THE MILITARY HEALTH SYSTEM

OVERVIEW STATEMENT

BY

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Mr. Chairman, distinguished members of this committee, thank you for the opportunity to discuss the Military Health System. Today, the Armed Forces of the United States have more than 275,000 service men and women deployed around the world in support of our national security commitments, including those serving in Afghanistan and Iraq. The Department is firmly committed to protecting the health of these and all service members, before, during and after their deployment and to our other healthcare beneficiaries, who now number more than 9 million.

The Fiscal Year (FY) 2007 Defense Health Program funding request is $21.4 billion for Operation and Maintenance, Procurement and Research, Development, and Test and Evaluation Appropriations to finance the MHS mission. We project total military health spending to pay for all health-related costs including personnel expenses, and contribution to fund retiree health costs, to be $39 billion for FY 2007.

Transformation

Given the complexities we face, and the nature of our national security threats, we must embark on transformational change - specifically, we must transform our forces, the way we conduct business, our medical benefit, and our facilities and information infrastructure. The transformation process is designed to provide the Armed Forces with world class operational medicine capabilities while delivering the outstanding TRICARE benefit to our beneficiaries. Secretary Rumsfeld has described transformation as “a process that shapes the changing nature of military competition and cooperation through new combinations of concepts, capabilities, people and organizations that exploit our Nation’s advantages and protect against our asymmetric vulnerabilities to sustain our strategic positions, which underpin peace and stability”. The entire

Department is participating in a transformation process to make the US military an elite fighting force that is both efficient and effective.

Military medical transformation is shaped by the recommendations for the Military Health System (MHS) contained in the Quadrennial Defense Review (QDR), Medical Readiness Review (MRR), and the Base Realignment and Closure Commission (BRAC). In addition, we also must address a health benefit whose long term costs may risk our ability to deliver high quality and customer focused health services.

As you know, the QDR is conducted every four years to evaluate the strategies and processes of the Department of Defense. For the MHS, it gave us the unique opportunity to review our medical mission and determine how we can better support the Department and our beneficiaries. In this process, we reviewed our manpower, infrastructure, business practices, and our healthcare benefit. We have been provided a once in a lifetime opportunity to refine the MHS and shape the future MHS into the premier healthcare system in the world. The QDR allows us to address the shortcomings of the MHS, and sustain the TRICARE benefit over the long term.

We have established the Military Health System Office of Transformation to help guide and coordinate efforts through this dynamic period of change. This office is providing leadership, advice and direction to those who are implementing our transformation objectives. Admiral John Mateczun, the deputy Navy Surgeon General serves as the director of this office. Representatives from each of the services have joined him. This team will have a two-year tenure to oversee and guide MHS transformation efforts at which time we anticipate that efforts will be undertaken by our Office of Strategic Planning and normal administrative structure.

Transforming the Force

The Medical Readiness Review (MRR) is the component of the QDR that reviewed our medical readiness posture and options for our future force structure. The three pillars of Force Health Protection drive the assessment of capability required for a future force that will possess the following: Service capability, interdependent and integrated forces, and joint options for operational medical requirements. The Medical Readiness Capabilities Group developed a current 'as-is' inventory of Departmental medical readiness capability and identified future capabilities to support the comprehensive concept of Joint Force Health Protection. The Casualty Estimation and Medical Risks Group performed war time casualty modeling using the Department's approved scenarios. The Metrics and Capability Needs Group has developed an analytical framework to support the determination of capability needs for resource programming. The Medical Readiness Resources Group analyzed and developed resource requirements from peacetime transition to contingency operations. The results of these reviews call for us to develop and adopt minimum standards across the Services for personnel, training, and capabilities. We are looking to shape our medical force to be more joint and interdependent as it supports the 21st century missions of our military.

Transforming the Business

Our new healthcare contracts, which we fully implemented in FY 2005, use best-practice principles to enhance quality of care, emphasize patient safety, improve beneficiary satisfaction and control private sector costs. Civilian contract partners must manage enrollee healthcare and can reduce their costs by referring more care to MTFs. In concert with these new contracts, and the implementation of the prospective payment system for military facilities, we need the

flexibility to move funds between direct care and private sector care. Current restrictions on funding, imposed by Congress, adversely affect MTFs as well as care in the private sector. We urge members of Congress to authorize the MHS to manage our funds as an integrated system, which will allow funds to flow on a timely basis to where care is delivered.

With this flexibility in funding, we intend to set the budgets of MTFs on workload output such as hospital admissions, prescriptions filled and clinic visits, rather than on historical resource levels such as number of staff employed, supply costs, and other materials. In addition, our hospitals will manage their Force Health Protection and healthcare delivery missions as a comprehensive whole using a single set of performance measures. We are in the second year of a planned four year transition to this new prospective payment system. It provides incentives and financial rewards for efficient management. Underpinning all of the transformation of the business effort is our evolving MTFs business planning process being implemented by the Services.

Finally, all of our activities in the MHS are continually prioritized, evaluated and measured through a constructive process using the Balanced Scorecard. The Services' medical leaders together with senior staff from TRICARE and Health Affairs work together to manage this process.

Transforming the Infrastructure

Three significant initiatives, BRAC, DoD/VA Sharing, and the United States Army Medical Research Institute of Infectious Diseases (USAMRIID) recapitalization, will allow us to transform our infrastructure. 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, like 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 consolidation of medical centers and the elimination of inpatient services at smaller facilities will produce a stronger and more efficient MHS. 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. BRAC is a forcing function for us. 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. We are truly shaping our infrastructure and our future.

Another substantial change to the MHS infrastructure is the development of joint facilities as a result of increased collaboration with the VA. The most visible example today is at Naval Hospital Great Lakes, where the pressing requirement to replace an aging and oversized hospital has been met by building a new outpatient facility at nearby North Chicago VA Medical Center. This facility will have an innovative governance and integration plan, which was developed locally, and will allow both Departments to become more efficient and cost effective while improving services to beneficiaries of both systems.

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, MD, 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.

Transforming the Benefit

An issue we must address is the rising costs of healthcare. Put directly, we need help from Congress to sustain our benefit over the long term. Our program has essentially doubled in size in the past five years, from about $19 Billion in 2001 to $38 Billion in 2006. Further, we estimate that our expenditures for healthcare could be $64 billion in 2015, approximately 12% of the Department's budget. This rapid growth in cost clearly puts the sustainability of our health benefit at risk. The facts show that the expansion of TRICARE, high health inflation, the reduction in beneficiary cost shares, and sharp increase of usage by our retirees under 65 is responsible for this growth.

In 1995, beneficiaries paid 27% of total health costs; today they pay 12% of total health costs. We believe that it is absolutely essential to achieve a financial balance between the government and individual's care contributions closer to when TRICARE was inaugurated 11 years ago. Our plan to increase cost sharing would ask retirees under 65 to pay higher premiums and co-payments for healthcare coverage. These plans would have three tiers with increases for junior enlisted retirees substantially less than those for officers. Furthermore, after a two-year transition, beginning in FY 2009, these increases would be indexed to the average percentage

increase in the Federal Employees Health Benefit Program premiums. In addition, we propose to also change pharmacy co-payments, for all beneficiaries except active duty members, to encourage use of mail order and MTF pharmacy refills and generic products, when appropriate. We also ask that Congress clarify to those who oppose the Department our legal authority to obtain federal pricing discounts for prescriptions obtained at retail pharmacies. To implement these changes to sustain our invaluable benefit, we need help from Congress.

We estimate that if our proposed changes are implemented the department will reduce costs a total of $735 million in FY07, and a total of $11.2 billion from FY 2007 – FY 2011. The total includes both premium/deductible changes and the pharmacy program adjustments.

We will have $249 million in expected cost reduction in FY 2007 from increasing deductibles and from instituting annual enrollment fees for TRICARE Extra and Standard and indexed to the annual rate of change in average premiums of the Federal Employee Health Benefits Program (FEHBP). Another $329 million is from increased annual enrollment fees for TRICARE Prime, also indexed to the annual rate of change in average premiums of the FEHBP.. There is $157 million in expected savings from the Pharmacy co-payment adjustments. Of these proposed benefit changes, we believe that only the implementation of the annual TRICARE Extra/Standard enrollment fees and increased deductibles require legislation.

In the ongoing discussions with the beneficiary organizations regarding our recommendations to increase select cost-shares, they have voiced concern that our initial focus should first be on “internal efficiencies” that can be gained before measures are taken to increase cost-shares. They are correct that this should be the first step. And we have implemented a number of actions in the last several years designed to slow the health care cost increases. These cost saving initiatives have been very successful, and yet they are insufficient in addressing all of

our cost drivers. We will detail these initiatives in this statement, and also discuss our additional recommendations to sustain quality and the overall health benefit while properly managing costs.

Our primary cost savings initiatives reduced defense health care costs by $419.1 million in 2002, and we target savings of $973.3 million in 2007. The key program initiatives that have led to these savings are:

1. the use of the federal supply schedule to lower pharmacy costs,

2. new private sector care TRICARE contracts that reduced administrative costs,

3. an increase in Department of Veterans Affairs (VA) and the Department of Defense (DoD) sharing of facilities, capabilities, and joint procurements.

4. the implementation of business planning tools to help local military hospital and clinic commanders identify efficiencies and optimize their facilities, and

5. the introduction of new prime vendor agreements to lower costs of MTF medical and surgical supplies.

As we continue these cost reduction efforts, we have established annual saving targets of 3% -5% of our annual Operation and Maintenance budget.

Pharmaceutical Management

In June 2004, the Department redesigned our pharmacy programs into a single, integrated program. This reorganization allows us to more efficiently and effectively manage this $5 billion per year program. We have achieved prescription drug cost savings through a number of means:

Joint DoD/VA Purchasing. We have successfully partnered with the Department of Veterans Affairs in an ever-expanding joint purchase program for prescription drugs. In 2004,

this program saved more than $138 million; and we project savings of almost $200 million in 2007.

Administrative Efficiencies. We have a single contractor providing both mail order and retail pharmacy network services to our beneficiaries.

Federal Pricing. We currently use federal pricing for mail order and MTF pharmacy services, which provides DoD with the lowest prices for prescription drugs. We strongly believe federal pricing authority extends to the prescription drugs dispensed to military beneficiaries through our pharmacy retail network. The pharmaceutical industry disagrees, and has worked to deny us this potent cost saving tool. This issue is now in the courts; we hope to have a decision later this year. We estimate that we would save an additional $251 million in 2007 based on the extension of federal pricing to our retail network, assuming the court agrees with our argument.

In our FY 2007 budget, we propose to adjust beneficiary cost-sharing for certain categories. Specifically, we propose to eliminate patient cost-shares for generic drugs obtained through our mail order pharmacy (the current cost-share is $3); and to increase cost-shares for generic and brand-name formulary drugs obtained through the retail network (generic cost-shares are proposed to increase from $3 to $5; brand name drugs from $9 to $15). Our objective is to provide our beneficiaries with a greater economic incentive to use the mail order venue, where costs are lower.

We will continue to look for ways to improve DHP cost savings in the pharmacy program, and we are now developing utilization management programs that can further increase our annual DHP savings.

TRICARE Contracting Initiatives

In 2005, we implemented the new TRICARE contracts, reducing 7 contracts to 3, reducing 12 geographic regions to 3, and reducing the number of contractors from 4 to 3. This program simplification led to significant administrative savings, and streamlined the bureaucracy. In FY 2005, we saved $190 million from these efforts, and we forecast savings of $198 million for FY 2007.

We added financial incentives for improving beneficiary satisfaction for the contractors, and ensured contractors are financially rewarded for care delivered in the private sector.

One source of the savings was to reduce administrative costs in our TRICARE contracts, over $125 million saved in FY 2005, and we project this trend to continue throughout the life of these contracts.

We have undertaken a benchmark analysis of our administrative costs to administer the TRICARE program, and our "per member per year" administrative cost compares very favorably with private sector experience – approximately $225 per member per year. And for the next series of TRICARE contracts, we will build upon these efficiencies and continue to achieve greater administrative and utilization savings.

Military Treatment Facilities Efficiency Initiatives

We also changed how local military medical commanders are incentivized by providing them with the responsibility for cost-effectively managing care delivered to patients in military hospitals and clinics. We have further established a performance-based model, assessing patient outcomes and provider productivity against private sector benchmarks (adjusted for military readiness requirements). This year – FY 2006 – represents our first year under this model and we have targeted savings at $94 million in 2006, followed by savings of $259 million in 2007.

In addition to implementing more efficient practices within MTFs, we will also begin to bear savings from the Base Realignment and Closure (BRAC) activities with an estimated savings of $40 million in 2007.

Of course, we maintain that even greater resource savings can be achieved through a "military to civilian conversion" for thousands of medical positions that are needed but can be performed by civilian employees. We have presented this plan to Congress, and are hopeful for your support of that plan this year.

Regional Supply Standardization

The Military Health System has worked aggressively to negotiate preferential pricings with preferred medical supply vendors across the country. Our savings continue to grow from $9 million in 2002 to a projected savings of $28.3 million in 2007

In addition to these efforts, we have also begun several innovative pilot programs using private sector disease management and behavioral health to further reduce costs and utilization. These programs are in their early stages, and we cannot project savings at this moment.

Cost Savings Summary

In 2007, the sum total of our major cost savings initiatives will total $973.3 million or approximately 4.5% of our Operations and Maintenance budget.

Although we are pleased with the actions we have undertaken to reduce inefficiencies and incentivize both military and private sector contractors to delivery quality, cost-effective care, these actions alone are not sufficient to reduce the explosive cost growth the Department has experienced over the last five years or the expected future cost growth.

We recognize that ours is a complex system with many variables, and that savings estimates, though conservative, cannot be predicted precisely. But ***not addressing*** the growing differential between private sector and DoD out-of-pocket cost shares will *certainly* increase future costs to the Department.

We have solicited the input and recommendations of the beneficiary organizations who serve our military families and retirees. And we welcome their engagement with us on the best approaches to reduce our cost growth. They have certainly identified additional areas for us to investigate for cost savings, and we are committed to evaluating their proposals.

The retired military service members have indeed earned their health care benefits. We are committed to ensuring that TRICARE remains the finest health plan in the country. Our military health system has and continues to deliver superlative care to our service members, their families, our retirees, and citizens around the globe in their hour of need. In order to sustain this benefit, we must ensure resources are available for continued investment; aggressive actions are continued to achieve internal cost savings; and the cost-sharing provisions are adjusted to reflect the cost of health coverage in 2007, not 1995.

We are committed to sustaining this great system for generations to come, and with this combination of internal efforts and re-balanced cost-shares, we believe that we will place the Military Health System on a firm, long-term foundation for continued success.

Reserve Components Health Benefits

At your direction, we are implementing the new health benefits that extend coverage to members of the Guard and Reserve. We have been providing and will continue to provide a great benefit to them. We have made permanent their early access to TRICARE upon notification of call-up, and their continued access to TRICARE for six months following active duty service for both individuals and their families. We implemented the TRICARE Reserve Select (TRS) coverage for Reserve Component personnel and their families mandated in the NDAA for FY 2005, and over 26,000 reservists and their families are enrolled. We are now working to implement the expanded TRS 50/85, as mandated in the NDAA for FY 2006, which will be effected on October 1, 2006.

Battlefield Healthcare Success

As healthcare providers to the men and women of our Armed Forces, we are continually looking for medical advances that can save lives, especially in combat. Today, military medical personnel are saving hundreds of lives that previously would have been lost on the battlefield. Better training, advanced equipment, and talented Soldiers, Sailors, Airmen and Marines also contribute to this success. Fewer than 3 percent of wounded service members who make it to a source of medical care, die of their wounds. This is the lowest figure in the history of warfare. On

its own, this milestone is a remarkable accomplishment. This success is achieved by the proficiency and professionalism of our medical personnel who have advanced battlefield medicine and medical transportation to new levels of capability. Our people likewise do an extraordinary job preventing illnesses and maintaining health. This progress is mirrored in our disease and non-battle injury rate that is about four percent in Iraq – rates which also are the lowest in military history.

Improving Mental Health Services

Despite these historically low rates, the Department of Defense continues to seek better ways to care for our service members. During the past decade, we have learned valuable lessons. Among these lessons we include identifying and gaining a better understanding of the health effects of deployments and operations; we are happy to report that the Department has made great progress in these important areas. To date in the current conflict, service members have completed more than one million pre- and post-deployment health assessments. Nearly 90 percent of this information is collected and transmitted to an electronic database. This information helps us to focus individuals' follow-up care and treatment, ensures our people get the care they need, and assists the Department with its medical planning efforts.

Another important lesson is that the period of greatest need for mental and family readjustment support may be weeks after returning home. With this in mind and in consideration of the potential for physical health issues to arise once service members return, we directed an additional post-deployment health assessment – a follow-up program that expands upon our previous efforts. We recognize that no one who goes to war remains unchanged. 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 new assessment includes a short questionnaire to be filled out by all service members -- including Reservists and Guardsmen, two to six months after they have returned home. 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 with a focus on 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, there remains a common, perception by some in our country – a stigma – regarding those who seek mental health services. We believe that through this new, follow-on reassessment tool, we reduce this "stigma" as an issue or barrier to needed care.

To ensure program success and smooth integration into existing processes, small scale implementation at high-deployment platforms began in June 2005. Lessons learned from that small scale implementation served to inform our successful program deployment, which began in January 2006. We continue implementation with units scheduled for return deployments and also based on Service identification of highest needs.

Military Vaccine Program

The Department has programs to protect our service members against a variety of illnesses. One important program is the Military Vaccine program; we believe there is a real threat of smallpox and anthrax used as potential bioterrorism weapons against our soldiers, sailors, airmen and marines. To date, with vaccines we have protected more than 1.3 million Department members against anthrax spores and over 875,000 against the smallpox virus. These programs have an unparalleled safety record and are setting the standard for others in the civilian sector. We worked with the Department of Health and Human Services, the Food & Drug Administration (FDA) and the Court to restart the important anthrax program, after it had been temporarily halted by a federal judge. Our service members deserve the protection the FDA-licensed anthrax vaccine provides, due to the ongoing, real threat posed by anthrax.

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 446 sharing agreements covering 2,298 health services with the VA and in FY 2005, 136 VA Medical Centers reported reimbursable earnings during the year as TRICARE Network providers. This is an increase of 59 percent over the previous year. Every day we collaborate to further improve the healthcare system for our service members; we have substantially increased joint procurement, we are working to publish jointly used evidence-based clinical practice guidelines for disease management to improve patient outcomes. As I mentioned, we are also working to establish the first Federal healthcare facility with a single management structure in North Chicago.

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 VA at the time of a service member's separation. We have transmitted messages to the FHIE data repository on more than 3.2 million unique retired or discharged Service members. Building on the success of FHIE, we are now sending electronic pre- and post-deployment health assessment information to the VA. Monthly transmission of electronic pre- and post-deployment health assessment data to the FHIE data repository began in September 2005 and has continued each month since then. More than 515,000 pre- and post-deployment health assessments on over 266,000 individuals are available to VA. VA providers began accessing the data in December 2005. DoD plans to add post-deployment health reassessment information later this year.

Both the VA and DoD are committed to providing our service members a seamless transition from the MHS to the Veterans Health Administration. DoD implemented a policy entitled "Expediting Veterans Benefits to Members with Serious Injuries and Illness," which provides guidance on the collection and transmission of critical data elements for service members involved in a medical or physical evaluation board. DoD began transmitting pertinent data to VA in September 2005, and has since provided five lists with a total of 5,177 service members while they are still on active duty. Receiving this data directly from DoD before these service members separate eliminates potential delays in developing a claim for benefits by ensuring that VA has all the necessary information to award all appropriate benefits and services at the earliest possible time.

AHLTA

DoD continues to build on the long history of transforming healthcare delivery through the use of information technology. After nearly a decade of investment, research, development and pilot testing, a collection of leading edge health information technology applications are being fielded and implemented around the world to support all facets of the Military Health System. Our vision is to completely digitize our health care system. AHLTA was publicly unveiled in November 2005, marking a significant new era in healthcare for the Military Health System (MHS) and the nation. AHLTA is the Department of Defense's global electronic health record and clinical data repository. It creates a comprehensive, life-long, computer-based patient record for each and every military health beneficiary regardless of their location. AHLTA provides seamless visibility of health information across our entire continuum of medical care, giving 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.

AHLTA has been implemented at 87 of 140 planned Military Treatment Facility (MTF) sites spanning 11 time zones worldwide, with 39,773 of 63,000 total users fully trained, to include 13,756 healthcare providers. DoD's Clinical Data Repository is operational, and currently contains electronic clinical records for over 7.50 million beneficiaries. AHLTA use continues to grow at a significant pace. To date, AHLTA has processed 15,005,274 outpatient encounters and

is currently processing over 75,400 patient encounters per workday. Worldwide deployment is expected to be completed by the end of calendar year 2006.

Humanitarian Operations

The Department's medical assets provide unique capabilities not found elsewhere in the world. Our resources are critical in response to natural disasters and humanitarian issues that are a constant challenge to the world. We have been involved in humanitarian assistance in South Asia following the devastating tsunami, in Guatemala for landslides, and also very recently in the Philippines for landslides, and Pakistan to assist with the relief following their earthquake. The result of our collaborative humanitarian assistance is strengthened good will and trust between our nation and those we assisted. Improving the image of the United States abroad through these efforts has been invaluable, especially in areas where negative images and propaganda have been widespread.

Hurricane Relief

We also support disaster relief in the United States, in accordance with Emergency Support Function number eight of the National Response Plan. Under this support function, the Department of Health and Human Services is the lead agency, and when state and local resources request federal assistance, we provide the assistance we have available in consideration of our other military missions. Our capabilities to provide support include health assessment, surveillance, personnel, supplies, patient evacuations, and delivery of emergency healthcare. Military medicine, because of our ability to provide healthcare and health-related activities in a very mobile fashion represent a vital part of this plan and its implementation operations. We

coordinate and collaborate with our federal partners to ensure the safety of the individuals involved in a national emergency and to provide healthcare to those affected by the devastation.

After Hurricane Katrina's landfall and breach of the levees, our Gulf Coast region faced an unparalleled and crippling disaster. In coordination with other federal agencies, state and local governments, the capabilities of military medicine assisted in both Louisiana and Mississippi. We deployed over 2,000 medical personnel to the area. We moved more than 10,000 patients including more than 2,600 by air evacuation. Our medical personnel treated more than 5,500 people. We opened field hospitals and we sailed the USNS Comfort to aid in the relief operation. Our medical personnel in coordination with the Department of Health and Human Services and the Centers for Disease Control and Prevention were heavily involved in monitoring the public health situation.

In addition to our support on the ground, we immediately considered how to ensure that our military beneficiaries who lived in the disaster areas and were displaced or adversely affected by Hurricane Katrina still receive their health benefits, especially chronic medications and recurring treatment procedures.

For Hurricane Rita, the lessons of Katrina were fresh and communication at all levels occurred two days before the storm hit. Jointly, we were able to assess capabilities and identify needed assistance. This analysis via teleconferences resulted in the military evacuating over 3,000 sick, infirm, and elderly individuals by military aircraft in less than 24 hours. The men and women of the Military Health System accomplished unprecedented work to save lives and help rescue those in need in the Gulf Coast region. I am very proud of these men and women who do so very much for this country.

Conclusion

The MHS has experienced another extraordinary year. We provided world class healthcare to our deployed forces, particularly in Iraq and Afghanistan, we launched our new electronic health record AHLTA, we improved collaboration with the Department of Veterans Affairs (VA), we achieved clinical and quality improvements, we established new measures for protecting the force, we implemented a new TRICARE benefit for Reservists, and we came to the aid of our countrymen and world neighbors in moments of disaster. Looking to the future, we will adapt to new challenges that face our nation and our national security by building on today's achievements. Our future relies on the transformation efforts now underway to sustain our comprehensive benefit and to deliver the best healthcare in the world to the men and women who serve in our Armed Forces. Transformation will take years of hard work and dedication from every member of the Military Health System. We also require assistance from our military and civilian leaders as well as from Members of Congress if we are to place the military health benefit on a sound financial foundation, thereby assuring its availability for future generations of military men and women and their families.

Our Military Health System – its personnel, healthcare capabilities, research, education and training – is a national asset, and we are pleased to have the opportunity to shape and lead it. The men and women of the Military Health System work hard to protect, care for, treat, manage and lead; their efforts reflect the American strength of will and character. Theirs is a most noble calling, the profession of medicine and the profession of the military; both professions of service and sacrifice. We must assist them by ensuring that the military health benefit, on the battlefield, in the air, at sea and at home, continues long into the future.