

JOINT STATEMENT  
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REGARDING

THE MILITARY HEALTH SYSTEM OVERVIEW

BEFORE THE

HOUSE ARMED SERVICES COMMITTEE  
MILITARY PERSONNEL SUBCOMMITTEE

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Mr. Chairman, Members of the Committee, thank you for the opportunity to appear before you today and discuss the future of the Military Health System (MHS), particularly our priorities for the coming year.

This is Dr. Jonathan Woodson's first public appearance before this subcommittee in his role as the Assistant Secretary of Defense for Health Affairs, and we want to first express our deep gratitude for the warm and helpful guidance both you and your staffs have offered in his first two months in this position.

We are committed to full transparency, and a straightforward accounting of our performance as a system, and our performance as leaders. We want to begin by acknowledging the people who comprise the MHS. They have a well-deserved reputation for exceptional professional performance and personal courage. We believe deeply that military medicine has proven itself time and again as a learning organization, capable of self-critical analysis and substantive improvement in those areas where it falls short of its own and others' expectations.

We begin 2011 on a strong foundation. Our medical achievements on the battlefield, in combat hospitals, and in the air continue to set new standards for medical outcomes in combat...anywhere in the world.

We are fortunate to have the continued, substantive support of both the Congress and the White House. This support has been greatly enhanced by the very public effort led by the First Lady and Dr. Biden to highlight the contributions of military families to our national security, and to focus on how the broader American community can acknowledge this and support military families on the home front. Within the MHS, we are engaged in this effort as well, and we will illustrate some of our efforts in this testimony.

Even with our successes, challenges remain. First, we continue to provide medical treatment to Service members in combat in some of the most austere environments on the planet. There is nothing routine about this, regardless of how long we have been or remain at war. We will not waver from our primary focus to ensure the medical readiness of all of our Armed Forces, and the readiness of the MHS to deliver highly trained medical professionals to support them.

International events and ongoing humanitarian crises also remind us that we must be prepared to respond to additional events on a moment's notice at the direction of national command authorities. Readiness is more than the center of our strategic plan; it is our fundamental obligation and reason for being.

A key component of our readiness obligation is to ensure we sustain the confidence of the Service members we support here at home, and who have borne the greatest burden of war – the Service members with serious wounds, visible and invisible, along with their

families who sacrifice, who grieve, and who carry their own wounds from this conflict. We will continue to dedicate our time and resources to our care for wounded warriors and their families.

Finally, we must also operate in an environment that recognizes financial resources are limited. We must prioritize what is most important, and make difficult decisions about programs and services that are worthy, but not necessarily vital to our core mission. Today, we will explain the actions we are taking to address this real challenge.

The MHS has adopted a strategic construct – the Quadruple Aim – that captures the core mission requirements of this unique system of ours: Assure Readiness; Improve Population Health; Enhance the Patient Experience of Care; and Responsibly Manage the Cost of Care.

This construct has been in place for over a year and it has value in capturing our leading strategic imperatives. We are committed to a plan that has relevance and consequences for our medical personnel at the tip of the spear – delivering care around the world, and to the people we serve. We will use it to drive our investments, our priorities, and our measures for determining successful patient care.

Within the MHS, we have established an Individual Medical Readiness (IMR) metric to determine the medical preparedness of each Service member to deploy. For several years, our IMR measures have shown that, on average, our active duty Service members are prepared. Within the Reserve Component, medical readiness is below our benchmarks. We find that, in general, the individual reservists can quickly be elevated to a prepared status during the pre-deployment period (e.g., complete health assessments and ensure minor dental procedures and immunizations, etc. are quickly performed). We are in the process of engaging with commanders, particularly in the Reserve Component, to focus attention and corrective action on these matters within their unit. Overall, the medical readiness of our forces remains sound, and for the last two years we have seen continuous improved readiness each quarter, across both the Active and Reserve Components.

Congress has expressed much interest in the Department of Defense's (DoD's) ability to accurately identify deployed environmental health threats, characterize any risks, and reduce hazardous exposures. More than 19,000 air, water, and soil samples have been taken within the Central Command area of responsibility since 2003 to identify environmental hazards that may affect either the short-term or long-term health of our Service members and deployed civilian employees. We are pleased to report that the level of hazardous exposures appears to be minimal. In addition, our disease and non-battle injury rates remain very low, a testament to the efforts of our medical professionals in preventive medicine and environmental health. While we have been unable to identify any long-term health risks, on a population-wide basis, associated with the high levels of

airborne particulate matter and with burn pit smoke, we do not rule out that a small number of individuals may be adversely affected. All burn pits in Iraq, serving more than 100 individuals, have now been closed, and programs are in place in Afghanistan to replace as many of the burn pits as is feasible. We will continue to apply the best possible science to identify any long-term health effects that may be associated with these exposures. VA has contracted with the Institute of Medicine (IOM) of the National Academies to study the long-term health effects of exposure to burn pits in Iraq and Afghanistan. IOM's report is due in the fall 2011.

We also continue to work closely with the Department of Veterans Affairs (VA) on the implementation of a special medical surveillance program for approximately 1,000 veterans and DoD civilian employees who may have been briefly exposed to a carcinogen at the Qarmat Ali Industrial Water Treatment Plant in 2003.

In addition to our focus on the medical readiness of our current force, we are also looking to more rapidly implement proven technologies and clinical approaches, as well as to sustain our medical research and development programs that are essential to our future readiness posture. We are advancing our understanding – and the understanding of the broader American and global health community – of how to prevent, diagnose, and treat scores of illnesses and injuries. We are transferring our knowledge from the research bench to the battlefield, and lives are being saved.

The MHS medical research and development investment strategy for Fiscal Year (FY) 2011 is focused on early Diagnosis and Treatment of Brain Injury; Polytrauma and Blast Injury; Military-Operational Health and Performance; Rehabilitation; Psychological Health and Well-Being for Military Personnel and Families; and Military Medical Training Systems and Health Information Technology Applications.

Recognizing that important, early-stage medical research is also being conducted outside of the Defense Health Program (DHP), particularly within the Defense Advanced Projects Research Agency (DARPA), our staff and DARPA staff are directly coordinating to ensure full awareness of our respective programs and funding priorities. We also invite representatives from the VA and National Institutes of Health (NIH) to participate in our research planning and to review activities to assure that we leverage programs and knowledge across federal agencies.

It is not possible to reflect on every research project or program initiative in our portfolio, but we would like to highlight just a few high-interest areas and point out where we are seeing particularly promising results or proven outcomes.

Our Service members continue to incur more than 20,000 cases of traumatic brain injury (TBI) every year. Although the vast majority of TBI incidents is diagnosed as “mild” and resolve with rest, the DoD has implemented numerous programs within the last three

years to ensure early detection and state of the science treatment in those who sustain a TBI.

Mandatory concussion screening occurs at multiple levels to maximize treatment opportunities for Service members who may have sustained a concussion: 1) in-theater at the point-of-injury; 2) at Landstuhl Regional Medical Center (for all medically evacuated personnel); 3) during Post-Deployment Health Assessments and Post-Deployment Health Reassessments; 4) and upon initial entry into VA facilities for all OEF/OIF/OND veterans. Our policies mandate medical screening for concussion similar to the “automatic grounding” that occurs after an aviation incident. These policies also address management of recurrent concussion to help protect Service members from repeated exposures to concussive events, and strengthen medical tracking of these injuries.

Clinical care instructions for all levels of TBI severity have been developed and cover both the deployed and the non-deployed environments. Educational materials include a pocket guide for TBI care, web-based case studies in TBI diagnosis and treatment and education modules on TBI care for the line commanders, providers, Service members and their families.

TBI research continues to be fast-tracked to assist our Service members with close collaboration among the line, medical, and research communities. Key areas of promise include understanding blast dynamics, rapid field assessment of mild TBI, to include identification of objective biomarkers to be used in the diagnosis of concussion, and TBI innovative treatment modalities such as the ongoing clinical trials for neuroprotectants.

A specific example of a successful federal partnership that is advancing our understanding of TBI is the Center for Neuroscience and Regenerative Medicine (CNRM). This is a collaborative intramural federal program between the DoD and the NIH to enhance the expertise of clinicians and scientists to catalyze innovative approaches to TBI research. The CNRM research programs emphasize those of high relevance to the military populations, with a primary focus on patients at Walter Reed and National Naval Medical Centers.

The National Intrepid Center of Excellence (NICoE), which opened its doors in 2010, is another vital new resource in the MHS. The NICoE is bringing novel technology and interdisciplinary care to patients with TBI, along with emphasizing the family dynamic and pathways of care for patients who suffer from simultaneous post-traumatic stress (PTS) and TBI.

As with any research efforts, the science regarding some treatments is not yet settled. There have been a number of inquiries by members of Congress and the media regarding cognitive rehabilitation therapy (CRT). This is a particularly complex medical issue, and we have delved deeply into our policies in this area in recent months.

Cognitive rehabilitation therapy, despite its name, is not one therapy. Just as the term “heart surgery” really refers to several different types of surgery on the heart, CRT refers to a number of individual types of treatments designed to improve problems with memory, attention, perception, learning, planning and judgment brought about by a traumatic injury to the brain. These treatments are delivered by a wide array of health professionals including psychologists, occupational, speech and physical therapists and physicians. And, just like the individual heart surgeries would be separately studied to determine if they were safe and proven to work, TRICARE has investigated, and will continue to investigate as required by law, whether and which cognitive rehabilitation treatments will truly work for our injured Soldiers, Sailors, Airmen, Marines and their family members. That urgent investigation is current and ongoing.

Let us get to the most important point. Every wounded warrior who requires cognitive rehabilitation for their injuries can receive that treatment in the Military Health System. Once again, any Soldier, Sailor, Airman or Marine with a traumatic brain injury that requires treatment for impaired memory, attention, perception, learning, planning and judgment can receive that treatment in our Military Treatment Facilities, through VA hospitals and clinics, or by providers in the private sector. In addition, special computer technologies that assist Service members in remembering appointments, medication schedules, and personal contact information are provided free to our injured service members. Through these programs and the DoD’s TRICARE health benefit, our Service members are able to receive occupational, physical, speech and cognitive rehabilitative services essential to their recovery. Since 2009, the Department has directly provided over 71,000 hours of cognitive rehabilitation for thousands of Active Duty, Guard and retired Service members with traumatic brain injury.

To protect our Service members and their families, the Department insists and the law requires that any medical treatment, including cognitive rehabilitation, is proven safe and effective. To do this, the Department is continuing to investigate which CRTs will make a measurable difference in clinical outcomes for our patients. Yet, there are times when treatments that are under ongoing evaluation are considered so promising and so important to the health and mission readiness of our Service members that the Department finds every means possible to provide that treatment. Under these circumstances, we have authority to provide the treatment for our Service members, while still considering the medical evidence that is required to make the intervention fully available to dependents under the TRICARE program.

This is the case with CRT. The Department is making these treatments available to our Service members now, because they offer the best hope of recovery for our injured warriors. We do this while we urgently perform research and intensively study the work of others. During this interval, a bundled or inclusive payment for a CRT package of services will not be available under TRICARE, but family members who require rehabilitation may access medically necessary physical, occupational, and speech

therapy, as well as psychological and behavioral therapy when delivered by a certified TRICARE provider and billed separately. In fact, we have funded more than 6,000 family members and retirees for such services since 2009.

We are pleased that the Institute of Medicine has convened a panel to assist us with reviewing the available medical evidence on the safety and effectiveness of the many cognitive rehabilitation strategies that are currently being offered. We promise to expedite decisions that derive from their recommendations. We have also directed urgent evaluation of our options to develop a bundled payment mechanism for certain cognitive rehabilitation day programs under TRICARE.

We want to be very clear, however, about one element of our decision-making process regarding health care coverage that has, at times, been misrepresented. We do not make our coverage decisions based on cost. TRICARE employs well-recognized scientific processes to search for and review reliable evidence, as well as to review policies of the Centers for Medicare and Medicaid Services (CMS) and other carriers. These processes utilize transparent and broadly accepted criteria for evaluating the quality and strength of the scientific literature on a topic. Utilizing the information available from these various sources results in a balance between ensuring the safety and efficacy of the care delivered to TRICARE beneficiaries and their access to evolving methods of clinical practice.

Along with TBI, we continue to confront the serious concern of mental health conditions, particularly post-traumatic stress disorder (PTSD) and depression. The Department continues to seek ways to mitigate the development of mental health disorders, and to reduce the number of suicides in our Armed Forces. We engage in a number of preventive, diagnostic and treatment approaches to reduce the incidence of these disorders, if possible, and to identify and treat those impacted. We assess Service members regarding their mental health before they deploy, when they return from deployment, and again three to six months later. We have added a new mental health assessment, to be done in a private setting to foster trust and to include a person-to-person dialogue, at the one- and two-year points after return from deployment

In Afghanistan and Iraq, mental health support is distributed across the theaters in order to: 1) manage those with stable mental health disorders; 2) provide support after traumatic experiences; 3) identify those needing increased support, consult with leadership; 4) and make recommendations regarding sustained deployment, or the need for medical evacuation.

Back at home, Service members receive and their family members are invited to participate in post-deployment programs, such as the Yellow Ribbon and Resiliency Training Programs. These programs help to identify signs of difficulty readjusting to home life and to help them take appropriate steps to overcome such problems.

Together with the line community, both officer and enlisted, we have undertaken a Department-wide effort to reduce and eliminate the stigma associated with seeking mental health care. Our leadership programs specifically train leaders to think about

mental health symptoms as they might think of physical injuries and to see treatment for those symptoms as essential to readiness as the treatment of any medical problem. These programs also advise leaders when to make appropriate and timely referrals before any problems can worsen. There are indications that this effort is working, as important measures are heading in the right direction. Specifically, we are seeing that significantly more Service members who are referred for mental health care seek it out, and stay in treatment. We are encouraged by this trend and believe it will continue in the right direction.

We know that mental health conditions, like most medical conditions, are treatable. Most patients with post-traumatic stress symptoms recover without treatment in a few months, and many recover with medication and/or psychotherapy. With your help, we have made a tremendous investment in behavioral health care, increasing from \$500 million in 2005 to over \$1 billion in 2010. That translates to the addition of nearly 2,000 behavioral health providers to our military hospitals and clinics, and 10,000 more to the networks. Together, they deliver 231,000 behavioral health visits per week to Service members and their families. By embedding mental health providers in our primary care clinics, we have improved access to mental health services for all of our beneficiaries.

The White House Interagency Policy Committee on Military Families has established “Enhancing psychological and behavioral health and ensuring the overall well-being of the military family” as one of its four priorities. This initiative will increase collaboration among federal, state, and local agencies in support of military family mental health needs.

Psychological support to military families spans the care continuum, from universal prevention to intensive mental health treatment. There are ongoing efforts by clinicians to share information about resources and programs that are available from DoD (such as Military OneSource, Military Pathways, the Joint Family Support Assistance Program, and the inTransition Program). The Services also provide programs such as the Army’s Strong Bonds program and the Navy’s Project FOCUS. These programs strive to provide families with access to the level of psychological care they need.

We continue to recruit and retain qualified mental health providers, directly benefiting families. As we mentioned earlier, our efforts with both direct care system hiring and expansion of TRICARE network providers have added more than 10,000 mental health providers nationwide to meet the needs of military families. To enhance services available to National Guard, Reserve, and Active Duty families who live in remote areas without easy access to installation-based psychological support, military and civilian providers are collaborating to educate local health care providers on military culture and treatment of psychological problems that military families encounter. We have also introduced the TRICARE Assistance Program, which offers 24/7 web chat with a licensed counselor, recognizing that family stress can often occur outside of normal provider hours, or in locations that do not have readily accessible counseling services. And we continue to fund an initiative with Health and Human Services to place 200

Public Health Service officers, who are credentialed mental health clinicians, in our MTFs.

Finally, the DoD/VA Integrated Mental Health Strategy is a new effort launched in 2010 to better align and coordinate the two Departments' mental health services. Included in the strategy are two action items directly focused on family members: 1) building family resilience; and 2) educating and coaching families to recognize mental health problems in Veterans and Service members.

Many of you have asked pertinent questions about our policies regarding the process by which health care providers assess whether Service members with psychiatric disorders or those who are prescribed psychotropic medication should be deployed. A Service member who suffered symptoms of PTS as a result of a previous deployment is not automatically disqualified from a future deployment. It is our policy to evaluate each case individually based on the unique considerations, circumstances, motivation, and actual condition of each member.

We recently updated pre-deployment policies, and our new policy mandates that a health care provider will perform a person-to-person mental health assessment to determine a Service member's readiness for deployment. This new policy ensures a thorough pre-deployment screening by mandating that the provider conduct a detailed review of self-reported mental health conditions, along with a thorough inquiry about current psychotropic medications (both prescription and over-the-counter), and a careful review of the medical record.

Service members requiring the use of psychotropic medications are evaluated for potential limitations to deployment or continued military service during every mental health assessment event during routine clinical care both in-garrison or in a deployed settings. Healthcare providers make recommendations, which may include requests for waivers and/or accommodations, to operational and Combatant Commanders, who may then make the final decision regarding waivers for deployment.

A key element in our efforts to improve care to Service members, enhance patient experience and responsibly manage the taxpayers' contributions to military and Veteran health care is our growing interoperability with the VA.

We continue to increase the number of sharing agreements between DoD and VA medical facilities. We are sharing more clinical data every day in a secure manner and are regularly adding new features and new forms of clinical data; and our early efforts to bring the Virtual Lifetime Electronic Record to reality are promising. In October 2010, we opened the Captain James A. Lovell Federal Health Care Center at North Chicago to serve both DoD and VA populations – the first integrated facility of its kind.

We are putting real money and manpower behind these efforts. The VA/DoD Health Executive Council has approved 116 Joint Incentive Fund projects valued at \$394 million

over the last eight years, and we appreciate that the National Defense Authorization Act (NDAA) for FY 2010 extended this very valuable program until September 30, 2015.

The Departments continue to identify opportunities to enhance DoD/VA electronic health data sharing. After a December 2010 review by the Vice Chairman of the Joint Chiefs of Staff (VCJCS), DoD and VA formed six teams to create a collaborative approach to the EHR Way Ahead. The teams—Enterprise Architecture, Data Interoperability, Business Process, Systems Capabilities, Presentation Layer, and Missions Requirements/Functions—cover high-level activities needed to plan, develop and deploy final recommended solutions. In-progress reviews of the joint EHR modernization collaboration effort have been held with the Deputy Secretaries of the two departments and team findings are being elevated to the DoD and VA Department Secretaries for discussion and consideration.

We believe this careful, collaborative approach will, in fact, enhance our decision-making process and lead to a solution that can be implemented in a more timely and coordinated manner. The EHR Way Ahead addresses specific challenges with the current EHR, including outdated legacy technologies; ongoing performance and data availability problems; and difficulty in using healthcare industry standards.

The MHS is fully engaged in implementing a new approach to primary care in our MTFs. Known as the Patient-Centered Medical Home (PCMH), the principles focus on developing a cohesive relationship between the patient and the provider team. This relationship focuses on prevention, attainment of health goals, and partnering for the control of chronic conditions.

We view the PCMH as a transformative effort within our system, with the potential to positively affect all aspects of our strategic focus—readiness, population health, patient experience and per member cost. With 655,000 patients enrolled to date, the results have been very promising – improved preventive service compliance, reduced use of the emergency room, and more timely care.

We are introducing processes and tools that are improving access to care – and deepening the patient’s engagement in managing their own health. TRICARE Online already allows patients to make appointments, refill prescriptions and download a basic personal health history. Secure patient-physician email, online laboratory results, nurse advice lines, and other technological tools will serve to greatly enhance our ability to communicate with our patients, redirect them away from inappropriate use of emergency rooms, and improve their overall health.

The Department is moving forward with a number of initiatives to improve population health. We closely monitor our performance in delivering necessary preventive services and compare ourselves to our civilian counterparts on important measures of prevention

and patient safety. And we are making a focused effort on anti-smoking and anti-obesity initiatives. We continue to perform well against most national benchmarks.

Yet, we are not satisfied with the status quo. In 2011, we will announce several demonstration projects that conform with NDAA for FY 2009 and 2010 direction to evaluate new approaches and help us determine whether incentives to beneficiaries will lead to improved health status and compliance with clinical preventive services.

One major new program that emerged from the NDAA for FY 2011 is a new and important benefit in TRICARE – allowing the Department to extend TRICARE coverage to adult dependents up to age 26. This provision ensures that TRICARE will be able to provide this benefit as included in the Patient Protection and Affordable Care Act, or the National Health Care Reform law. We are pleased we will be able to extend coverage to this population.

Health Affairs staff is working closely with the Comptroller, Office of Management and Budget, and other partners to complete the regulatory and contracting actions to put this law into effect, with benefits that will be retroactive to January 1, 2011. This premium-based coverage will provide eligible dependents with access to the TRICARE Standard benefit, including access to military medical treatment facilities. We anticipate a TRICARE Prime option will become available later in 2011.

We are also nearing resolution of the protests that delayed implementation of the third round of TRICARE contracts, or T-3. As the Committee is well aware, the awards that were first announced in the summer of 2009 were delayed when contract protests were upheld by the Government Accountability Office. Transition in the North region is almost complete and we will begin health care delivery on April 1st. The TRICARE acquisition team is working diligently to address issues in the remaining regions and recently announced the award of the South region contract to Humana.

We are now planning for the next series of TRICARE contracts, or T4. We have engaged outside health care experts who are helping us shape a contracting strategy that reflects the needs and imperatives of our unique system, and adopts best practices in health service delivery and health plan management. As the strategy evolves, we will include provisions to ensure continued access to high quality primary care as the demand for primary care services well exceeds the supply in some states.

The MHS is making tremendous progress in improving health care in our National Capital community, and serving as a leader for the civilian health community. In addition to our groundbreaking work in battlefield medicine and medical research, for the last several years, we have been building a model for 21<sup>st</sup> century medicine in the National Capital Region (NCR). The vision of many is about to be realized. Our new community hospital at Fort Belvoir and the new Walter Reed National Military Medical Center will

both open their doors in 2011. These facilities will serve as showcases for leadership in patient-centered care, in patient safety standards, in environmental responsibility and sustainability, and in medical quality and outcomes. This achievement could not have occurred without the sustained interest and investments by the Congress, and we are grateful for your unwavering support through the last several years.

Today, however, we are cognizant that the federal budget cannot continue to expand. As Secretary Gates has repeatedly declared, we in this Department must tighten our belts just as so many Americans have done over the last several years. We share the Secretary's concerns that the exponential growth in DoD health care costs can pose a long-term threat to our defense capabilities.

In the budget proposed by the Department, we have included a number of specific initiatives that, viewed as a whole, can set us on a path to proper financial stewardship of the taxpayers' dollar. Secretary Gates, Chairman Mullen, and the Joint Chiefs have all spoken on this issue consistently and with clarity – we will continue to provide the finest health benefit in the country for our active and retired Service members and their families.

We have benefited from lessons learned in previous efforts to control rising military health care costs. First, the Department has looked internally as our number one priority to find and implement efficiencies. In the coming year, we will reduce TRICARE Management Activity contractor overhead by a substantial amount. Our actions will be carefully considered, and will not detract from any activities that directly support patient care, although some management programs will either be eliminated or significantly reduced.

This is just a first step, and together with the Surgeons General, we will continue to identify and rapidly implement other initiatives that take advantage of joint purchasing and greater optimization of our medical supply chain.

Second, we are pursuing a more equitable management of benefits across all health care programs. Congress has long directed us to align our reimbursement policies with those of Medicare. We will continue to make the necessary regulatory changes to follow the law. In 2011, we will adjust our payments for care provided by facilities designated as Sole Community Hospitals to also align with Medicare reimbursement levels. We also seek to ensure all health care providers are reimbursed in the same manner regardless of their geographic location. We propose to amend our Uniformed Services Family Health Plan (USFHP) enrollment policies so that they align with all other TRICARE providers. All current enrollees will be grandfathered into the current program. In our budget, we propose that all future USFHP enrollees will convert to TRICARE For Life benefits upon reaching Medicare eligibility.

Finally, for working age retirees, we are proposing minor changes to out-of-pocket costs that are exceptionally modest, manageable and remain well below the inflation-adjusted out-of-pocket costs enjoyed in 1995, when TRICARE Prime was first introduced. We also propose minor adjustments in prescription drug copayments that include both reductions and increases in co-pays, the increase or decrease dependent upon the outlet selected by beneficiaries. We want to offer incentives to use the most appropriate and cost-effective outlet for their needs, and believe the minor changes to this copayment will be accepted and assist us in this goal. We are heartened by support expressed by leading beneficiary organizations for this change. We have made progress in the last few years in encouraging beneficiaries to elect prescription drug home delivery, and we believe this proposal will accelerate the adoption of this option as it has demonstrated greater medication compliance while saving on overall costs for the beneficiary.

Our proposals have been carefully considered. We have incorporated numerous safeguards – grandfathering in all current enrollees to unique programs; phasing-in new reimbursement methodologies for providers; and exempting certain beneficiaries (survivors and medically retired Service members) from enrollment fee changes – in order to protect our most vulnerable beneficiaries and providers. None of these proposals affect the free health care we deliver to our Active Duty Service members.

As the Congress assesses these proposals, we will continue to wisely invest in items of vital interest – improved research, diagnosis and treatment of Service members with mental health disorders or TBI; enhanced access to health services; and better service delivery for military families.

We would be remiss if we did not mention the critical importance placed on our Nation’s outstanding university – the Uniformed Services University of the Health Sciences (USU), located in Bethesda, Maryland. This critical resource provides top quality military physicians, nurses, scientists and other health professionals to the DoD at a time when these key resources are gravely needed. Besides USU’s key role as an educational platform for our military health professionals, it also plays a significant role in biomedical research and consultation, both within the military community and to many sources external to the military.

What makes USU so special is that the university ensures that the health care providers educated there are equipped to deal with the unique challenges of military medicine and the wide scope of public health issues. Many of the faculty that teach our military students at USU have extensive military experiences themselves and that experience readily extends the student’s educational experiences even further.

Since the first class graduated in 1980, USU alumni have become an integral part of our MHS and many of USU’s graduates are assigned in key leadership positions throughout each of our Service medical departments.

The value of a USU education was never more evident than following the recent tragic shooting that occurred in Tucson. In the aftermath of this tragedy, it was the medical education received at USU that set in motion the training that the University of Arizona Health Science Center's Chief Trauma Surgeon, Dr. Peter Rhee, called upon as he provided the initial care and treatment to Representative Gabrielle Giffords. His extensive military experiences, coupled with his strong educational foundation, proved extremely beneficial in providing the best care possible to the Congresswoman. And, when he needed to consult on her care plan to ensure his approach was optimal for her condition, he called upon his USU classmate, neurosurgeon Dr. James Ecklund and USU's Interim Chief of Neurology, Dr. Geoffrey Ling.

USU is a national treasure and its value to our Nation is seen every day in the battlefields of Iraq and Afghanistan, in the care we provide worldwide to our very deserving Service men and women, in the research being carried on in the fields of TBI and PTS, and in the many laboratories conducting research on emerging infectious disease and many other public health issues.

In conclusion, we will never lose our focus on those members of our Armed Forces in combat. We will honor the sacrifices of so many Service members and families. We have always been personally inspired by the commitment and dedication of our soldiers, sailors, airmen, marines, and coast guardsmen. These talented young men and women, who have been asked to shoulder the responsibilities for defending this Nation and have suffered the consequences of nearly a decade of war, deserve the best medical care both at home and abroad.

We are both pleased and proud to be here with you today to represent the men and women who compromise the MHS, and we look forward to answering your questions.