Prepared Statement

of

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REGARDING

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BEFORE THE

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Chairman Frelinghuysen, Ranking Member Visclosky and members of the Subcommittee, I am pleased to represent the Defense Health Agency (DHA) and present our medical program funding request for fiscal year 2017. I am honored to represent the dedicated military and civilian medical professionals in the DHA who join me in collaborating with the Military Services, providing direct support to our combatant commanders, and facilitating health care services to the many individuals who rely upon us for their care. I am also pleased to represent the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) who has overall responsibility for the Defense Health Program (DHP) appropriation.

The budget we have presented is fully aligned with our enduring commitments around the globe and with the strategic objectives of the Department, in which the Military Health System (MHS) is a vital component of our national security strategy through our primary mission of readiness. In addition to providing an integrated and indispensable system of health services to the 9.4 million uniformed and other military beneficiaries worldwide, we sustain the clinical skills of our medical forces to ensure that we have a medically ready force and a ready medical force.

As the Director of the Defense Health Agency, which achieved full operational capability on October 1, 2015, my primary goals include providing value-added support to the Military Services as required to accomplish their missions, developing our capabilities as a Combat Support Agency and optimizing the internal operations of the DHA. These lines of effort will enhance the DHA's effectiveness in managing and executing the DHP appropriation as directed by the ASD (HA); managing shared services, to include the TRICARE health plan; supporting the coordinated management of the enhanced multi-service markets; and exercising authority,

direction and control over two military hospitals in the National Capital Region (Walter Reed National Military Medical Center and Fort Belvoir Community Hospital).

Over the last two and half years, the MHS has fully embraced an enterprise management approach to our health systems operations. Collectively, the DHA and the Service's Medical Departments have developed shared strategies, policies, enterprise support activities, and leadership development programs that benefit the system as a whole. Our approaches to access, quality and safety are designed and executed in a collaborative, interdependent manner. Operationally, where we work together in deployed environments or in multi-service markets, we are moving to a more integrated operating model that facilitates support to line commanders, Service members and our patients.

While the DHA's establishment targeted savings and efficiencies through aggregation of commonly performed functions, the DHA is also designated as a Combat Support Agency (CSA), by which the DHA is also accountable to the Chairman, Joint Chiefs of Staff and the combatant commanders. Our ability to serve the operational needs of the Combatant Commands directly, as well as, through and with the Military Services is undergoing rigorous development and refinement as we prepare for our first biennial Chairman's CSA assessment in the coming year. Our efforts to mature our CSA are pursued collectively with the Services, but are also targeted to identify those capabilities that are uniquely provided by the DHA.

As part of the DHA's effort to optimize our operations, we are implementing a common cost accounting methodology within the DHA to improve accountability and transparency to the Department, the Services, Congress, and the public with improved insight into how resources are allocated in support of our mission. This effort will complement our resource management

responsibilities to the Assistant Secretary of Defense (Health Affairs) who has financial authority, direction and control of the Defense Health Program. DHA will assist putting together the annual budget and distributing resources to the Services and other organizations to execute our shared medical mission.

For Fiscal Year 2017, DoD is requesting approximately $33.5 billion for the Defense Health Program, representing a 1.5% increase from last year's budget request. Almost $25 billion, or 78%, of our request directly supports patient care – delivered either in our military hospitals and clinics or in the private sector. Of this $25 billion, approximately $9.2 billion supports direct care (exclusive of military personnel salaries) and $15.7 billion is spent on purchased care.

Congress continues to grant the Department carryover authority each year, which has been an invaluable tool that provides needed flexibility to manage issues that emerge during the year of budget execution. Given the size of our program and the complexity in medical services delivery, costs, and medical claims management related to our TRICARE program, carryover authority allows DoD to maintain better funding flows to minimize disruption of health care services to our beneficiaries. That authority has been extremely helpful to the Department, and we request that it be continued in FY 2017.

The FY 2017 budget not only allows us to meet our global obligation in support of National Security goals, it also supports the core values of the MHS strategic plan and our strategic framework of the Quadruple Aim: improved readiness, better health, better care, and lower cost.

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

Events of the past year reinforce the fundamental need to maintain a high state of readiness for all types of threats. Our continuing obligations of combatting terrorism around the world in multiple areas of responsibility, the threats posed by outbreaks of infectious disease, and our need to expand partnerships in the Pacific region highlight just some of the MHS' responsibilities and capabilities in providing medical support to military commanders for a wide range of emerging and evolving threats.

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

We remain committed to sustaining the superb battlefield medical care we have provided to our warriors and the world-class treatment and rehabilitation for those who bear the wounds of past military conflicts. Our proposed FY2017 budget sustains the long-term medical research and development portfolio allowing us to continually improve our capability to reduce mortality from wounds, injuries and illness sustained on the battlefield.

Specific research programs support efforts in combat casualty care, traumatic brain injury, psychological health, extremity injuries, burns, vision, hearing and other medical challenges that are of particular concern and interest to the military community.

Our readiness mission extends to the long-term investments we make in the area of global health. Following last year's response to the Ebola crisis in West Africa, the MHS is again responding to another infectious disease outbreak – Zika – in South and Central America. Our formidable capabilities in surveillance, prevention, detection, and treatment of novel diseases are again providing the country and the world with indispensable support to combat this threat. We continue to partner with host-nations around the globe to build capacity and assist other nations in their preparedness to respond to all types of health crises.

Another critical support component of our readiness mission is the fielding of a modernized Electronic Health Record (EHR). In August 2015, the Department achieved a major milestone when it awarded a multi-billion dollar contract for a new EHR. Our decision to purchase a commercial, off-the-shelf product provides DoD with a system that supports our readiness mission, accelerates our journey to high reliability, allow ongoing private sector innovation to be incorporated into future releases, and support our interoperability objectives in sharing information with both the VA and with private sector providers. The DHA is working closely with the Service Medical Departments and with the Office of the Under Secretary of Defense for Acquisition, Technology and Logistics to successfully implement the EHR. We will begin our roll-out in the Pacific Northwest at the end of this calendar year. The DHA will ensure the infrastructure is in place to support our technology, and we will ensure our people are trained and clinical and business processes are reengineered to best integrate the new technology into the military health care delivery system.

We also continue our close collaboration with the Department of Veterans Affairs (VA). DoD and the VA continue to share more information than any two other large-scale health systems in the country. Over 75,000 providers in both agencies have the ability to view the

individual medical records in the counterpart system – whether that is DoD's AHLTA record or the VA's VistA record, through the Joint Legacy Viewer. Additionally, an increasing number of community partners are now also able to view service member and veteran records through JLV.

The demand for interoperability extends beyond just DoD-VA information sharing. Integration of our health information with the private sector is essential – more than half of the care provided to the DoD population is delivered through our TRICARE network partners. DoD continues to improve data sharing efforts in partnership with the VA and the private sector to create an environment in which clinicians and patients from both Departments are able to share current and future healthcare information for continuity of care and improved treatment.

Meeting the requirements for military medical personnel readiness is also tightly linked to providing health care within our system of military medical treatment facilities (MTF) for our beneficiaries, whether they are active duty Service members, family members or our retirees and their families. In 2015, the Military Compensation and Retirement Modernization Commission (MCRMC) acknowledged the challenges to sustain the readiness of our medical forces. The Department has accepted a number of recommendations from the MCRMC and has launched a process to identify the essential medical capabilities needed to support the full spectrum of military operations.

In 2016, we plan to expand choices for our beneficiaries – allowing them the opportunity to more freely seek care from either military or civilian providers. There are a number of ways by which we can expand our service offerings. For example, retirees who are Medicare eligible can receive care in MTFs. Caring for these types of patients helps ensure military medical provider readiness. Likewise, resource sharing agreements with the Department of Veterans

Affairs allow Veterans to receive care within MTFs, giving our military medical providers exposure to a more complex set of patient health needs. Other unique arrangements, such as civilian access to our Level I Trauma System and burn center at San Antonio Military Medical Center, ensure that our providers remain current with best practices in trauma and burn care – important skills to maintain for military operations. In other external resource sharing arrangements, military providers obtain admitting privileges at nearby civilian institutions, where they can provide a wider range of care for our beneficiaries, also allowing for clinical skills maintenance. Civilian partnerships have allowed training opportunities for thousands of uniformed personnel.

Better Health

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

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

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

learned from Operation Live Well and the Healthy Base Initiative in 2016 in order to further our efforts to improve health and wellness.

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

TRICARE Modernization: Better Care

The DHA is deeply involved in the conduct and follow-on actions from the Secretary of Defense's Review of the Military Health System. A major outcome from the MHS Review was to better implement principles of a high-reliability organization (HRO), those areas "where harm prevention and quality improvement are second nature to all in the organization." For the MHS, this does not represent a fundamental change, but an evolution in culture and practice that permeates every level of the organization.

One of the key findings from the MHS Review was that no single set of metrics was used across the enterprise to monitor performance in access, quality and safety. On January 1, 2015, the Defense Health Agency, to better support the enterprise and the Services' paths toward greater excellence as an HRO, established the MHS Partnership for Improvement (P4I) system in collaboration with the Military Services, providing a set of common measures across both direct care and purchased care settings that included clear performance goals with standardized metrics.

Over the past year, we have refined our enterprise dashboard and identified focus areas to drive specific improvement in select measures.

We are using the information gleaned from our P4I system and from our other measurement instruments to drive change in how we ensure access, quality, safety, satisfaction, and better manage our costs. Here are some of the initiatives we are introducing to effect this change.

Access – Easier, Patient-Centered. We are overhauling every aspect of our how our patients receive care – whether primary or specialty care. Our patients deserve high quality care delivered safely and expeditiously. In our internal review, we heard that patients are concerned about being told to call back for an appointment and are dissatisfied with delays in receiving care because of a cumbersome pre-authorization and referral system.

During the MHS Review, we found that MTFs generally meet defined access to care standards. However, there was a great deal of variation – there were MTFs that did not meet these standards and others who consistently performed better than the standard. The same access standards apply to both MTF provided care and TRICARE Prime care delivered in the private sector. Assessment of purchased private sector primary care access is largely determined from patient experience surveys. According to survey data, individuals who use TRICARE Standard or Extra are more satisfied with the care provided when compared to those who use TRICARE Prime. In 2016, we will be exploring beneficiary concerns more deeply by engaging focus groups on specific subjects.

Recent Congressional testimony from beneficiary groups suggests that the lower satisfaction with TRICARE Prime is related to the inability to get an appointment at an MTF and

to the associated referral and authorization processes. NDAA 2016 called for improving access in the following ways: 1) make it easier for beneficiaries to move among the identified TRICARE managed care support contract regions; 2) allow TRICARE Prime beneficiaries access to urgent care centers without a preauthorization requirement under a pilot project; and 3) expand the public transparency of quality, safety and satisfaction information.

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

We have put a number of other policy and operational actions into motion this year.

The Services and DHA undertook a listening tour to MTFs and with beneficiaries around the country. We learned a great deal from these visits. In response, we are extending hours to evenings and weekends in a number of our MTFs. We have increased the number of urgent appointments by 32% since May 2015, and we have expanded the overall number of appointments by more than 11%.

Part of our enterprise approach is to effectively use the demonstration authority that Congress has provided us and pilot new approaches to patient care delivery. We recognize that patients, particularly those with complex or chronic medical conditions, require ongoing services from a mix of primary care and specialty providers. Working with Dr. Woodson and the

Services, we will explore demonstration projects in which we evaluate the use of "integrated practice units (IPUs)" into our medical homes. The most important feature of the IPU is that it organizes medical services around the patient's needs and medical condition rather than organizing medical services from the health system's perspective.

Contemporary access to healthcare is no longer confined to the four walls of a doctor's office or dictated by drive time standards. Instead, information technology offers a variety of opportunities for patients to engage the medical system. Providers can extend their reach to treat or advise their patients beyond the clinic's open hours or without requiring distant travel. Furthermore, many of these modalities offer new opportunities to support the warfighter wherever they are deployed. In January 2016, the ASD(HA) expanded policies to encourage greater use of telehealth and permit its connection to the patient's home. The new policy will enhance our abilities to provide telemedicine services and expand access for our beneficiaries. We are also working closely with the Department of Veterans Affairs through the DoD-VA Tele-Health Working Group to coordinate telehealth service support to our shared population.

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

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

In 2016, the MHS will begin to deploy smart phone applications that will make it easy for our patients to contact their providers, access all of the TRICARE Online capabilities, and find useful information about the nearest MTF. DoD will also implement a pilot program that allows enrollees to access urgent care centers without requiring a preauthorization, consistent with NDAA 2016. I am confident that these additional means of access – both virtual and physical – will have a significant, positive effect on satisfaction with accessibility and customer service among our Prime population.

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

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

installation to installation. We will reduce TRICARE regions from three to two, eliminating unnecessary administrative overhead for both the government and contractors.

Quality of Care. The MHS Review found that the MHS performed well along the quality and safety parameters studied. However, similar to our findings on access, we found wide variation across MTFs and across safety and quality measures. We have implemented a number of important measures to achieve that objective. In 2015, we standardized quality and safety measures across the enterprise and can now compare performance across all MTFs. We are now amending our TRICARE contracts to establish similar reporting for private sector care. Senior leaders monitor performance on a monthly basis.

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

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

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

Comprehensive information on service delivery – access, quality, safety and satisfaction – is available online to the public for the military health system as a whole with some limited information visible at the MTF level. Additional information will soon be available at the MTF, consistent with the direction from the Secretary of Defense and the NDAA 2016. We have engaged and will continue to engage our military and veteran beneficiary organizations in how we might present this information in ways that make the information more relevant and easier to understand. And, the DHA is working with CMS to place MHS performance information on Hospital Compare to provide another outlet where our performance information will be publicly shared.

The MHS has identified six communities where there is a significant military medical presence by more than one Service Medical Department. We refer to these communities as "multi-service markets." Collectively, over 40 percent of all care we deliver in DoD medical facilities occurs in these markets and an equally significant amount of care is purchased from the private sector in these markets. We have provided senior medical leaders in these markets with

enhanced authorities to coordinate service delivery; standardize appointing and referral policies; and reallocate local resources to best meet beneficiary needs. We have achieved some early successes in these markets relative to access to care and patient satisfaction.

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

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

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

TRICARE Support. In October 2015, the DHA reached Full Operating Capability. The TRICARE Health Plan is one of the principal enterprise support activities – or shared services – for which the DHA is responsible. Working closely with the Service Medical Departments, we

are better able to coordinate policy and operational decisions in support of TRICARE changes in a more agile and transparent manner. Our other enterprise support activities – pharmacy operations, health information technology, medical logistics, health facilities, public health, medical research and development, medical education and training, contracting, and budget & resource management – also provide essential support services to both combatant commanders and the Services.

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

Cost -- Responsible, Moderate Changes in Beneficiary Cost-Sharing. The full complement of improvements and services that we have put forward also requires investment. Most of these additional costs will be borne by the Department. For example, the implementation of shared services led the Department to reduce defense health costs by $3.5 billion over five years, savings that have already been decremented from our proposed budget.

Since TRICARE and then TRICARE For Life were introduced, the percentage of care delivered in the private sector rather than in DoD medical facilities has grown. Today, over 60% of all DoD-funded health care is delivered in civilian settings through TRICARE. The

integration of care delivered in military and civilian settings is – and will remain – a necessary feature of military medicine. TRICARE offers the most efficient means of integrating that care. Over the last several years, overall defense health program costs have been well managed, with a flat to declining budget.

Although costs have stabilized in recent years through both management actions on the part of the Department and a general slowdown in US healthcare inflation, National Health Expenditure projections, a product of the Centers for Medicare and Medicaid Services, anticipate a gradual increase in per capita health care costs to roughly 5 percent in coming years. Within the MHS, we are beginning to see medical inflation rise, particularly in the area of prescription drug prices. We are monitoring our spending closely, and taking actions to manage this growth internally, but fee adjustments are necessary in the years going forward.

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

- A simpler system — provides beneficiaries with two care alternatives and overall less complexity in their health plan. TRICARE Select is an HMO-like (managed) option that is MTF-centric and TRICARE Choice is a PPO-like (unmanaged) option offering greater choice at a modestly higher cost.
- Economically emphasizes TRICARE Select leveraging MTFs as the lowest cost option for care to make full use of Direct Care capacity and also provides needed workload for

military providers for readiness training.

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

ADFM emergency room use, including in the network.

- The Department will offer a second payer option with a lower fee for those with other health insurance.
- Fees and copays will be indexed at the National Health Expenditures (NHE) per capita.

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

The MHS continues to serve as a unique and indispensable national security asset. It supports our active duty force and it retains its clinical skills through an active clinical practice in both peace and war. It offers a ready asset to respond to humanitarian assistance needs and disaster response. The full complement of preventive, public health, primary care, specialty and specialty care services that we offer are necessary components for meeting the national security obligations of the United States.

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

The Defense Heath Agency serves as a strategic enabler to the Department in providing value to the Services and achieving savings and efficiencies in a responsible, business-focused manner. By building a management structure with an enterprise focus, we are ensuring a medically ready force and ready medical force are ready for any contingency for which they are called to serve.

The FY 2017 budget provides the Department with the resources it needs to meet its mission and ensure we can meet the appropriately high expectations that beneficiaries have for us. Our proposal represents a balanced, comprehensive package of reforms that are directly aligned with and address each element of our Quadruple Aim. We have initiatives that will improve readiness, improve health, improve care, and lower cost. We look forward to working with you over the coming months to further refine and articulate our objectives in a manner that improves value for everyone – our warfighters, our combatant commanders, our patients, our medical force, and the American taxpayer.

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