**MEMORANDUM**

TO: REDC

FROM: Center Road Solutions

DATE: April 20, 2021

**RE: Senate Committee on Appropriations; Subcommittee on Defense hearing on the Defense Health Program**

On April 20, the Senate Committee on Appropriations’ Subcommittee on Defense hosted a [hearing](https://www.appropriations.senate.gov/hearings/defense-health-program) on the budget for the Department of Defense (DOD) and its investment in military health research. The hearing’s goal was to understand what research is currently taking place in the military health departments and find out if the military’s medical services are properly funded for meeting medical needs of troops and families while dealing with the Covid-19 emergency. The witnesses were Dr. Terry Adirim, Acting Assistant Secretary for the Defense for Health Affairs; Lt. Gen. R. Scott Dingle, Surgeon General in the Army; Rear Adm. Bruce L. Gillingham, Surgeon General in the Navy; and Lt. Gen. Dorothy A. Hogg, Surgeon General in the Air Force.

**Member Issue Snapshots:**

* Budget Funding: Tester (D-MT), Shelby (R-AL)
* Medical Budget Shortfalls: Tester (D-MT)
* Tricare: Tester (D-MT)
* Medical Research: Shelby (R-AL)
* Covid-19 Response: Tester (D-MT), Shelby (R-AL), Baldwin (D-WI)
* Vaccinations: Baldwin (D-WI)

**Key Takeaways:**

* The Defense Health Program (DHP) is important in medical research and providing health services to over 9 million service members and families. Medical military personnel are dedicated to protecting troops and families and prioritize both mental and physical health. Costs relating to the pandemic have increased and the military requires funding to continue to provide those same services during 2021.
* Military research departments work closely with the National Institutes of Health (NIH) in comparing research and statistics, however the military also provides additional research pertaining to troops that does not apply to the civilian sector.

**Opening Remarks:**

**Subcommittee Chairman Jon Tester (D-MT):**

* Around 9.5 million Americans in or associated with the forces depend on the health care services you [Surgeon Generals] oversee. The DOD has invested in the military’s wellbeing but there is nothing more important than the physical and mental health of the force.
* This Committee wants to do our part to meet the medical needs of all service members, at home and abroad, which has been especially crucial during the global pandemic.
* I want to know how the DOD is dealing with Covid’s impact on families and troops and whether the military health care system is properly funded for this emergency.

**Committee Chairman Richard Shelby (R-AL):**

* We are here today to review the Defense Health Program (DHP). The pandemic has tested our military’s health system profoundly. I want to recognize the DHP’s work and achievements during these times.
* Our military depends on a strong and reliable health care system. In order to guarantee high standards for service members, we must make sure the program is resourced and prioritized. I look forward to hearing the challenges you [witnesses] have faced during recent transitions.
* Our military’s health system also conducts medical research in topics including cancer, infectious diseases, and brain injuries. Funding for this research has grown from $210 million to $1.5 billion which is a large investment that does not take into account the billions of dollars also provided to the National Institutes of Health (NIH) for research in the same areas.
* I question whether DOD’s medical investment research is just simply investing in scarce defense resources that are also taking place at NIH.
* This research is necessary; however, I hope the witnesses can provide clear answers as to what the DOD medical research scholars are doing that NIH is not doing.

**Dr. Terry Adirim, Acting Assistant Secretary, Defense for Health Affairs (**[**testimony**](https://www.appropriations.senate.gov/imo/media/doc/STATEMENT%20Dr.%20Adirim%20AASD%20Health%20Affairs%20(4.20.21).pdf)**):**

* My testimony will provide the subcommittee on information about major activities that will influence our budget proposal for the upcoming year. The national response to the Covid pandemic is looming over all of our projections.
* My testimony provides a comprehensive review of the critical health support the military is providing worldwide in support of our mission. We are deeply appreciative of the FY20 supplemental appropriation of $2.2 billion that remains a part of the CARES Act which covers the costs during the initial months of the response.
* In FY21, costs attributing to the pandemic continue to rise and as of March 31, 2021 our mid-year review of the health program estimated short falls as part of the pandemic response.
* When released, our budget will present a balanced comprehensive strategy that aligns secretaries priorities to include ongoing response to the pandemic.

**Lt. Gen. R. Scott Dingle, Surgeon General, Army (**[**testimony**](https://www.appropriations.senate.gov/imo/media/doc/STATEMENT%20LTG%20Dingle%20SG%20USA%20(4.20.21).pdf)**):**

* Covid 19 and unexpected challenges to our national security attempted to attack the foundation of our nation but it did not disrupt the Army’s response to the Constitution.
* Within days of our nation’s call, we collaborated with the Department of Health and Human Services, the Department of Homeland Security, and our state governments. We expanded critical testing capacity, deployed vaccine teams, and partnered with medical research.
* My vision for Army medicine is clear. We want to stay responsive and relevant in this time of global complexity.
* I will ensure that integrated medical efforts occur with strong fiscal stewardship and partnership among medicine and the Defense Health Agency. Goals for army medicine remains at building readiness, trained units, and modernized to be ready for future challenges.

**Lt. Gen. Dorothy A. Hogg, Surgeon General, Air Force** [**(testimony)**](https://www.appropriations.senate.gov/imo/media/doc/STATEMENT%20LtGen%20Hogg%20SG%20AF%20(4.20.21).pdf)**:**

* Airforce medics have been responding from the beginning to the Covid pandemic and continue to show their support. Covid epicenters were facing staff shortages and we are acting quickly placing members directly into service.
* We used the SeaStars training program for trauma and readiness skills for disease containment to treat early Covid patients and our aeromedical evacuation capabilities to transport Covid patients.
* We have worked alongside the Defense Health Agency to identify all processes needed to mature their capabilities. We implemented a new medical reform model to improve readiness. Covid has provided challenges but also given opportunity for change and evolution.

**Rear Adm. Bruce L. Gillingham, Surgeon General, Navy** [**(testimony)**](https://www.appropriations.senate.gov/imo/media/doc/20APR21_SAC-D_Military_Health_System_Final%20-%20corrected.pdf)**:**

* Navy medicine operations remain high as we protect marines and their families. We have deployed over 6,000 active medical personnel in Covid-19 missions. We quickly recognize that protecting our personnel along with maintaining operational effectives will be our primary mission.
* Actions and interventions across Navy medicine directly impacted our ability to better understand the virus, mitigate and contain it’s spread, effectively support ongoing fleet operations, and preserve Navy and Marine ongoing readiness.
* Our highest priority remains ensuring that all departments and personnel have access to the vaccine to protect their community.

**Q&A Session:**

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* Dr. Adirim, in your testimony you talked about a $1.8 billion shortfall: $1 billion with Tricare, $800 million with military. Do these shortfalls impact the delivery of service and care to our service members and families?

**A: Dr. Adirim:**

* Our first priority is our health care to our troops and family members. That will never suffer any decrement. Those numbers that I cited are projections we’re making. Currently we have $763 million in costs that were not expected due to the Covid response.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* What are your plans to address these shortfalls? Does Congress need to step up?

**A: Dr. Adirim:**

* The department isn’t planning to ask for supplemental [funding]. We are looking to other programs within the DHP such as sustainment modernization funding. We’ll have to postpone facilities maintenance. We’re looking for things like that and will likely have to look at the department as well to fill these shortfalls.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* So, you’re going to fill these shortfalls within the Department of Defense?

**A: Dr. Adirim:**

* We are looking now to how we can mitigate the shortfalls in any way that we can. It’s a challenge.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* Can you tell me what impact is the recent implementation of enrollment fees for Tricare select having on the numbers of beneficiaries enrolled?

**A: Dr. Adirim:**

* I’m not aware that there has been an impact due to any historical increase in fees. I can get you more precise information for the record, but I’m not aware that there’s been a decrement due to enrollment because of the fees.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* So, you are not seeing a decline in enrollment?

**A: Dr. Adirim:**

* Senator, I think I would like to take this to the record, so I can get you a more precise answer.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* In 2018, when the military health system was beginning to implement reforms, we saw decreases in Tricare copays for specialty care. This includes physical therapy and mental health, two treatments that are very common in military and veteran communities. Can you speak to the impact these co-pays have had on utilization of physical therapy and mental health treatments under Tricare?

**A: Dr. Adirim:**

* I’m not aware that there has been an impact of the utilization of those services due to the co-pay. I’m happy to take that back to and get you a more precise answer, and we can compare years.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* That would be good. I think it’s critically important that we know this information. I’m hearing about this on the ground in Montana, I’m sure a lot of other Senators are hearing about it too. So, considering the reforms that have taken place for Tricare beneficiaries over the last 3 years, do you believe this benefit has retained the same level of historical value?

**A: Dr. Adirim:**

* Absolutely, I think it’s a very rich benefit, especially when you compare it to the civilians sector. It’s a uniform benefit, so all beneficiaries have access to the same benefit menu of services that Tricare offers. I believe that with the new T-5 request for proposal coming out and that new contract, that we will see even more benefits for beneficiaries.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* I want to go back to the shortfall, the $1.8 billion, and this is for the other folks who are here. Do you have any concerns whether we are risking a shortfall, I mean with this shortfall this is going to impact care to your troops?

**A: Lt. Gen. R. Scott Dingle:**

* As the Army looks at the operational force, what we do in conjunction with the DHA and OSD Health Affairs, we identify our readiness requirements upfront. Right now, we do not have a shortfall as we’ve worked through our readiness requirements and identified those to assess that as the fiscal year continues on.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* The answer right now is no?

**A: Lt. Gen. R. Scott Dingle:**

* Correct, yes sir.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* General Hogg?

**A: Lt. Gen. Dorothy A. Hogg:**

* So, along the same lines chairman, medical readiness of our force is monument number 1, so everything we do will be directed toward that, so at this point, yes no short falls. I do, however, have a concern that, as we move forward, that if there is a shortfall, how that is going to get covered.

**Q: Subcommittee Chairman Jon Tester (D-MT):**

* Admiral Gillingham.

**A: Rear Adm. Bruce L. Gillingham:**

* Yes, thank you. Like my colleagues this is something that we will watch carefully and continue to watch internally. At present, I don’t see a threat to our medical readiness and as always, we’ll make sure that we provide the highest quality and effective care that we can to our beneficiaries.

**Q: Committee Chairman Richard Shelby (R-AL):**

* Dr. Adirim and General Dingle, I’ll ask the first questions to you. As I noted in my statement, this committee continues to invest in medical research without regard to other similar federal investments. It seems to me that NIH, and maybe NIH is doing things you’re doing better, I don’t know that − Can you answer the question that I posed in my opening remarks, which is this: What specifically are defense medical research scholars doing that NIH funding cannot or is not doing?

**A: Dr. Adirim:**

* We focus our research priorities within the department on the war fighter and on the needs of the joint force, and on those conditions which may greatly impact our troops. We work very closely with the NIH and other agencies to coordinate very closely on research.

**Q: Committee Chairman Richard Shelby (R-AL):**

* What do you mean by working closely? Is that collaborative—working together on specific things? Name some of them.

**A: Dr. Adirim:**

* For example, for something like suicide and mental health, there’s collaborative research that we work with NINDS. We have annual meetings on the research that comes out of both departments, and the work groups work together to ensure that the research that is being done and sponsored by each department, or together because sometimes these research proposals come out of both departments, are aligned to the requirements of our force.

**Q: Committee Chairman Richard Shelby (R-AL):**

* I realize this, and I think we all do, that the military has certain needs that the general population doesn’t need. But the military at the same time probably also needs all the things that the general population needs, in addition to the military specific things. Is that a fair statement?

**A: Dr. Adirim:**

* Sure, sir.

**Q: Committee Chairman Richard Shelby (R-AL):**

* So, name the top three research areas that you’re doing through the military research.

**A: Dr. Adirim:**

* I’ll turn it over to my colleague, General Dingle.

**A: Lt. Gen. R. Scott Dingle:**

* One of the things to tag on to what Dr. Adirim was saying, the thing that the military also brings as it takes the National Defense Strategy, the DOD guidance and our service guidance, the focuses on the survivability of the soldiers, so trauma care the latest technologies that we get from the civilian sector or from NIH but taking civilian technologies, it takes that military service research and development to incorporate that into tomorrow’s military battlefield and how it’s going to be incorporated into a multidomain environment, and I think that’s one of the key things that we bring from the military as we couple with the civilian sector academia and the industry.

**Q: Senator Tammy Baldwin (D-WI):**

* Dr. Adirim, how many cases of Covid-19 has the military seen this year and in 2020? And I would like to hear the breakdown of the number of military personnel who have been hospitalized or passed away from Covid-19.

**A: Dr. Adirim:**

* I don’t have the precise numbers, so we can get that to you, but what I can say is having look at our percent positivity and following hospitalizations, it is much less than in the civilian sector. Which is what you would expect for a younger, healthier population. Currently right now we are seeing, a testing positivity rate of about 4.4% out nationally, so we have a lower-case rate, and we have lower hospitalization rates as well.

**Q: Senator Tammy Baldwin (D-WI):**

* Okay, I think you can get a sense of the point that I’m trying to make. There’s been a lot of concern over vaccines declination rates for Covid 19 vaccines. There’s also been a long history of concern over compulsory vaccinations beginning in the end of the 1990’s. I’d love to hear details on how the DOD has increased voluntary participation in vaccines in the past and how does the department approach making decisions about whether vaccinations should be compulsory for our service members.

**A: Dr. Adirim:**

* Thank you for that question, and I can talk about Covid. We’re doing a lot with regard to helping our service members make their decision about taking the vaccine. Under the EUA, the vaccine is voluntary and we’re using every avenue to provide information about the vaccine. And as you alluded to, we don’t have a perfect acceptance rate because we only just yesterday opened up vaccination to all eligible beneficiaries, but we do track this, and we are very interested in helping our service members make the decision to get vaccinated.