entire MHS.

Finally, the aging and overcrowded facilities at USAMRIID will be replaced with a cutting edge, modern research facility that will continue to produce medical countermeasures to the world's deadliest diseases. The new USAMRIID will serve as the cornerstone of the emerging National Biodefense Campus at Fort Detrick, Maryland, which is currently under development with the Department of Homeland Security and the National Institute of Allergy and Infectious Diseases. We are also planning for a replacement facility to support the U.S. Army Institute of Chemical Defense at Aberdeen, Maryland, the nation's premier center of excellence to identify and develop medical countermeasures for chemical warfare agents. The transformation of our physical infrastructure will help us meet the demands of the evolving war on terrorism and the potential threats we face today.

Despite our success in more efficiently managing healthcare costs utilizing a variety of initiatives, much work remains to be done. We continue to use a number of proven means to reduce healthcare costs in our system. These include:

- Obtaining significant savings for pharmaceuticals at our military treatment facilities and mail-order venue when compared to the retail point of service. The acquisition price of brand-name drugs, which represent the bulk of pharmaceutical expenditures in DoD, average 25 percent to 40 percent less at military treatment facilities and mail-order when compared to retail.

- Implementing the new TRICARE pharmacy formulary. We estimate savings of more than $500 million in just the past two years due to key formulary-management changes and decisions.

- Contract strategies. Effective TRICARE contracting strategies have reduced administrative costs, and our effort to further enhance the next generation of the TRICARE contract is well underway. Once again, our Chief Financial

Officer estimates several hundreds of millions of dollars in savings due to these new contracts.

- Further increases in Department of Veterans Affairs (VA) and the Department of Defense (DoD) sharing of facilities, capabilities, and joint procurements.

- The introduction of new prime vendor agreements to lower costs of military treatment facility medical and surgical supplies. The MHS has aggressively negotiated preferential pricings with medical-supply vendors across the country, and we project savings of $28.3 million in 2007.

In support of the Secretary of Defense initiative to relieve stress on operational forces by returning military billets to a war-fighter role, we embarked on a thorough analysis of our medical force structure. The Medical Readiness Review was an integrated approach to analyzing our force composition and defining an optimal balance of uniformed personnel and civilians. As a result of this analytical process, we are now leveraging military-to-civilian conversions as an effective tool to reduce costs and sustain operational readiness while continuing to provide high-quality, accessible healthcare.

We are carefully evaluating proposed conversions for potential impact. Only those opportunities that will not increase costs and will not degrade quality of or access to care are selected for implementation. Since the beginning of this initiative, the Congress has required that the Service Secretaries certify that conversions will not negatively impact their mission. This certification process has been delayed by successive FY 2007 Continuing Resolutions, in which funding for planned conversions has not been provided. Inadequate or delayed funding impedes our ability to certify and execute the conversions and puts projected savings at risk. It also has the potential to impact access to care if funds are not available to hire qualified staff to replace the departing service member.

We continue to implement a prospective payment system in a phased, manageable way, and we incentivize local commanders to focus on outputs, rather than on historical budgeting. We are confident this budgeting approach will ensure our hospitals and clinics remain high-quality, highly efficient medical institutions in service to our patients.

Using our strategic planning tool – The Balanced Scorecard – we are identifying the most critical mission activities, and then using the Lean Six Sigma methodology to create a data-driven, decision-making culture for process improvement. The Service Surgeons General have aggressively incorporated this methodology into their business operations, and we are already witnessing the fruits of this engagement.

In the fall 2006, we began the Innovations Investment Program, designed to identify the best practices in place at select military treatment facilities or best practices utilized by private-sector healthcare firms and introduce them to DoD on a global scale. Our intent is to accelerate the introduction of these best practices, using a joint-service, interdisciplinary team of experts to evaluate, validate and then implement proven approaches to better healthcare delivery. The evaluation phase is already underway, and we plan to begin substantive program changes in the coming year.

Finally, last year the Administration proposed to Congress changes in the TRICARE benefit to place the Defense Health Program on a sustainable financial footing. The Department of Defense has not altered the TRICARE benefit in the last 13 years, except when this benefit was enhanced through reductions in co-pays, expansions in covered services (particularly for military beneficiaries age 65 and over), new benefits for the Reserve Component, and other select benefit enhancements.

These benefit enhancements have come at a time when the private sector is shifting substantially more costs to employees for their healthcare. The twin effect of greater benefits for DoD beneficiaries, coupled with reduced benefits for those in the private sector has led to a significant increase in military retirees electing to drop their private health insurance and become entirely reliant on TRICARE for their health benefit.

Although the Congress took no action last year to change TRICARE co-payments, the underlying problem continues unabated. In 2006, our proposals were estimated to reduce military healthcare costs by more than $11 billion over 5 years. Our estimates for cost growth through 2013 are not complete, but we are still witnessing sizable growth in the number of TRICARE-reliant beneficiaries in our system, and the pressures on the defense budget grow. Military health care costs continue to increase substantially. The FY 2008 President's budget request includes a legislative proposal that aligns TRICARE premiums and co-payments for working age retirees (under age 65-years) with general health insurance plans. The Department may modify or supplement this request after it considers recommendations from the Department of Defense Task Force on the Future of Military Health Care that has been recently established with distinguished membership from within the Department, other federal agencies and the civilian sector. A key area the Task Force will study and on which it will make recommendations is "beneficiary and government cost-sharing structure." We believe this and the other recommendations they make will markedly benefit the MHS in the future.

Simply put, the Department and Congress must work together to allow the Department to make necessary changes to the TRICARE benefit to better manage the long-term cost structure of our program. Failure to do so will harm military healthcare and the overall capabilities of the Department of Defense – outcomes we cannot afford.

**Sharing Initiatives with VA**

As we continue to seek ways to improve the healthcare for our beneficiaries, we constantly explore new avenues of partnership with the Department of Veterans Affairs (VA). We have established 504 sharing agreements covering 2,090 health services with the VA, and in FY 2006, 98 VA Medical Centers reported reimbursable earnings during the year as TRICARE Network providers. Every day we collaborate to further improve the healthcare system for our service members. We have substantially increased joint procurement, and we are working to publish jointly used evidence-based clinical-practice guidelines for disease management to improve patient outcomes.

We are committed to working with the VA on appropriate electronic health information exchanges to support our veterans. The Federal Health Information Exchange is an important capability that enables the transfer of protected electronic health information from DoD to the VA at the time of a service member's separation. We have transmitted messages to the FHIE data repository on more than 3.7 million retired or separated Service members.

Building on the success of FHIE, we are now sending electronic pre- and post-deployment health assessment information to the VA. We began this monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository in September 2005. More than 1.5 million pre- and post-deployment health assessments on more than 623,000 individuals are available to the VA.

In December 2006, we added weekly data pulls of post-deployment health reassessments for individuals referred to the VA for care or evaluation. DoD and the VA are also in the process of assessing our requirements for the joint development of an inpatient module for our electronic medical record.

Both the VA and DoD are committed to providing our service members a seamless transition from the MHS to the VA. DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness." This policy provides guidance for collecting and transmitting critical data elements for service members involved in a medical or physical evaluation board. DoD transmitted pertinent data to the VA from October 2005 through May 2006; thereafter transmissions were discontinued while enhancements to the security were, and continue to be, explored.

We have provided information for 13,622 service members while they were still on active duty, allowing the VA to better project future workload and resource needs. When the VA receives these data directly from DoD before service members separate, it eliminates potential delays in developing a benefits claim. This process ensures that the VA has all the relevant information to decide claims for benefits and services at the earliest possible time.

**Conclusion**

Our military engagements in Iraq, Afghanistan and other locations, combined with our medical humanitarian missions and our peacetime health-delivery mission have simultaneously tested the MHS. Our medics continue to exceed the expectations of all our stakeholders.

Yet, the critical concept that MHS leaders share is simple – we can never be satisfied with our accomplishments. The people we serve – our line commanders and civilian leadership; our service members and military families; and the representatives of the American people in the Congress – expect us to accomplish even more, and to build upon our successes.

And there is more work to do: Investments in medical technologies to protect and defend our military community against future threats; wise stewardship of limited

taxpayer dollars to sustain a quality health system serving more than 9 million Americans; and the commitment to continued military and professional development of medical professionals of all types – physicians, dentists, nurses, enlisted specialists, and administrators.

The expectations that so many people, in so many places, hold for this country's military health system are very high. Our responsibility in the coming year – and years – is to continue to exceed these expectations. Our obligations are to those who follow us – today's sergeants and corporals, lieutenants and captains, and civilians now rising through the system.

With the assured support of the DoD leadership and of the Congress, the MHS remains committed to sustaining and passing on this legacy of achievement and stewardship for the medical leaders of the future. On behalf of the MHS, I am grateful for the resources and encouragement you provide to all who serve, and look forward to working with you in the coming year.

- END -

## QUESTIONS AND ANSWERS SUBMITTED FOR THE RECORD

FEBRUARY 13, 2007

## QUESTIONS SUBMITTED BY DR. SNYDER

Dr. SNYDER. Are you planning to provide us additional information on the status of your budget so that we might analyze that?

Dr. WINKENWERDER. The Department is waiting for recommendations from the Task Force on Military Health Care before issuing any specific proposals this year. As directed by Congress, the Department has not increased enrollment fees for TRICARE Prime, changed the deductibles for TRICARE Standard, or implemented an enrollment fee for Standard. There have also been no changes in the co-payments for pharmaceuticals. As a result, the cost-share paid by beneficiaries has remained flat while overall health care costs have gone up significantly. The result is that the Department of Defense's (DOD's) health care budget continues to be a larger portion of the DOD overall budget than it should.

Dr. SNYDER. Why has the DOD recommended, and approved a plan to obtain state-of-the-art second opinion pathology consultations by an ill-defined, fragmented system of commercial laboratories with uncertain outcomes, when the world-renowned AFIP has been doing this in an exemplary fashion? The plan is to outsource these secondary consults to the very same organizations that are currently sending these specimen to the AFIP. If these consults are not available, how does the quality of care of our Active Duty men and women, as well as our veterans, be affected?

Dr. WINKENWERDER. The Secretary of Defense's recommendation to outsource second opinion pathology consultations was based on the recommendation from the Medical Joint Cross-Service Group (MJCSG), one of seven cross-Service groups established by the Base Realignment and Closure (BRAC) process. The MJCSG was chartered to review DOD health care functions and to provide BRAC recommendations based on that review.

The MJCSG developed key strategies to guide deliberations based on the key objectives above. These strategies came from an analysis of the BRAC final selection criteria. The MJCSG focused its efforts on:

- Supporting the war fighter and their families, in-garrison and deployed;
- Maximizing military value while reducing infrastructure footprint and maintaining an adequate surge capability;
- Maintaining or improving access to care for all beneficiaries, including retirees, using combinations of the Direct Care and TRICARE systems;
- Enhancing jointness, taking full advantage of the commonality in the Services' health care delivery, health care education and training, and medical/dental research, development, and acquisition functions;
- Identifying and maximizing synergies gained from collocation or consolidation opportunities; and
- Examining outsourcing opportunities that allow DOD to better leverage the large United States health care system investments.

Based on leveraging university and hospital services and commercial laboratories, the Department will rely on the civilian market for second opinion pathology consults and initial diagnosis when the local pathology laboratory's capabilities are exceeded.

Dr. SNYDER. Why have you not assessed the current outsourcing plan, as far as quality, cost and feasibility from the global deployment of the armed services are concerned? Why have you not calculated the projected costs over period of time?

Dr. WINKENWERDER. The Medical Joint Cross Service Group (MJCSG) has assessed the outsourcing of secondary consultations for the Department. According to the MJCSG report, "Over half of Armed Forces Institute of Pathology's (AFIP's) capacity is being dedicated to commercial activities with private industry. Since these are not Department of Defense (DOD)/Defense Health Plan core business requirements, they are considered excess and should be discontinued. Additionally, AFIP's low military value is reflective of its small portion of military-related workload." Based on this assessment, the recommendation was to stop performing secondary consultations within DOD for both civilian and military cases and to leverage the large United States health care system investments. As a result of this recommendation, in the future, the Department will rely on the civilian market for sec-

ond opinion pathology consults and initial diagnosis when the local pathology laboratory's capabilities are exceeded.

Dr. SNYDER. After September 11th, the AFIP has shown that it can respond 24/7 worldwide in quality, scope and flexibility to medical threats; e.g., SARS, anthrax, avian flu. The private analysis (Bearing Point study) commissioned by the Army SG office this year recommended maintaining a somewhat leaner but vibrant AFIP organization and moving it to USUHS in Bethesda. That analysis also stated: "For DOD, disestablishment may result in the loss of immediate response capability to medical threats that could impact combat effectiveness or operational forces. For the nation, it eliminates robustness in capacity to respond to potential bioterrorism threats such as the recent anthrax and SARS situations." Who will respond to urgent military needs around the world if our core of pathology experts is disbanded? How can DOD replace this "battle-tested" unit with a proven track record by an intangible outsourcing replacement to nebulous commercial laboratories?

Dr. WINKENWERDER. The DOD participates in the international Laboratory Response Network and environmental surveillance. All of the Services have laboratory and epidemiological capabilities that can be mobilized or deployed during infectious disease outbreaks. These Service capabilities can be augmented by commercial and DOD organizations. Assisting organizations in the DOD/Military Services network include the Global Emerging Infections Surveillance and Response System (DOD–GEIS), United States Army Medical Research Institute for Infectious Diseases (USAMRIID), the Air Force Institute for Operational Health (AFIOH), and the Naval Health Research Center (NHRC) Respiratory Disease Laboratory. United States Public Health Service and State organizations may also provide support.

The DOD–GEIS oversees the conduct of microbiological surveillance and focused surveillance activities at various DOD laboratories worldwide, and at the public health centers of the Air Force, Army, and Navy. The DOD–GEIS taps a network of collaborating experts and laboratories to provide emerging infectious disease consultation; identify vulnerabilities in surveillance, response and infrastructure; and, assists DOD partners to develop projects and implement programs that mitigate emerging infection threats.

USAMRIID develops vaccines, drugs, diagnostics, and information to protect United States Servicemembers from biological warfare threats and endemic diseases. It is the only laboratory within DOD with the capability to study highly hazardous viruses requiring maximum containment at Bio-Safety Level 4.

The AFIOH, Brooks City Base, Texas, provides active respiratory disease surveillance through a network of sentinel sites around the world as well as associated epidemiology support. The NHRC, San Diego, California, performs systematic, population-based respiratory disease surveillance among United States military trainee and shipboard populations.

Dr. SNYDER. The BRAC Commission's noting that the medical community argued that AFIP is an irreplaceable resource for disease research and education; why are these AFIP capabilities being eliminated especially since we are at war with our troops again stationed all over the world?

Dr. WINKENWERDER. The Department of Defense (DOD) will retain capabilities from AFIP that are critical to the military. These capabilities will be absorbed by DOD organizations and redistributed across DOD sites in the National Capital Area, Dover, Delaware, and San Antonio, Texas. The capabilities identified for absorption support the Secretary of Defense's BRAC goals to more efficiently and effectively support its forces, increase operational readiness, and facilitate new ways of doing business. When combined with full implementation of the BRAC law, the result is a set of capabilities that directly support the DOD mission.

Dr. SNYDER. In your letter dated March 27, 2006, to Representative Van Hollen, you stated "it is recognized that some of the functions of the institute are critical to military and civilian medicine and must be retained." You further stated that the independent contractor, Bearing Point, will recommend and identify these critical components of the Institute and based on its recommendation an appropriate course of action will be taken. Why are you not accepting Bearing Point's recommendation: "Retain Diagnostic and Consultative Services . . . to perform multidisciplinary diagnostic pathology . . . and allow for robust use of the repository"?

Dr. WINKENWERDER. The disposition of the Armed Forces Institute of Pathology's second opinion pathology consultation service is specified in the Base Realignment and Closure Commission's final recommendation, and is, therefore, not eligible for retention within the Department of Defense. Therefore, the Department does not have the option to accept Bearing Point's recommendation.

Dr. SNYDER. The tissue repository obviously must be kept by the DOD; therefore, why do you assume that it will remain viable and robust with no expert group of pathologists and staff to input cases?

Dr. WINKENWERDER. The Department continues to develop a plan for the optimal use of the tissue repository and the staff requirements to support this use.

Dr. SNYDER. Why have you not fully analyzed the impact of closing the AFIP with its resulting effect on other federal agencies; e.g., Department of Veterans Administration and the U.S. Public health services?

Dr. WINKENWERDER. The VA and the United States Public Health Service are members of the AFIP Board of Governors and have been involved in all discussions concerning the impact of the Base Realignment and Closure plan on the Department and their agencies. Both agencies collaborated on the capabilities to be retained within the Department of Defense and will continue to be involved in planning for the outsourcing of second opinion consultations.

Dr. SNYDER. Why have you not communicated your final decision to the appropriate committees in the Congress? Why are the AFIP executive committee and Board of Governors going ahead and eliminating positions in October of this year?

Dr. WINKENWERDER. The plan and timeline for the disestablishment of AFIP, according to the Base Realignment and Closure (BRAC) law, is contained in a report to Congress that will be forwarded shortly. The execution of the BRAC implementation plan for AFIP is contained in Business Plan #169. In order to meet the savings contained in this plan, the manpower reductions at AFIP must occur in October of 2007. Therefore, the process to implement this reduction in force must begin now.

Dr. SNYDER. Autism—The FY07 John Warner National Defense Authorization Act required the Secretary to develop a plan to provide services to military dependent children with autism. The plan was required to address the education and training requirements for providers, the standards for identifying and training individuals with various level of expertise, and the procedures to ensure that these services are in addition to those publicly provided. The report is not due until April 2007, but a recent CDC report indicates the incidence of autism among 8 years olds is greater than previously assumed. Thousands of these children are in the military health care system and their parents are in need of support. What is the status of the plan, will we receive it on time, and are there any early indications that the Department will need legislative authority to implement any changes?

Dr. WINKENWERDER. The final report, in preparation at this time, will propose an interim solution for improving the number and availability of TRICARE certified providers of Applied Behavior Analysis (ABA). The Department expects to submit the report to Congress in a timely manner (Summer 2007). At this time, the Department does not expect that legislative authority to implement the plan is required.

Dr. SNYDER. Health Care Costs—Health care costs in the direct care system are assumed to be lower than obtaining similar services from civilian community. While both systems have similar services, they have different missions. Comparisons between the two currently are apples and oranges, has this comparison ever been studied? If so, why not? Shouldn't we understand the true costs before losing military capacity to the civilian sector?

Dr. WINKENWERDER. You are correct when you say that the different systems have different missions and that, because of those differences, direct comparisons are difficult. When detailed studies have been made on similar services, Direct Care, for the most part, has been shown to be more expensive than obtaining those same services from the civilian community (the notable exception is pharmacy where the Direct Care system can obtain pharmaceuticals at Federal ceiling prices). However, part of the additional expense of the Direct Care system is the result of its "other" mission, i.e., its primary mission of supporting the war fighters, especially in this time of ongoing conflicts. We are now beginning an effort to quantify those mission essential activities so they can be accounted for in future analyses of the true cost of providing Direct Care services. It is still clear, however, that, for the infrastructure and military personnel we need for our primary mission, using those assets to provide health care and maintaining those providers' medical skills is better than obtaining all of the beneficiary care in the civilian sector.

Dr. SNYDER. Medical Recruiting and Retention—The nation is facing a national nursing and physician shortages, and the military health care system is not immune from this environment. In addition, other health care providers, such as psychologists and pharmacists are also in high demand. What is Health Affairs doing to proactively address this issue?

Dr. WINKENWERDER. Health Affairs is working closely with the Services to utilize the significantly increased authorities in the National Defense Authorization Act for Fiscal Year (FY) 2007—for Medical/Dental accession bonuses, Health Professions Scholarship Program (HPSP) stipend, Financial Assistance Program (FAP) annual grant, and Health Professions Loan Repayment Program (HPLRP) maximum annual amount. The implementation of these authorities and the budgeting for them is currently being staffed with the Services. Some of the actions already undertaken

have been to raise the Dental Officer Accession Bonus from $30K to $60K, the Four Year Nurse Accession bonus was increased to $25K. Health Affairs has recommended that the Services implement incremental increases in the stipend for the HPSP and FAP for the FY 2007–2008 school year. The Services and Health Affairs are currently staffing a plan to implement and budget for the up to $400K accession bonus for medical/dental critically short wartime specialties.

The Services can also request Critical Skills Retention Bonuses, as the Air Force has, to improve retention of psychologists, as the Army has for psychologists, pharmacists, nurses, and other allied health professions in specific year groups.

Health Affairs and the Services are also working closely with the Quadrennial Review of Military Compensation to provide new ideas to restructure incentive and special pay to meet the demands of the future.

Dr. SNYDER. Military to Civilian Conversions—The Navy's share of Military-Civilian (Mil-Civ) conversions was recently increased. Given that the Marine Corps end strength is increasing and Navy individual augmentation continues to increase, is the Department monitoring the impact of military to civilian conversions on the Navy medical system? Another concern is that some of the positions identified for military to civilian conversions include doctors, nurses and mental health providers, given the deployment demands on these communities, has there been any thought of exempting these types of medical professionals from the military to civilian conversions?

Dr. WINKENWERDER. The Medical Readiness Review (MRR) evaluated military medical billets that had been identified by the Military Departments as excess to readiness requirements to determine if they could feasibly be converted to civilian or contract personnel at no additional net cost to the Department of Defense. Only billets that met these criteria were selected for conversion, and the Military Departments agreed to these conversions. The Assistant Secretary of Defense for Health Affairs has placed no restrictions or exemptions on the types of positions converted. Rather, the Service Surgeons General and their staffs have maximum discretion in determining what specialties (e.g., physicians, nurses, technicians, etc.) to convert from military to civilian based upon the current and projected needs of each Service. These conversions are not projected to have a detrimental impact on health care delivery capability or quality at Military Treatment Facilities and have no impact on readiness capabilities.

In an action separate from the military-to-civilian conversions resulting from the MRR process, 901 Navy military billets were identified for elimination. This action was taken based on programmed adjustments to active duty Navy and Marine Corps end strength. The Department analyzed the health care usage patterns of active duty Navy and Marine Corps personnel and their families and determined the appropriate reductions for Private Sector Care and In-House Care resources to reflect the end strength adjustments. The In-House Care resources were further allocated into Defense Health Program Operation and Maintenance reductions and Navy Military Personnel reductions, to reflect the reduced requirement for military labor. The net adjustment to Navy and Marine Corps end strength over the period addressed by the Program Decision Memorandum is a decrease of 4.0%; the 901 Navy Medical end strength reduction is a decrease of 3.8% over the same time period.

The Department is committed to maintaining the military medical force structure necessary to support readiness requirements, as well as to maintaining a superb health care benefit for all of our eligible beneficiaries. We look forward to working closely with the Committee and appreciate your continued support of the Military Health System.

Dr. SNYDER. Mental Health—There have been a number of media reports regarding servicemembers that have returned from OIF/OEF and have exhibited symptoms of Post Traumatic Stress Disorder (PTSD). Some of these service-members have indicated a reluctance to seek mental health services because of the stigma associated with mental health. What is Health Affairs doing to help reduce mental health stigma? A military mental health professional indicated we do not have an adequate number of mental health providers or the requisite training needed to take care of the long-term psychological challenges that we may see as a result of OIF and OEF. What is Health Affairs doing to prepare for the future challenges that we may face in this arena?

Dr. WINKENWERDER. To reduce stigma, mental health education is fully integrated and mandatory at multiple levels of military training, deployment, and post-deployment. For example, suicide prevention activities in all Service branches train servicemembers at all levels to recognize others in distress at a low threshold. Specialized training programs exist for supervisors and leaders in suicide prevention. In addition, most branches utilize Web-based and compact disc-based Leaders'

Guides for Personnel in Distress to assist supervisors and commanders to appropriately manage members with 37 of the most common mental health stressors encountered in our population. Pre- and post-deployment briefings for members and their families review anticipated stressors and ways to manage them, including referral resources. Substantial counseling resources are available to servicemembers and their families with confidentiality and no stigma. These include confidential screening using the free and confidential online service, utilization of chaplains with full confidentiality, MilitaryOneSource that includes online, e-mail, phone, and face-to-face counseling with Master's level counselors for prevention, education, and referral services; family support counselors; and family advocacy services. Members requiring more intensive assistance are referred to mental health providers who seek to respect confidentiality, consistent with mission need.

Dr. SNYDER. Traumatic Brain Injury—Much focus has been placed on the treatment of those with the visible injuries. Yet, not all Traumatic Brain Injuries are visible, but early intervention and treatment are critical to recovery. How are we assessing servicemembers who do not manifest overt signs of injury? Are we capturing TBI injuries adequately? Is there a tracking mechanism to ensure these servicemembers do not slip through the cracks?

Dr. WINKENWERDER. Servicemembers in-theater who are exposed to a possible TBI-producing incident, whether by fall, explosion, motor vehicle accident, or other event known to create a risk for TBI, are assessed according to a clinical practice guideline that was implemented in-theater in August 2006. This guideline requires using a tool called the Military Acute Concussion Evaluation (MACE), which will provide a reasonable assessment of whether a TBI exists as a result of that event, regardless of other injury. It is clear that in the confusion and chaos of a major Improvised Explosive Device explosion with loss of life or serious injury, TBI in those visibly injured, and in those otherwise not apparently injured, may be missed. We are providing training to raise medical and leadership awareness of TBI as an injury that may impair the war fighting abilities of those affected, and so imperil them and their fellow servicemembers if not identified and appropriately treated. All servicemembers with injuries that require evacuation to Landstuhl Regional Medical Center are assessed using the MACE if TBI was not previously documented. Starting June 1 2007, screening for TBI will be part of the Post-deployment Health Assessment, the Post-deployment Health Reassessment, and the Periodic Health Assessment.

Dr. SNYDER. DOD–VA Seamless Transition—For years both Departments have been attempting to develop a seamless transition for servicemembers, however, it still seems as though there are a number of obstacles for servicemembers. Can you provide us with a list of programs that have been implemented, and can you identify what the status is of each of these programs?

Dr. WINKENWERDER. The Departments of Defense (DOD) and Veterans Affairs (VA) are collaborating to coordinate transition of health care for servicemembers and veterans, including those severely wounded during Operation Iraqi Freedom and Operation Enduring Freedom. The objectives of coordinated transition include ensuring continuity of care from DOD to VA health care providers; providing clear and comprehensive benefit information to servicemembers and their families; and, transferring medical records and results of separation physicals from the DOD to the VA.

Severely injured servicemembers often require prolonged treatment and rehabilitative care. The DOD met this challenge by establishing specialty centers of excellence and partnerships with the VA. Key components of DOD and VA healthcare for severely injured servicemembers include three DOD amputee care centers, the Brooke Army Medical Center Burn Center, the Defense and Veterans Brain Injury Center, and four VA Polytrauma Rehabilitation Centers (Tampa, Florida, Minneapolis, Minnesota, Richmond, Virginia, and Palo Alto, California).

The four VA polytrauma centers are designed to meet the needs of active duty Servicemembers and veterans who experienced severe injuries resulting in traumatic brain injuries, spinal cord injuries, amputations, or visual impairment. From March 2003 to December 2006, 342 active-duty servicemembers were treated in the four polytrauma centers. In addition to the four polytrauma centers, 21 new VA Polytrauma Network Sites opened in Fiscal Year 2006 to provide continuing care to injured veterans. In addition, the VA provides care to injured veterans at 23 spinal cord injury centers and 10 blind rehabilitation centers.

The Military Severely Injured Center, MilitaryOneSource, and four Service-specific programs provide linkages to VA to ensure continuity of care as the servicemember transitions to veteran status. The Military Severely Injured Center, established in February 2005, provides 24/7 support to servicemembers and their families, ensuring they are aware of all available options, and interacting with the

involved agencies to ensure uninterrupted, highest-quality care. These programs reach out to servicemembers, evaluate their needs, and coordinate referrals to programs to provide the appropriate services. Four Service-specific programs provide assistance: the Army Wounded Warrior Program, Marine for Life, Air Force Palace HART, and Navy Safe Harbor. Each provides counseling, employment assistance, family support, and other services needed to transition to home and the community.

The critical elements for the transition of medical care from DOD to VA include:

- A thorough understanding of medical care capabilities within both agencies by the involved medical providers,
- Clear communications of the transition plan between providers in each agency and with the patient and patient's family,
- Transfer of medical records at the time of transfer of the patient, and
- Continuation of communication after the transfer of the patient between the medical providers in each agency and with the patient and patient's family.

In August 2003, a joint DOD/VA program was established at Walter Reed Army Medical Center (WRAMC) to provide case management for combat veterans. When severely injured servicemembers need long-term medical care, VA social work personnel and VA benefits counselors work with them to coordinate VA services. This joint program has expanded to nine other facilities: the National Naval Medical Center, Naval Hospital Camp Pendleton, Naval Medical Center San Diego, and six Army hospitals (Brooke, Eisenhower, Darnall, Madigan, Evans, and Womack). Twelve VA social workers provide the linkage from these ten hospitals to follow-up care at a VA Polytrauma Center, if continued inpatient care is needed. If outpatient care is needed, the social workers provide the linkage to VA facilities near the servicemembers' homes.

The VA social workers and counselors assigned to the military hospitals are usually the first VA representatives to meet with servicemembers and their families. They provide information about the full range of VA benefits and services, which include health care and readjustment programs, disability compensation and related benefits, the traumatic injury benefit provided under the Servicemembers Group Life Insurance Program, as well as educational and housing benefits. As of February 28, 2007, there had been 7,082 VA referrals at the ten military hospitals.

Weekly video teleconferences are scheduled between WRAMC and the four VA polytrauma centers. These provide ongoing communication between DOD and VA physicians and nurses about patients who will be transferred. There is also communication between case managers at the Military Treatment Facility and the VA polytrauma centers that takes place before transfer. In addition, Army liaison personnel work at the four VA polytrauma centers to facilitate communication between the patients, families, health care providers, and to resolve issues that might arise related to military pay, travel, family housing, and other problems.

Servicemembers who apply for disability compensation benefits under the Benefits Delivery at Discharge (BDD) program undergo a medical examination while still on active duty. The Program is a jointly sponsored VA and DOD initiative to provide transition assistance to separating servicemembers who have disabilities related to their military service. The program helps servicemembers file for VA service-connected disability claims prior to separation from service, so that payment of benefits can begin as soon as possible after discharge. Under the BDD Program, servicemembers can complete an application for VA disability compensation benefits up to 180 days prior to separation. The single VA/DOD medical examination meets the military's needs for a separation physical and also fulfills VA's examination requirements for processing the disability claim.

Dr. SNYDER. Unified Medical Command—The proposed unified medical command issued by Secretary England is a departure from what the services were seeking as a genuine Unified Medical Command, which sought to increase efficiencies and gain savings. If the intent is to seek efficiencies and generate savings, why was the decision made to pursue a hybrid proposal as opposed to the UMC that was proposed by the Services? Where all of the Surgeon Generals involved in the decision making process? What were their recommendations on the UMC and how do they differ from what Secretary England approved?

Dr. WINKENWERDER. Program Budget Decision (PBD) 753 directed the Under Secretary of Defense for Personnel and Readiness (USD(P&R)) to work with the Chairman of the Joint Chiefs of Staff to develop an implementation plan for a Joint Medical Command by the Fiscal Year (FY) 2008–2013 Program/Budget Review. A work group chartered under the USD(P&R) and the Chairman, Joint Chiefs of Staff prepared recommendations and possible courses of action for a UMC. Each of the Service Surgeons General was represented on this work group. During the same time, the Defense Business Board studied the issue and recommended one route to unifi-

cation to the Secretary of Defense. Despite considerable effort, consensus was not achieved on a specific solution. After due consideration, the Deputy Secretary of Defense approved a framework for Achieving More Jointness and Unity of Command on November 27, 2006.

The approved framework consists of incremental and achievable steps that will yield efficiencies throughout the Military Health System (MHS). Economies of scale are achieved by combining common functions. The structural and functional changes create a foundation for implementing MHS Quadrennial Defense Review (QDR) transformation while preserving a Service unique culture for each medical component. Each aspect of the framework supports principles of unity of command and effort while creating a joint environment for the development of future MHS leaders. The concept includes accelerated consolidation of medical headquarters under Base Realignment and Closure law, maintenance of USD(P&R) oversight of the Defense Health Program (DHP), and positions the MHS for further unification, if warranted.

Structural changes are included in the Deputy Secretary of Defense approved framework. These include:

- Establishment of a joint command for the National Capital Area, and a similar command for San Antonio;
- Establishment of joint commands for other multi-service markets;
- Establishment of a joint command for the Joint Medical Education and Training Center in San Antonio;
- Combination of all medical research and development assets under the Army Medical Research and Material Command;
- Creation of a joint Military Health Directorate to consolidate shared MHS services such as human capital, finance, IM/IT, logistics, and force health sustainment;
- Re-focusing of the TRICARE Management Activity on the benefit and health plan management and beneficiary support mission; and,
- Health Affairs' role in MHS policy development, strategy management, DHP budget development and oversight, and legislative strategy will remain unchanged.

The Assistant Secretary of Defense for Health Affairs is working with the Services and Joint Staff to develop a detailed implementation plan for each of the elements of the concept for more unity. The Service Surgeons General are directly involved in this work. An implementation team will be formed during FY 2007 and will be tasked with delivering the implementation plan within one year. All of the design elements contained in the Deputy Secretary of Defense's memorandum of November 27, 2006 are to be in place by the end of FY 2009.

The road map for achieving increased unity will yield improvements in quality, efficiency, patient satisfaction, and war fighter support consistent with the MHS Strategic Plan; each of the elements of the plan should contribute to the achievement of stability and uniformity of healthcare processes and resource acquisition:

- By establishing more unity of command in each of the major markets, the market leaders will be able to distribute resources across hospitals and clinics within a market to meet the needs of the entire population of eligible beneficiaries. In addition, the increased span of control will enable improved continuity of care and coordination of safety and quality programs.
- Through the establishment of a joint command for the Joint Medical Education and Training Center, the MHS will improve the quality and consistency of training for all enlisted, contributing to a culture of jointness and interoperability.
- The combination of all medical research and development assets under the Army Medical Research and Material Command will foster better coordination of research activities, eliminate redundant efforts, and focus resources on developing novel solutions for both the war fighter and the clinician.
- The creation of a joint Military Health Directorate to consolidate shared services has perhaps the most potential to improve quality of care, quality of service and efficiency:
  - The potential to combine data management and analysis functions should lead to greater standardization, shared quality and performance measures, and much improved workload and cost data needed for optimal management decisions. This is also a critical element of the MHS QDR Roadmap for Medical Transformation.
  - Coordinated implementation of the DOD Continuous Process Improvement program incorporating lean and six sigma methodologies will result in reduced variation, improved quality, and elimination of waste.

- Implementation of other shared services (human capital management, logistics, financial services, facilities planning, and design), will further enhance economies of scale and optimal distribution of resources.
- By refocusing the TRICARE Management Activity on the benefit, health plan management, and beneficiary support mission we will build upon gains already achieved in the area of beneficiary support, effective communication of the TRICARE benefit and performance based contracting for high quality health care services.
- The co-location of the headquarters functions of Health Affairs, the TRICARE Management Activity, the Army Medical Command, the Navy Bureau of Medicine, and the Air Force Medical Service will enhance efforts to achieve unity of purpose for MHS policy, strategy, and financial programming and yield greater consistency across the Services in program execution.

Taken as a whole, this set of incremental changes will result in more unity of effort by eliminating duplicative layers of command and control, leveraging efficiencies through combining common support functions, standardizing policy, training and doctrine for all our forces, rationalizing span of control at both tactical and strategic levels, and improving resource management, transparency, and accountability. This set of structural changes will be the foundation for the continuing MHS transformation that is described in the QDR Roadmap and the MHS Strategic Plan.

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## QUESTION SUBMITTED BY MR. MCHUGH

Mr. MCHUGH. What kind of look-see is your office, your department, doing to make sure that we are going to not unnecessarily and very harmfully erode the ability and the availability of mental health positions, particularly in deployed areas, particularly given the surge that we have talked a little bit about here today?

Dr. WINKENWERDER. We examine mental health staffing throughout the Department in order to maintain the current levels of filling uniformed positions, set by the Department of Defense (DOD). In January this year, our staffing numbers indicated that, across DOD, 92% of mental health personnel positions were filled. There were some imbalances between professions due to personnel fluctuations, with mental health clinical provider staffing ranging by specialty from 75% to 85%. When trends suggest potential shortages of particular specialists in the future, the Services respond by offering incentives to improve accession and retention of needed personnel. Branch-utilized incentives include offering annual Critical Skills Retention Bonuses as well as educational loan paybacks. Physician bonuses for psychiatrists are adjusted for all services, as required. The DOD continues to monitor their ability to attract and retain health care personnel and adjust incentives accordingly. Factoring in the need for deployable mental health assets should drive military-to-civilian conversion limitations.

Mr. MCHUGH. Can you give us an idea of how much of the $94 million, if any, did we achieve in efficiencies in the 2006 budget? What did you do to reach them? And what kind of efficiencies are we talking about when you are looking at $248 million for next year's budget?

Dr. WINKENWERDER. The Fiscal Year (FY) 2006 Defense Health Program Budget was reduced by $94 million in anticipation of efficiencies accomplished by the Services that would decrease costs. During the execution of the FY 2006 budget, efficiencies were achieved through a combination of implementing the TRICARE Uniform Formulary, which decreased drug expenditures in the direct care system for all three Services, and the following Service-specific initiatives:

- The Army Medical Department focused on increasing inpatient and outpatient market share, and rewarded successful facilities with additional resources earned through the Prospective Payment System.
- Navy Medicine focused on the consolidation of dental activities into the organization structure of their medical treatment facilities, enabling elimination of duplicative overhead activities and the achievement of staffing efficiencies in dental and support areas.
- The Air Force Medical Service focused on elimination of inefficient inpatient care facilities, with reinvestment of personnel at locations where significant workload recapture potential exists.

For FY 2007 and FY 2008, the focus is for the Services to continue to build on the FY 2006 efficiencies that were initiated and to continue to realize savings in pharmacy expenditures produced by the TRICARE Uniform Formulary. In addition, the Director of TRICARE Management Activity and the Service Surgeons General are taking action to identify opportunities for efficiencies by identifying the most

critical mission activities and then applying Lean Six Sigma methodology to achieve process improvements.

Note the FY 2008 incremental increase in the Efficiency Wedge was reduced from $248 million to $227 million to account for an overlap in cost reductions targeted for a different initiative.

Mr. MCHUGH. If you could get the figures as to what we did save in 2006 and what we did to save them, and also what the target is, where the target areas lie with respect to the $248 million for next year.

Dr. WINKENWERDER. The Fiscal Year (FY) 2006 Defense Health Program Budget was reduced by $94 million in anticipation of efficiencies accomplished by the Services that would decrease costs. During the execution of the FY 2006 budget, efficiencies were achieved through a combination implementing the TRICARE Uniform Formulary, which decreased drug expenditures in the direct care system for all three Services, and the following Service specific initiatives:

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For FY 2007 and FY 2008, the focus is for the Services to continue to build on the FY 2006 efficiencies that were initiated and to continue to realize savings in pharmacy expenditures produced by the TRICARE Uniform Formulary. In addition, the Director, TRICARE Management Activity and the Service Surgeons General are taking action to identify opportunities for efficiencies by identifying the most critical mission activities and then applying Lean Six Sigma methodology to achieve process improvements.

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## QUESTIONS SUBMITTED BY MRS. DRAKE

Mrs. DRAKE. What are military members told in recent years when they sign up to join the military? Are they told, "You are going to have affordable health care"? Are they told, "You have health care"? What are they told, and what is their expectation?

Dr. WINKENWERDER. In accordance with the TRICARE Operations Manual, Chapter 12, Section 2, Paragraph 1.4, each managed care contractor is available to brief recruiters three times annually. Additionally, each TRICARE regional office provides virtual briefings for recruiters and others interested in learning about the TRICARE benefit.

New Servicemembers and their families are invited to orientations and TRICARE briefings where information about TRICARE is provided. They are told they will be covered under TRICARE but they will need to make choices between Prime, Standard, and Extra. We provide pamphlets that explain the military health benefit and we also direct servicemembers to the TRICARE Web site which provides additional detailed information about the benefit. Reservists are also provided informational brochures and briefings to explain the new benefits under TRICARE Reserve Select.

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