



WRITTEN TESTIMONY OF

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PRESIDENT AND CEO
HUMANA MILITARY HEALTHCARE SERVICES, INC.**

BEFORE THE

**HOUSE COMMITTEE ON ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL**

MARCH 27, 2007

INTRODUCTORY COMMENTS

Mr. Chairman and Members of the Subcommittee, on behalf of the dedicated professionals of Humana Military Healthcare Services, Inc. (HMHS), thank you for the opportunity to update the Subcommittee on our efforts to provide access to high quality, affordable health services to the military community under the TRICARE program. Our company values the special trust the Government has bestowed on us as a TRICARE partner.

As President and CEO of Humana Military Healthcare Services, and as a TRICARE beneficiary myself, I want to personally thank the Subcommittee for its continued support of the Military Health System (MHS). Delivering exceptional healthcare benefits under TRICARE is a complex undertaking for everyone. Together with our Department of Defense (DoD) partners, we at HMHS believe we are effectively and efficiently administering the TRICARE benefit that you oversee.

COMPANY BACKGROUND

Humana Military Healthcare Services (HMHS) is a wholly-owned subsidiary of Humana Inc., one of the nation's largest health benefit companies. Our subsidiary was formed in 1993 to deliver military health solutions. We were awarded our first TRICARE contract in 1995, and we began serving military beneficiaries in 1996.

Today, under contract with DoD, our company provides support for approximately 2.8 million TRICARE-eligible beneficiaries in DoD's South Region of the United States. The South Region includes the states of Georgia, Florida, South Carolina, Alabama, Louisiana, Mississippi, Arkansas, and Oklahoma, as well as most of Tennessee and the majority of Texas. Our company is made up of more than 1,500 employees, many of whom are beneficiaries of the MHS. We provide services in 70 TRICARE Service Centers (TSC) located throughout the South Region.

Further, as part of our South Region contract, we are responsible for processing all claims for TRICARE services rendered outside the United States. We also administer the Continued Health Care Benefits Program (CHCBP). Supporting us in these endeavors, is an exceptional team of partners, including: PGBA, LLC of Columbia, South Carolina (for domestic claim processing); Wisconsin Physicians Service Insurance Corporation (WPS) of Madison, Wisconsin (for foreign claim processing); ValueOptions, Inc. of Norfolk, Virginia (for behavioral health services); and BlueCross BlueShield of South Carolina (for operations in the State of South Carolina). As a team, we have more than eleven years of TRICARE experience.

Under separate contracts, Humana Military Healthcare Services also furnishes limited TRICARE support for active duty members and their families in the Commonwealth of Puerto Rico. In addition, we provide patient appointing services for several military treatment facilities (MTF) including: Keesler Air Force Base, Mississippi; Fort Bragg, North Carolina; Wright-Patterson Air Force Base, Ohio; Fort Carson, Colorado; the United States Air Force Academy, Colorado; Peterson Air Force Base, Colorado; and Barksdale Air Force Base, Louisiana.

As we begin our fourth year of the five-year South Region contract, we believe we are contributing to the overall success of the TRICARE program. Today, I would like to focus on four areas in which we are adding value to the Defense Health Program (DHP): (1) cost control; (2) clinical quality; (3) access to care; and (4) beneficiary service. My perspectives on these important subjects follow below.

COST CONTROL

As TRICARE partners, we understand the need to control costs and to ensure maximum value for taxpayers. With healthcare costs continuously rising across the country, it is appropriate for DoD and Congress to seek opportunities to provide TRICARE services in the most cost-effective manner possible. Within that context, I thought it might be helpful to provide the Subcommittee some examples of measures we have collaboratively taken with DoD to control TRICARE spending.

- a. Provider Network Expansion. Since contracted healthcare providers normally agree to accept discounted reimbursement for their services, building a robust provider network is an essential cost control strategy. I am pleased to report that our South Region TRICARE provider network is both comprehensive and growing. To illustrate, on November 1, 2004 (when we began full operation in the South Region), our network of contracted hospitals, physicians and other health professionals was made up of just over 43,000 providers. Today, our network consists of 61,172 providers – a 42 percent increase in just over two years – and last month, over 79 percent of *all* claims submitted were paid to network providers. We calculate that the savings to the Government from our discounted arrangements exceeds \$175 million annually.
- b. MTF Optimization. Fully utilizing MTFs and MTF personnel is another way in which we help our DoD partners to control healthcare spending. Collectively, we call our efforts “MTF Optimization” and we are proud of our progress in this regard. One “Optimization” approach involves the placement of civilian providers and support personnel into military facilities. I am happy to report that, in the past year, we saw an increase of 75 percent in such arrangements, netting healthcare cost savings of more than \$7 million annually. Another “Optimization” tool – called “External Resource Sharing” – allows military providers to deliver care to TRICARE beneficiaries in civilian network facilities. Last year, our External Resource Sharing efforts yielded an additional \$3.9 million in savings.
- c. Case Management. Individually managing the healthcare services rendered to the most complex patients helps to ensure cost-effective, high quality outcomes. Case management savings are achieved in several ways, including the individual negotiation of reimbursement rates for costly services such as: high-dollar durable medical equipment; inpatient rehabilitation; long-term acute care; pediatric bone marrow transplantation; hourly nursing; and care rendered by highly specialized non-network

providers. Last year, we realized more than \$5 million savings from case management interventions.

- d. Disease Management. Management of patients with specific diseases represents another way in which costs can be controlled while simultaneously enhancing the quality of healthcare services. Under our South Region TRICARE contract, patients with chronic heart disease have long been eligible to participate in our disease management program. As of early February 2007, a total of 2,700 patients were enrolled in our chronic heart disease program. The impact on cost and utilization has been significant. For example, last year we demonstrated an overall 9.4 percent decrease in annual inpatient days/per 1,000 participants; among those most at risk, inpatient days decreased 45 percent. At the same time, emergency room visits decreased 8.4 percent for beneficiaries who actively participated in the program. Such results reduced costs by millions of dollars.

Last year, the Government added asthma as a second approved disease management program. Today, approximately 5,600 patients are enrolled in our asthma disease management program. It is too early to accurately calculate the financial effects of this program, but we are confident they will be substantial.

- e. Program Integrity. Identification of potential fraud is an important element of our cost control effort. To that end, our company has been extremely active in reporting potential cases of fraud and abuse to the Government. Last year, we reported 64 instances of questionable services claimed in both the domestic and overseas environments to the TRICARE Management Activity (TMA). As part of our ongoing auditing efforts, we also seek to identify duplicate claims for the same services. Through the continuous dedicated efforts of our Program Integrity team, we achieved more than \$5 million in savings through duplicate claim reviews and recoupments.

Finally, we employ commercially-available claim editing software to identify inappropriate claim submission practices. Last year, we estimate these tools yielded savings of more than \$44 million.

- f. Electronic Claims. Congress has long expressed a desire to increase the volume of TRICARE claims processed electronically. I am delighted to report that our company has achieved remarkable growth in the number of Electronic Media Claims (EMC). In January 2005, 49 percent of the claims submitted by our network and non-network providers were filed electronically. By January 2007, the percentage had grown to 73 percent – a 24-point increase over a two-year period. Based on our claim volume in the South Region, this increase in EMC represents a reduction of the Government's claim processing costs equal to approximately \$9 million per year.
- g. Promoting the TRICARE Mail Order Program (TMOP). Though pharmacy service is no longer a part of our contractual responsibility, we at HMHS recognize that pharmacy is the most rapidly increasing component of expense within the MHS. We also understand that it is much more cost-effective to provide pharmacy service through the

mail order system than in the retail setting. Therefore, when TMA asked us to actively promote beneficiary use of TMOP, we gladly agreed to do so at no cost. I'm pleased to report that our multi-channel communication efforts have been very effective. To illustrate, TMOP usage in the South Region grew by more than 25 percent in the past twelve months, to approximately 125,000 unique users. As of January 2007, the South Region continued to lead the nation in TMOP usage with more than 40 percent of the unique users in the nation.

Looking ahead, we will continue to strive for additional opportunities to generate cost savings in the delivery of high quality services. Our contract provides an effective incentive for us to do so, and as partners with the Government, we feel an obligation to ensure that the TRICARE program is using taxpayer dollars wisely.

CLINICAL QUALITY

Over the years, Humana Military Healthcare Services has been committed to providing the highest possible quality of health services to the TRICARE beneficiaries we serve. Especially at this time of war, we believe this commitment is critical to the success of our nation. Today, I would like to share several indicators, and actions we have taken to ensure the delivery of high quality clinical services to those we serve.

- a. Program Accreditation. Since becoming a TRICARE contractor, we have routinely sought outside validation that our policies, procedures, and services meet or exceed best industry practices. Today, I am pleased to report that we have received impartial outside evaluations of several of our programs from URAC (formerly the Utilization Review Accreditation Commission), one of the nation's leading organizations dedicated to healthcare quality assurance. We currently carry URAC accreditation for our programs in: (1) Utilization Management; (2) Network Management (including Provider Credentialing); (3) Case Management and Disease Management; and (4) HIPAA (Health Insurance Portability and Accountability Act of 1996) Privacy. URAC accreditation demonstrates that we at HMHS are delivering appropriate standards of care, that patients are receiving their due process through our appeal procedures, and that healthcare information is being handled in a confidential and appropriate manner. It also ensures that patient safety is a priority in all of our operations.
- b. Clinical Quality Reporting. Objective evaluation of outcomes is also a key element for ensuring the delivery of high quality health and wellness services. To that end, our company recently studied 2005 healthcare outcomes for South Region TRICARE beneficiaries. We published the results of our study in a document titled, "*Mapping the Patient Experience – Humana Military's Clinical Quality Report Card.*" Measurement methodologies, benchmarks and goals were acquired from respected sources including the National Committee for Quality Assurance (NCQA), the Agency for Healthcare Research and Quality (AHRQ), and Healthy People 2010.

Our *Report Card* addresses 25 separate indicators across 7 domains of healthcare quality in the purchased care environment: (1) Preventive Services and Wellness – use of screenings to identify diseases that benefit from early detection; (2) Mental Health; (3) Living with Illness – provision of best practice, evidence-based care to persons with chronic diseases; (4) Patient Safety and Selected Procedure Utilization; (5) Provider Network – the numbers, distribution, and quality of providers available to beneficiaries; (6) Cost of Care – controlling health plan costs within budget; and (7) Customer Service – meeting service standards and satisfying beneficiaries.

Overall, HMHS compared favorably with accepted national standards for indicators measured in the *Report Card*. Specific results appear below.

Domain	Number of Metrics	Better Than Expected	Results As Expected	Worse Than Expected
Preventive Services and Wellness	4	-	4	-
Mental Health	2	-	2	-
Living with Illness	7	1	5	1
Patient Safety & Procedure Utilization	8	6	1	1
Provider Network	1	1	-	-
Cost of Care	1	1	-	-
Customer Service	2	1	1	-
TOTAL	25	10	13	2

Figure 1 – 2005 HMHS Health Care Quality Report Card Results in Purchased Care Sector

As noted, two measures fell below expectations based on national benchmarks: (1) our screening of diabetic patients for kidney disease did not meet national standards; and (2) our rate of hysterectomies in the South was higher than the nationwide norm. In response to these shortcomings, we mailed reminders for kidney screening to selected physicians and patients, and we are implementing a clinical study to explore possible interventions to influence our rate of hysterectomies.

Notwithstanding these two outliers, we are pleased with the results to date, and we will continue to measure and intervene where indicated.

- c. Disease Management. As noted above, disease management programs can have a significant impact on controlling costs. Such programs also enhance the delivery of high quality clinical services. Our first program, focusing on patients with a history of heart disease – the nation’s leading cause of death – began nearly two years ago, and currently serves nearly 2,700 beneficiaries. At the direction of the TRICARE Management Activity, we implemented a disease management program for asthmatics about seven months ago. In a very short timeframe, we were able to target and enroll over 5,600 people into the asthma program. Both programs teach patients

how to live healthy lifestyles, and they provide participants medical guidance from registered nurses. Our nurses provide realistic goals for each patient with appropriate follow-up, and they facilitate physician appointments when necessary.

Our data demonstrate that active participation in these programs assists beneficiaries and providers with the management of patient diseases. For example, among participants in our heart disease program, we have documented an 11 percent increase in the use of ACE inhibitors and beta blockers. Moreover, 75 percent of smokers in the program who set goals to reduce or quit smoking have succeeded.

We have also seen a high degree of acceptance and satisfaction among program participants. Beneficiary feedback indicates 96 percent of a recent sample expressed satisfaction with the information provided to them. Seventy-nine percent of those enrolled in the programs indicate their health status has improved. Seventy-eight percent felt their quality of life had improved since enrolling in a disease management program and 89 percent indicated they would be willing to participate in other disease management programs if offered.

With the obvious success of these programs, HMHS would like to expand our disease management offerings to include other clinical conditions. We are anticipating new programs coming on-line this year as a result of the legislative language in the 2007 National Defense Authorization Act, requiring DoD to offer additional disease management programs for diabetes, cancer, chronic obstructive pulmonary disease, and depression/anxiety disorders. We stand ready to implement these much needed programs when directed to do so by DoD.

- d. Case Management. Humana Military Healthcare Services also provides case management services on a variety of clinical needs for participants of special programs. The focus of case management is to empower beneficiaries and families to actively participate in their own care. Fully supporting the case management process, HMHS has established and maintains a regional system of case management that ensures the coordinated delivery of quality and cost-effective services, with primary emphasis on patients with medically complex conditions and a high potential for extraordinary costs. Helping beneficiaries and families gain a greater understanding of their conditions enables them to make informed decisions and engages them in the planning and delivery of their care. At the same time, our case managers provide personalized attention to beneficiaries' particular needs and assist them in dealing with the complexities of the healthcare delivery system.

HMHS provides education, assistance, and coordination of care to selected TRICARE beneficiaries and their health care professionals. For example, upon entering the case management program, we mail a packet to the beneficiary that contains a welcome letter introducing the beneficiary to the case manager, resource information, and a document explaining the beneficiary's rights and responsibilities. This activity

improves access to resources and cost-effective utilization of appropriate military and community health and health-related resources and services.

- e. Post Traumatic Stress Disorder (PTSD). Like Americans everywhere, all of us at HMHS have become aware of the special impacts of the Global War on Terror on returning service members. Our valued partner, ValueOptions, has focused on the need for assisting those who may be suffering from PTSD – either diagnosed or undiagnosed. ValueOptions is acutely aware of the increased incidence of PTSD symptoms of returning service members and has taken the following steps to address this issue.
- 1) In 2005, we sent a detailed educational summary to all behavioral health providers discussing the prevalence of PTSD, tips on diagnosing the condition, and treatment recommendations.
 - 2) In February 2007, we sent a revised summary to providers supplying additional information on PTSD such as the percentage of behavioral health issues in service members returning from Iraq and Afghanistan; the paradigm of looking at post traumatic stress; and a new treatment being pioneered in San Diego regarding virtual reality exposure in the treatment of PTSD.
 - 3) We are working collaboratively with our partner, Value Options, to provide educational materials to primary care physicians focused on screening for PTSD in the primary care setting.
 - 4) The HMHS website has been enhanced to include educational materials, tools and tests on PTSD and other behavioral health risk factors and issues that can be accessed from one's home.
 - 5) In the spring of 2006, we jointly distributed a brochure to over 32,000 activated National Guardsmen and Reservists explaining risk factors for PTSD, depression, substance abuse, etc. However, we have not seen any significant change in behavior based on this outreach.

In addition to the above focus, ValueOptions encourages providers, through Primary Care Manager (PCM) education and provider mailings to educate family members of returning veterans on signs and symptoms to watch for as soldiers transition back to their pre-combat life.

- f. Transparency. Finally, I would be remiss if I didn't discuss our work to support the Presidential Executive Order on Transparency. In August 2006, the President issued Executive Order 13410, which directs federal health programs, like TRICARE, to promote transparency regarding healthcare quality and price, and make relevant

information available to beneficiaries, enrollees, and providers. We are currently developing two strategies to help the MHS fulfill this directive. First, users of our on-line provider locator will see information on how providers compare regarding the cost for certain episodes of care, clinical quality issues, and compliance with TRICARE administrative requirements. And second, to help beneficiaries evaluate inpatient care, we plan to make quality information about hospitals available through our website.

In sum, we believe we are having a positive impact on the quality of clinical services being provided to TRICARE beneficiaries throughout the South Region. We look forward to additional advances in the future.

ACCESS TO CARE

Unlike other TRICARE Regions, we offer TRICARE Prime to any beneficiary who resides in the South. This means that we have committed to building a network of contracted TRICARE providers to meet the access needs of TRICARE Prime enrollees who live in both urban and rural areas. In so doing, we have enhanced access for all beneficiaries, including those who have chosen to use the TRICARE Extra and TRICARE Standard benefits.

To illustrate, today there are approximately 77 million people who reside in the South Region. Of those, approximately 2.8 million (or 3.7% of the total population) are eligible for TRICARE. On a state-by-state basis, the breakdown is as follows:

STATE	TOTAL POPULATION (2004 US CENSUS)	TRICARE ELIGIBLES	TRICARE PERCENT OF TOTAL
ALABAMA	4,530,182	151,124	3.3%
ARKANSAS	2,752,629	92,246	3.3%
FLORIDA	17,397,161	760,270	4.3%
GEORGIA	8,829,383	396,400	4.4%
LOUISIANA	4,515,770	129,974	2.8%
MISSISSIPPI	2,902,966	123,711	4.2%
OKLAHOMA	3,523,553	140,170	3.9%
SOUTH CAROLINA	4,198,068	226,039	5.3%
TENNESSEE	5,900,962	118,483	2.0%
TEXAS	22,490,022	686,454	3.0%
GRAND TOTAL	77,040,696	2,824,871	3.7%

Figure 2 – South Region Population

At the same time, there are slightly more than 151,000 licensed practicing providers in the South Region. Of those, about 61,000 (or approximately 42% of the total) are part of our TRICARE network of contracted providers. Again, a state-by-state breakdown may provide some insight:

STATE	LICENSED PRACTICING PROVIDERS	HMHS NETWORK (MD, DO, PSYCH)	PERCENT OF TOTAL
ALABAMA	9,746	3,480	36%
ARKANSAS	5,405	2,962	55%
FLORIDA	38,216	13,991	37%
GEORGIA	16,483	7,642	46%
LOUISIANA	10,963	3,797	35%
MISSISSIPPI	5,074	2,234	44%
OKLAHOMA	6,888	3,792	55%
SOUTH CAROLINA	8,974	2,415	27%
TENNESSEE	13,960	6,238	45%
TEXAS	35,681	14,621	41%
GRAND TOTAL	151,390	61,172	42%

Figure 3 – South Region Provider Data

When we overlay the two elements, the following perspective emerges:

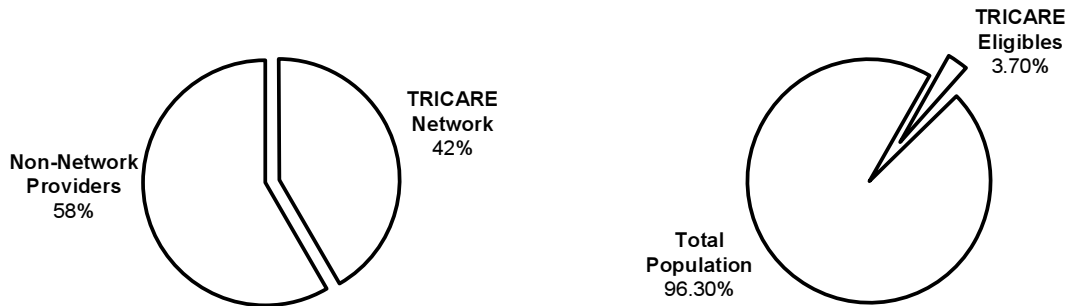


Figure 4 – South Region Network in Perspective

In sum, we believe our provider network offers good access for all beneficiary categories – TRICARE Prime, TRICARE Extra, and TRICARE Standard alike.

However, we also recognize that some beneficiaries will exercise their right to go outside of our network. In such cases, we try to ensure that they have access to non-network providers who *participate* in TRICARE – that is they will agree to see TRICARE patients and file their claims, but without agreeing to discount their reimbursements below the maximums allowed by the TRICARE program. We do not know all the reasons why some providers refuse to see TRICARE beneficiaries, and we do not know how many actually do so. However, what we do know is that approximately 139,000 providers (or about 92% of all licensed practicing providers

in the 10-state South Region) have seen a TRICARE beneficiary and submitted a claim on their behalf during the past year.

To be sure, there are some areas within the South Region that are medically underserved, and as a result, access to medical services is very limited. These areas are very challenging for us, and they sometimes lead to a perception of a lack of access for our beneficiaries. Currently, there are no TRICARE Prime enrollees, and only 24 TRICARE Prime Remote beneficiaries out of 1.4 million TRICARE Prime enrollees who are currently not assigned to a contracted network PCM.

Additionally, the recent Government Accountability Office (GAO) Report issued in December 2006 on *Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE Managed Care Option* states on the Highlights page, “. . . that access is generally sufficient for non-enrolled beneficiaries.” It also says, “Throughout the three regions, about 16 percent of non-enrolled TRICARE beneficiaries reside outside of the Prime Service Area (PSA). Because the South Region has extensive PSAs, no TRICARE beneficiaries live in locations without a civilian provider network.”¹

We are well aware of the need for behavioral health access – particularly in light of the increased demand for such services brought about by the Global War on Terror – and the Subcommittee’s concern for this matter. The data are positive, though certainly there is room for improvement.

According to the Center for the Study of Traumatic Stress, nearly 31% of National Guardsmen and Reservists returning from active duty overseas deployment are doing so with warning signs for several behavioral health disorders, including PTSD and depression.² This continues to be a rising concern for our men and women of the armed forces, and a focal point for us.

In December 2006, our partner, ValueOptions, provided testimony to the DoD Task Force on Mental Health. During this session, the ValueOptions representative noted that the use of behavioral health services in the South Region has continued to increase since 2002. Fortunately, network access has remained high. From November 2005 to November 2006, reimbursement for 90 percent of behavioral health inpatient admissions and 87 percent of behavioral health outpatient services (including unmanaged visits) was made to network providers, while 96 percent of all referrals were made to either MTFs or the network. Not only has network utilization been high, but beneficiaries have had *convenient* access to at least three hospitals within 40.3 miles and three providers within 8.7 miles. Again, we recognize that there are some remote locations within the South Region that contain few TRICARE-certified providers, and that can result in a beneficiary having to further, or experience a delay in scheduling an appointment. Nonetheless, these areas are minimal and when identified are aggressively pursued for network development by our partners at ValueOptions.

¹ Staff Writer, “Access to Care for Beneficiaries Who Have Not Enrolled in TRICARE’s Managed Care Option.” GAO Report, December 2006 Summary ppg 1.

² Staff Writer, “Mental Illnesses Appear Common Among Veterans Returning From Iraq and Afghanistan.” Archives Internal Medicine, Spring 2007; 167:476-482.

In sum, these indicators reflect excellent access to quality healthcare services for beneficiaries in the South Region. Notwithstanding the successes to date, however, we continue to expand our network coverage to meet the special needs of the TRICARE population we serve.

BENEFICIARY SERVICE

Throughout our history, Humana Military Healthcare Services and our subcontracting partners have been customer-centric organizations. Stated simply, we strive to provide excellent service to all TRICARE beneficiaries. Depicted in the chart below is a small sample of the service metrics that we continuously and carefully monitor.

Service Metric	Standard	Mar 06	Jun 06	Sep 06	Dec 06
Phone Answered in 30 Sec.	95.00%	99.00%	98.97%	96.24%	98.94%
Initial Call Resolution	80.00%	97.42%	97.35%	97.36%	97.08%
TRICARE Service Center – less than 10 minute wait time	100.00%	99.93%	99.93%	99.90%	99.97%
Routine Correspondence reply in 15 days	85.00%	99.74%	99.81%	99.86%	99.72%
Enrollments Processing completed in 5 days	80.00%	100.00%	100.00%	100.00%	100.00%
Medical Prior Authorizations processed in 2 days	90.00%	98.63%	98.41%	100.00%	97.95%
Referrals Processed in 2 days	85.00%	99.37%	99.10%	99.37%	99.44%
Percent of referrals to MTFs or the HMHS network	96.50%	97.69%	98.02%	97.07%	97.49%
Claims processed in 30 days	97.50%	99.95%	99.98%	99.96%	99.97%

Figure 5 – Selected South Region 2006 Customer Service Levels

We are proud of our ability to provide these high levels of performance, and we continue to look for opportunities to improve the experience of TRICARE beneficiaries.

We believe our high levels of operational performance have translated into positive attitudes from the TRICARE beneficiaries we serve. Our website seeks to obtain voluntary feedback by posing several questions. Feedback on one question (“*I would recommend my TRICARE health plan to a friend*”) seems particularly illuminating. On a scale of 1 (“Strongly Disagree”) to 5 (“Strongly Agree”), overall results have been consistently high as reflected in the following graph:

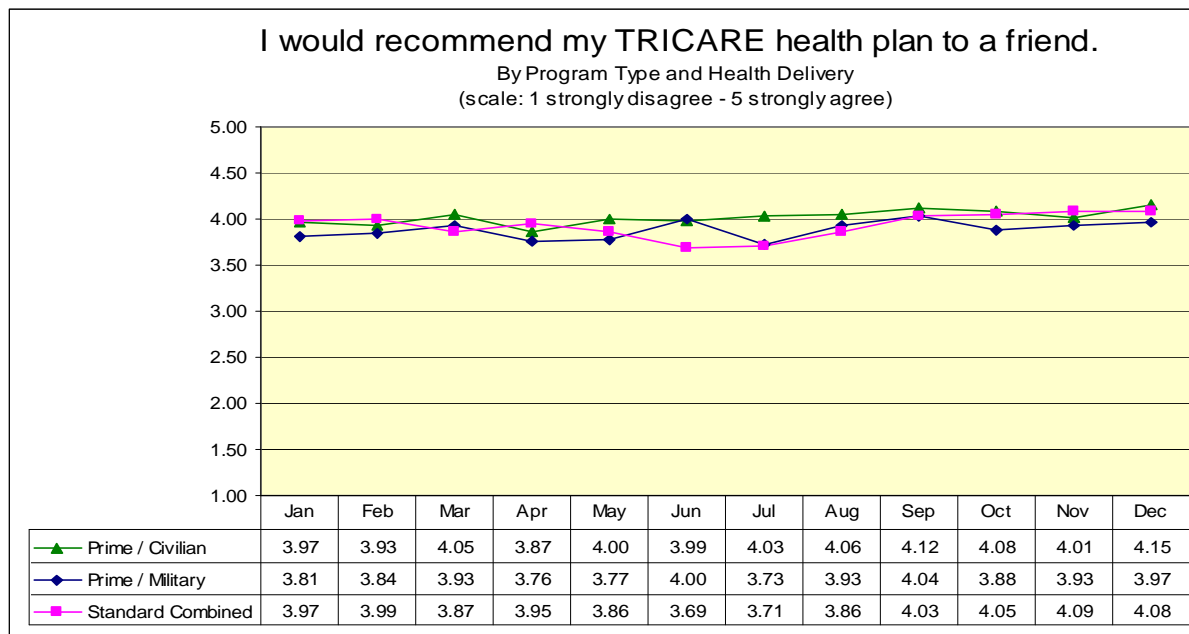


Figure 6 – 2006 South Region Beneficiary Feedback

In summary, we believe we are providing high levels of service across the entire spectrum of beneficiary interaction – as required by the Government under the terms of our South Region TRICARE contract – and as we are committed to do in support of this most deserving population. In turn, these performance levels have yielded positive feedback from those we serve. Notwithstanding our successes, we are committed as a company to continuously improving the level of services – just as the Congress has repeatedly encouraged us to do in the past.

CONCLUSION

As I believe the foregoing statement illustrates, today, we are delivering on the original objectives of the TRICARE program when it was established more than 15 years ago. We have implemented a multitude of industry best practices to help control costs, and enhanced the clinical quality of services delivered to military beneficiaries throughout the South Region. At the same time, we have expanded access to care for all TRICARE beneficiaries, and we believe our operational service levels are unequaled anywhere in the United States.

Achieving these results has required a total team effort on the part of all TRICARE stakeholders. Earlier, I noted the HMHS team, including our partners at PGBA LLC, BlueCross BlueShield of South Carolina, Value Options, Inc., and Wisconsin Physicians Service Insurance Corporation. I am convinced that there is no finer group of industry professionals collaboratively working to ensure service excellence on all levels.

At the same time, I would like to personally commend the Department of Defense for the leadership provided to us on a daily basis. In particular, I respectfully call the Subcommittee's attention to the staff of the TRICARE Management Activity under the skilled leadership of Major General Elder Granger, MC, USA, as well as the dedicated members of the TRICARE Regional Office-South, professionally led by Mr. Michael Gill, SES. Collectively, these exceptional public servants have challenged those of us in industry to provide "world class" healthcare support service to members of the military community. Under their stewardship, I believe we are doing so.

In conclusion, please allow me to also thank you, Mr. Chairman, and the Subcommittee for the guidance and leadership you have provided, as well as for the opportunity to submit my testimony for the record. The health and wellness of our military personnel – and their families – is essential to the success of our nation. We look forward to working with the Subcommittee and with the entire Congress to achieve even greater success in the future.

I stand ready to answer any questions you may have.



DAVID J. BAKER
President and Chief Executive Officer,
Humana Military Healthcare Services (HMHS)

Mr. Baker serves as President and Chief Executive Officer of Humana Military Healthcare Services, Inc. of Louisville, Kentucky.

Following a distinguished active duty career of 27 years in the United States Air Force Medical Service Corps, Mr. Baker joined Humana Military Healthcare Services as the Region 3 Executive Director in 1996. In this capacity, he was responsible for all HMHS field operations in Georgia, Florida, and South Carolina. In 1999, he became the Chief Operating Officer, and in January 2000, he assumed his current position.

Mr. Baker holds a Masters Degree in Business Administration (with a concentration in Health and Hospital Administration) from the University of Florida and a Bachelors of Science Degree in Business Administration from the University of Maryland. He is also a graduate of the Executive Program in Health Care Management of The Ohio State University. While on active duty, Mr. Baker completed the Interagency Institute for Federal Health Care Executives, Air War College, Air Command and Staff College, and Squadron Officer School.

Raised in an Air Force family, Mr. Baker is the only TRICARE CEO who is a life-long beneficiary of the military health system.