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HEARING
ON
NATIONAL DEFENSE AUTHORIZATION ACT
FOR FISCAL YEAR 2012
AND
OVERSIGHT OF PREVIOUSLY AUTHORIZED
PROGRAMS
BEFORE THE
COMMITTEE ON ARMED SERVICES
HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS
FIRST SESSION
SUBCOMMITTEE ON MILITARY PERSONNEL HEARING
ON
**MILITARY HEALTH SYSTEM OVERVIEW
AND DEFENSE HEALTH PROGRAM
COST EFFICIENCIES: A BENEFICIARY
PERSPECTIVE**

HEARING HELD
MARCH 16, 2011



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CONTENTS

CHRONOLOGICAL LIST OF HEARINGS

2011

	Page
HEARING:	
Wednesday, March 16, 2011, Military Health System Overview and Defense Health Program Cost Efficiencies: A Beneficiary Perspective	1
APPENDIX:	
Wednesday, March 16, 2011	29

WEDNESDAY, MARCH 16, 2011

MILITARY HEALTH SYSTEM OVERVIEW AND DEFENSE HEALTH PROGRAM COST EFFICIENCIES: A BENEFICIARY PERSPECTIVE

STATEMENTS PRESENTED BY MEMBERS OF CONGRESS

Davis, Hon. Susan A., a Representative from California, Ranking Member, Subcommittee on Military Personnel	2
Wilson, Hon. Joe, a Representative from South Carolina, Chairman, Subcommittee on Military Personnel	1

WITNESSES

Barnes, MCPO Joseph L., USN (Ret.), National Executive Director, Fleet Reserve Association	4
Cooke, Mary H., Vice President, Johns Hopkins U.S. Family Health Plan, Chair, U.S. Family Health Plan Alliance	9
Hanson, CAPT Marshall, USNR (Ret.), Director Of Government Relations, Reserve Officers Association	9
Holleman, Deirdre Parke, Executive Director, The Retired Enlisted Association	7
Jones, Richard A. "Rick," Director of Government Relations, National Association for Uniformed Services	5
Moakler, Kathleen B., Director of Government Relations, National Military Family Association	8
Strobridge, Col. Steven P., USAF (Ret.), Director of Government Relations, Military Officers Association of America	3

APPENDIX

PREPARED STATEMENTS:

Barnes, MCPO Joseph L.	41
Cooke, Mary H.	89
Davis, Hon. Susan A.	34
Hanson, CAPT Marshall	78
Holleman, Deirdre Parke	59
Jones, Richard A. "Rick"	49
Moakler, Kathleen B.	65
Strobridge, Col. Steven P.	36
Wilson, Hon. Joe	33

IV

	Page
DOCUMENTS SUBMITTED FOR THE RECORD:	
The Association of the United States Navy Statement	99
The Combined Statement of the Air Force Association; Air Force Women Officers Associated; Army Aviation Association of America; Association of Military Surgeons of the United States; Association of the U.S. Army; Commissioned Officers Association of the U.S. Public Health Service, Inc.; Chief Warrant & Warrant Officers Association of the U.S. Coast Guard; Enlisted Association of the National Guard of the United States; Iraq & Afghanistan Veterans of America; National Guard Association of the United States; Society of Medical Consultants to the Armed Forces; U.S. Army Warrant Officers Association; and U.S. Coast Guard Chief Petty Officers Association	113
The Military Coalition Statement	117
The Veterans of Foreign Wars of the United States Statement	143
WITNESS RESPONSES TO QUESTIONS ASKED DURING THE HEARING:	
[There were no Questions submitted during the hearing.]	
QUESTIONS SUBMITTED BY MEMBERS POST HEARING:	
[There were no Questions submitted post hearing.]	

**MILITARY HEALTH SYSTEM OVERVIEW AND DEFENSE
HEALTH PROGRAM COST EFFICIENCIES: A BENE-
FICIARY PERSPECTIVE**

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ARMED SERVICES,
SUBCOMMITTEE ON MILITARY PERSONNEL,
Washington, DC, Wednesday, March 16, 2011.

The subcommittee met, pursuant to call, at 8:00 a.m. in room 2212, Rayburn House Office Building, Hon. Joe Wilson (chairman of the subcommittee) presiding.

**OPENING STATEMENT OF HON. JOE WILSON, A REPRESENTA-
TIVE FROM SOUTH CAROLINA, CHAIRMAN, SUBCOMMITTEE
ON MILITARY PERSONNEL**

Mr. WILSON. Good morning, ladies and gentlemen. Thank you for being here this morning. I would like to welcome everyone to the Military Personnel Subcommittee hearing.

Today we will be hearing from the veterans service organizations on behalf of the issue of “Military Health System Overview and Defense Health Program Cost Efficiencies,” and this is the beneficiary perspective.

This morning, the subcommittee meets to hear the testimony on the Military Health System and the Department of Defense’s proposed cost-saving initiatives from the beneficiary perspective.

I understand this is an unusually early time—actually, 7:00 a.m. standard time, but thank goodness we have moved ahead—for the Military Personnel Subcommittee to hold a hearing. And I appreciate everyone’s willingness to be here this morning to discuss this important subject.

For several years, the Department of Defense has raised concerns about the rising cost of health care and the challenge of maintaining the viability of the Military Health System over the long term. We must seek reasonable solutions for ensuring the availability of world-class health care, not only for our returning wounded, and injured, and their families, and veterans, but to future generations of brave young men and women who answer the call to serve our Nation.

The Department of Defense has proposed several measures aimed at reducing the cost of providing health care to our servicemembers, and their families, and veterans. The plan is a more comprehensive approach than previous cost-cutting efforts. That being said, these proposals will affect not only beneficiaries, they will affect the people who support military health care, such as local pharmacists, hospital employees, and contractors.

We are joined today by an outstanding panel consisting of representatives of several dedicated military service organizations and a representative of organizations that support the Military Health System.

I look forward to hearing your views on the Department of Defense proposals. What do you support? What do you oppose? And do you recommend alternatives to the proposals that we may consider?

Before I introduce our panel, let me offer Congresswoman Davis an opportunity to make her opening remarks.

[The prepared statement of Mr. Wilson can be found in the Appendix on page 33.]

STATEMENT OF HON. SUSAN A. DAVIS, A REPRESENTATIVE FROM CALIFORNIA, RANKING MEMBER, SUBCOMMITTEE ON MILITARY PERSONNEL

Mrs. DAVIS. Thank you, Mr. Chairman.

And let me also welcome our beneficiary representatives today: Colonel Steve Strobbridge, Mr. Joseph Barnes, Rick Jones, Deirdre Parke Holleman—can't see everybody—and Kathy Moakler, Marshall Hanson. I also wanted to welcome Mary Cooke, who is representing the U.S. Family Health Plan. Thank you for being here.

As you all know, yesterday, the subcommittee heard from Under Secretary of Defense for Personnel and Readiness Dr. Stanley, Assistant Secretary of Defense for Health Affairs Dr. Woodson, and the Surgeons General on their views on the status of the military health-care system and their efforts to improve the care being provided to our service men and women, retirees, survivors, and their families.

Today, we will hear firsthand from the folks who really make the most difference here, from those who are the beneficiaries of the system, and the experience that they are having with the military health-care system and their thoughts on the health-care proposals put forth by the Department of Defense.

As you all know, our country is facing difficult economic times, and we are now faced with making some hard decisions that could impact the lives of those who are currently serving and those who have served. I know that our beneficiary representatives here today understand the challenges that we face, as several have previously made sacrifices when they served in uniform or are family members of those serving or who have served.

We need to work together to find a way forward that will continue to ensure the very, very best quality of care for those serving, especially those in harm's way, and to ensure that the benefit being provided remains sustainable into the future. I look forward to a productive dialogue this morning on your thoughts on how we can move forward.

Thank you, Mr. Chairman.

[The prepared statement of Mrs. Davis can be found in the Appendix on page 34.]

Mr. WILSON. Thank you, Ms. Davis.

We have seven witnesses today, which is a large panel. As such, I would respectfully remind the witnesses that we desire that you summarize, to the greatest extent possible, the high points of your

written testimony to 2 minutes. I assure you that the written comments and statements will be made part of the hearing record.

In addition, I ask unanimous consent to issue the following statements into the record: The statement from The Military Coalition; the statement from the Association of the United States Navy; the statement of the Veterans of Foreign Wars of the United States; and the statement representing the views of the Air Force Association, Air Force Women Officers Associated, Army Aviation Association of America, Association of the United States Army, Commissioned Officers Association of the U.S. Public Health Service, Incorporated, Chief Warrant and Warrant Officers Association of the U.S. Coast Guard, Enlisted Association of the National Guard of the United States, Iraq and Afghanistan Veterans of America, National Guard Association of the United States, Society of Medical Consultants to the Armed Forces, the U.S. Army Warrant Officers Association, and the U.S. Coast Guard Chief Petty Officers Association.

Without objection, so ordered.

[The information referred to can be found in the Appendix on pages 99, 113, 117, and 143.]

Mr. WILSON. Let us welcome the panel: Mr. Steve Strobridge, director of government relations, Military Officers Association of America; Mr. Joe Barnes, the national executive director of the Fleet Reserve Association; and returning we have Mr. Rick Jones, director of government relations of the National Association for Uniformed Services; Mrs. Deirdre Holleman, executive director of the Retired Enlisted Association; Mrs. Kathy Moakler, director of government relations for the National Military Family Association; Mr. Marshall Hanson, director of government relations for the Reserve Officers Association; Ms. Mary Cooke, vice president, Johns Hopkins U.S. Family Health Plan, and chair of the U.S. Family Health Plan Alliance.

As we begin today, we will be hearing from each of the witnesses, and then the members of the subcommittee will be asking their questions. And we will each, beginning with me, be subject to a 5-minute rule. And we have someone who is impartial, above repute: Jeanette James is going to be the timekeeper and scorekeeper.

So, with that, we will begin right away with Mr. Strobridge.

STATEMENT OF COL. STEVEN P. STROBRIDGE, USAF (RET.), DIRECTOR OF GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA

Mr. STROBRIDGE. Thank you, Mr. Chairman.

Mr. Chairman and Ranking Member Davis, members of the subcommittee, I am here representing MOAA [the Military Officers Association of America], but 13 other military associations have asked to add their names to our statement. And I have submitted the statement for the record, as indicated by the chairman.

MOAA has not taken the position that fees should never rise, but that Congress should establish principles in that regard to explicitly recognize that the bulk of what military people pay for their health care is paid upfront in service and sacrifice. We are encouraged that the new DOD [Department of Defense] proposal does a

far better job of acknowledging that than did those of several years ago.

Our principal objection is to DOD's plan to index future TRICARE Prime increases to some undetermined health-care index that they project to rise at 6.2 percent per year.

In our view, the main problem is that current law leaves much of the fee-setting to DOD's discretion. DOD went years proposing no changes, making beneficiaries believe that there wouldn't be any. Then a new Secretary proposed tripling fees, which upset beneficiaries and implied that they had not earned their health care through their service.

We have statutory guidelines for setting and adjusting basic pay, retired pay, survivor benefits, and most other military compensation elements. We believe strongly that the law should specify several principles on military health care:

First, it should acknowledge, if only as a sense of Congress, that the military retirement and health-care package is the primary offset for the extraordinary demands and sacrifices inherent in a multi-decade service career.

Second, it should acknowledge that those decades of service and sacrifice constitute a very large prepaid premium for their health care and retirement over and above what they pay in cash.

Finally, it should explicitly acknowledge that extraordinary upfront premium in the adjustment process, by limiting the percentage growth in TRICARE fees in any year to the percentage growth in military retired pay.

In the meantime, MOAA and The Military Coalition pledge our support to work with DOD and the subcommittee to find other ways to hold down military health cost growth. We believe much more can be done to encourage voluntary use of the mail-order pharmacy system, reduce costs of chronic conditions, reduce system duplication, and cut contracting and procurement costs, to name a few.

Thank you very much for the time.

[The prepared statement of Mr. Strobridge can be found in the Appendix on page 36.]

Mr. WILSON. Thank you very much.

Mr. Barnes.

STATEMENT OF MCPO JOSEPH L. BARNES, USN (RET.), NATIONAL EXECUTIVE DIRECTOR, FLEET RESERVE ASSOCIATION

Mr. BARNES. Mr. Chairman, Ranking Member Davis, and members of the subcommittee, thank you for the opportunity to appear before you today.

Military service isn't like any other career or occupation, and associated with this and requirements associated with maintaining readiness are fulfilling commitments to provide health care and other benefits for career personnel after retirement.

FRA's [the Fleet Reserve Association's] reaction to drastic health-care fee-increase proposals from 2006 to 2008 included support for legislation that would shift oversight of these matters from DOD to Congress and support for a Senate bill in the 110th Congress prohibiting fee adjustments from exceeding the annual Consumer

Price Index associated with retired-pay COLAs [cost-of-living allowances].

DOD's 2012 TRICARE Prime fee adjustments plan is more reasonable than past proposals. However, initial adjustments are only part of the plan, and our association is very concerned about the yet-to-be-determined baseline index for inflation in 2013 and beyond.

FRA supports the elimination of co-pays for generic drugs via home delivery and notes that survivors and medically retired personnel are not impacted by the plan. There are also no Active Duty fee increases, no changes to TRICARE Standard, and no additional TRICARE for Life fees.

FRA agrees with GAO [the Government Accountability Office] that management efficiencies and cost-saving initiatives can significantly offset higher health-care costs. And our members ask that Congress find a permanent "doc fix" to pending cuts in Medicare physician reimbursement rates, which is essential to ensuring access to care for all beneficiaries, including those under TRICARE for Life.

Thank you again for the opportunity to present our views.

[The prepared statement of Mr. Barnes can be found in the Appendix on page 41.]

Mr. WILSON. Thank you very much.

Mr. Jones.

**STATEMENT OF RICHARD A. "RICK" JONES, DIRECTOR OF
GOVERNMENT RELATIONS, NATIONAL ASSOCIATION FOR
UNIFORMED SERVICES**

Mr. JONES. Chairman Wilson, members of the subcommittee, thank you very much for the opportunity to present testimony this morning.

The National Association for Uniformed Services asks Congress to hold the line. Our association is not alone in this request to hold the line. We do not speak for them, but we are pleased to stand with the millions of veterans who form the American Legion, the Veterans of Foreign Wars, the AMVETS [American Veterans], the Air Force Sergeants Association, Jewish War Veterans, to name a number of major associations representing the men and women who actually served in the Armed Forces and who also reject the Pentagon plan.

Our country has asked a great deal from these former troops. They have responded, kept the faith, kept our strong defense. We are better today for it.

At first look, the plan for TRICARE increases may indeed seem modest, as the Department has described. However, it is clear the plan is a nose under the tent, a Trojan horse designed to divide Congress and divide military associations' voices and to start a roll-out for substantial increases in TRICARE fees and co-pays. Defense Comptroller Robert Hale called the Pentagon plan a slow start. And then he said, "It is a way to get Congress and the military associations in agreement, and then we can roll out the rest of it."

To achieve their plan, the Pentagon officials began with a public affairs attack that suggested that a pre-war fee, a cost for military

health care at \$19 billion, and a rise currently to \$52 billion was the fault of retirees.

Gentlemen, we are at war. The cost of military health care will always increase during war. It has never been mentioned by the Pentagon. It is always the retirees. And it always will be costly unless we leave our troops on the field, which American veterans and those generations we hope to come later will never do while they breathe American air. Again, the blame for the dramatic rise in military health-care costs is the war, not the retiree.

Our members tell us it is hard to imagine really anything that can be so callously said and directed at their members as to hear of the stories in the national media that depict the cost of retiree benefits as being responsible for threatening available funding for our national security.

This benefit is a benefit that has been earned. It is for honorable military service. And for those who don't understand it, these benefits were earned the hard way. They are part of a moral contract. They are different from private-sector, regular Federal health-care plans. They are provided in return for a career in military service.

And for those outside this room who wish to compare military fees to other government programs and who do not understand the risk inherent in military service, allow me to point out that there is a stark difference between running in Reeboks or Rockports to catch a carpool and running in combat or desert boots to catch cover—protective cover.

The National Association for Uniformed Services is certainly not comfortable with defense leadership actually suggesting to the public that the price we pay for health care is more than the value our Nation received from those who served more than 20 years, all to start slowly and to gain a nose under the tent.

Certainly, there are a number of lower-priority programs that can be reduced. If cuts are needed to tighten the budget, there are things big and small that can be done. Our members understand this, yet they see resources fly out of the Federal Government for the Professional Golf Association, for a museum for the groundhog Punxsutawney Phil, for the cowboy museum, for other projects really too numerous to list. Money was even directed to the Grammy Association, an association of millionaire record producers, artists, and the like.

As we see \$120 billion stolen by fraudsters in various medical and social programs, we wondered why they point to an earned benefit. Incredibly, there are additional questionable priorities. What signal, for instance, is being sent when our government directs our Nation's hospitals to pay the medical-care costs for treating illegal aliens? Does illegal-alien health care trump the health-care benefit provided by those who give a lifetime protecting American freedom?

We have faith in our leaders, but we are not blind. Before we begin whacking our military earned benefits, let us make certain that we use our best wisdom and select our most important programs over our lesser important ones. And let us not forget: We are at war.

And it should be pointed out that many of our military retirees are on fixed incomes. Many cannot afford even the modest, so-

called modest, 13-percent increase in monthly expense. Lifetime health care is an earned benefit. And please consider, our members have not received a COLA over the past 2 years.

Mr. Chairman, we thank you very much for your time and thank you very much for the opportunity to bring our view to your panel.

[The prepared statement of Mr. Jones can be found in the Appendix on page 49.]

Mr. WILSON. Thank you, Mr. Jones.

Mrs. Deirdre Holleman.

**STATEMENT OF DEIRDRE PARKE HOLLEMAN, EXECUTIVE
DIRECTOR, THE RETIRED ENLISTED ASSOCIATION**

Mrs. HOLLEMAN. Good morning, Chairman Wilson, Ranking Member Davis, and distinguished members of the subcommittee. On behalf of TREA [The Retired Enlisted Association], I, too, would like to thank you for the chance to quickly speak about these critical issues.

Your question is concerning the Administration's proposed defense health cost efficiencies. It is clear from both the testimony yesterday and already today that we all acknowledge that the primary mission of the Military Health System is readiness, and the cost of that mission must be paid by the entire Nation. It should not be the responsibility of those who have served a career in the military.

Obviously, the present proposals are not as appalling as previous ideas, and for that, we are grateful. That does not mean, however, that we support all the proposals.

It is not clear to TREA or others which medical inflation index DOD is planning to use, but it is completely clear that, at least for now, DOD is using a compounding figure of 6.2 percent. In a short amount of time, that figure will dramatically eat into a retiree's earned retirement package. It would completely destroy the present purpose of the COLA for the retirement pay.

TREA is completely opposed to this part of the proposal. And we feel no assurance that, if this change is made, more costs would not be added or more groups would not be included after Governor Baldacci finishes his study.

As you can tell from my written testimony, TREA was planning to focus on the need to keep the U.S. Family Health Plan running in its present structure. However, since you have invited a representative of that fine program, let me simply state that we know how hard it is to get up and running any effective program. USFHP [the U.S. Family Health Plan] does a wonderful job for its beneficiaries. We should be very careful not to dislodge its smooth functioning.

While of course we are focused on the new budget proposals, I do not wish to miss the chance of mentioning the continuing need to focus on our goal of a seamless transition for our wounded warriors transferring from DOD health care to VA [Department of Veterans Affairs] health care.

In particular, at this moment, both departments should be urged to coordinate their Wounded Warrior caretakers program. Presently, the ending of DOD's program and the starting of the VA's program do not mesh. This really needs to be corrected.

Thank you very much for your attention. I look forward to trying to answer any of your questions.

[The prepared statement of Mrs. Holleman can be found in the Appendix on page 59.]

Mr. WILSON. Thank you, Mrs. Holleman.

And I would like to point out, there appears to be a technical problem with the microphones, and so everyone needs to get a bit closer, beginning with Mrs. Kathy Moakler.

STATEMENT OF KATHLEEN B. MOAKLER, DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL MILITARY FAMILY ASSOCIATION

Mrs. MOAKLER. Thank you, Mr. Wilson.

The National Military Family Association appreciates the opportunity to speak with you about military families and a benefit that they consistently rate as important: military health care.

We agree that DOD's proposed increase of Prime enrollment fees for working-age military retirees and their families is fair. Our association has concerns, however, with using a civilian-based index in determining these fees after 2012. And we have always supported the use of the cost-of-living allowance as an index for increasing fees.

While we agree that it can drive efficiencies through changing behavior, we do have some concerns with the proposed increase in co-pays for retail medications and the impact this increase will have on beneficiaries who have no choice but to rely on the retail pharmacy for urgent, non-maintenance medications. We should not penalize a military family when their child needs an antibiotic for pneumonia and they have no other option than the retail pharmacy.

Family readiness calls for access to quality health care and mental health services. Military families may be encountering access challenges and provider shortages as we look ahead to the prospect of decreasing Medicare reimbursement fees, new contract renegotiations with the T-3 [Third Generation of TRICARE] contract, and the uncertainties faced by providers in regards to health-care reform.

We are pleased with the many resources that have been provided for families for non-medical counseling. We are concerned about a shortage of behavioral health providers in the MTFs [military treatment facilities] and the network. While we know that the services are addressing this with new programs, we are troubled by the increases in servicemember suicides and also by the increase in suicide and suicide attempts by military family members. Our written statement goes into greater detail about these issues.

Thank you for letting us be on the panel today.

[The prepared statement of Mrs. Moakler can be found in the Appendix on page 65.]

Mr. WILSON. Thank you, Mrs. Moakler.

And, at this time, Mr. Marshall Hanson.

STATEMENT OF CAPT MARSHALL HANSON, USNR (RET.), DIRECTOR OF GOVERNMENT RELATIONS, RESERVE OFFICERS ASSOCIATION

Mr. HANSON. The Reserve Officers Association would like to thank Chairman Wilson, Ranking Member Davis, and members of the committee for today's invitation.

Being brief, ROA [the Reserve Officers Association] finds DOD's proposal of a fee increase of \$60 a year for TRICARE Prime families, and half that for individuals, a modest rise and doesn't find the proposed increases for pharmacy co-payments excessive. We hope that initial prescriptions at retail sites are exempted, though, permitting the beneficiary follow-up time to take advantage of mail-order savings.

Where we hesitate is that DOD is suggesting an index for increasing TRICARE Prime fees in future years. While ROA would accept an index based on COLA, we also feel there is a need to explore other indices should a COLA basis not be accepted.

The most important point of this hearing is to establish a process to involve Congress, the beneficiary associations, and DOD in determining acceptable rates. Unilateral decisions by the Pentagon worry ROA members.

While ROA was once open to a cards-on-the-table approach to health-care discussions, we have grown hesitant by how the Pentagon implements programs. ROA is frustrated that DOD treats Reserve Component health care for drilling reservists as a health insurance program, even though Reserve Component members have mobilized over 800,000 times.

And we are quite disappointed with the market-level premiums levied upon "gray-area" retirees. We hope that the committee will agree to a GAO review on premiums for TRICARE Retired Reserve the same way the HASC [House Armed Services Committee] prompted reductions in costs for TRICARE Reserve Select.

Also, ROA asks that you look into DOD allowing TRS [TRICARE Reserve Select] beneficiaries who are discharged the option of being in the Continued Health-Care Benefit Plan. Selected reservists are the largest group in the United States not provided transitional COBRA [Consolidated Omnibus Budget Reconciliation Act] protections.

Lastly, we need to work with your staff to ensure that all Guard and Reserve members coming off of Active Duty are permitted a TAMP [transition assistance management program] coverage. Some individuals are being told they are not covered.

Thank you once again, and I am ready for questions.

[The prepared statement of Mr. Hanson can be found in the Appendix on page 78.]

Mr. WILSON. Thank you, Mr. Hanson.

And we will now conclude with Ms. Mary Cooke.

STATEMENT OF MARY H. COOKE, VICE PRESIDENT, JOHNS HOPKINS U.S. FAMILY HEALTH PLAN, CHAIR, U.S. FAMILY HEALTH PLAN ALLIANCE

Ms. COOKE. Thank you.

Mr. Chairman, Representative Davis, and distinguished members of the subcommittee, thank you for the opportunity to testify

today on behalf of the Uniformed Services Family Health Plan. I am honored to be here today to share this opportunity with my colleagues from the military beneficiary associations who serve our Nation's heroes and their families so well. U.S. Family Health Plan is proud to share in this commitment.

My brief statement will focus on the successful partnership between U.S. Family Health Plan and the Department of Defense and our concern that a proposal contained in the President's budget request, if enacted, would prohibit us from caring for many of our Nation's heroes and their families. The President's budget proposal would end the U.S. Family Health Plan's ability to care for those beneficiaries who need it the most and is designed to undermine this highly effective program.

Thirty years ago, the Congress directed that our organization continue the tradition of providing health care to uniformed services beneficiaries, including those age 65 and over. With the introduction of the TRICARE program, new legislation made us a permanent part of the Military Health System, establishing the U.S. Family Health Plan as a fully at-risk managed-care model designed to provide comprehensive health care while maintaining cost-neutrality.

Today, the U.S. Family Health Plan provides the TRICARE Prime benefit to nearly 115,000 military beneficiaries in 16 States and the District of Columbia. The six not-for-profit health-care organizations administering the U.S. Family Health Plan are Johns Hopkins, Martin's Point Health Care, Brighton Marine Health Center, St. Vincent's Catholic Medical Centers of New York, CHRISTUS Health, and Pacific Medical Centers. As a proud partner with the Military Health System, our objectives are aligned with the Department's stated goals, which include readiness, the patient's experience of care, population health, and controlling per-capita costs.

U.S. Family Health Plan continues to be the highest-rated health plan in the Military Health System. This year's independently administered satisfaction survey found that 91 percent of our members rated our program highly, as compared to only 62 percent of members in commercial managed-care plans.

With regards to cost, by statute total payments for health-care services to enrollees of the U.S. Family Health Plan cannot exceed an amount equal to what the government otherwise would have incurred had our enrollees received care from alternative sources, whether those sources be military treatment facilities, TRICARE, or Medicare.

Because we are reimbursed on a capitated basis, our financial incentives are aligned with our longitudinal approach to population health—namely, to engage our members in living healthy lives and preventing chronic illnesses that both diminish quality of life and disproportionately contribute to escalating health-care costs.

Given our high level of beneficiary satisfaction and our success in adopting innovative strategies to improve health outcomes, we were disturbed that the President's budget proposes to require all new members to disenroll from our program at age 65, just when they need the benefits of our program the most.

The proposal does not save the government any money. It would merely shift the cost of care for our older beneficiaries from the Department to Medicare. In doing so, military beneficiaries and their families, who choose our plan in large part due to our integrated approach to population health, would lose access to our highly effective prevention and medical management programs.

It appears, then, that the budget proposal and its destabilizing impact on the U.S. Family Health Plan is in conflict with the stated goals of the Military Health System. Perhaps most concerning is the fact that, over time, thousands of aging military beneficiaries who need our help in managing complicated medical conditions simply won't have access to it.

We understand the challenges the Department and the Congress face in needing to reduce costs, but the elimination of innovative programs like the U.S. Family Health Plan is counter to the goal of reducing government health-care costs. Accordingly, we urge Congress to reject this proposal and protect military families' and retirees' access to the quality of care they like, need, and deserve.

Thank you very much for the opportunity to be here today.

[The prepared statement of Ms. Cooke can be found in the Appendix on page 89.]

Mr. WILSON. Thank you very much.

And now we will begin with the 5-minute rule. And Ms. James is very precise in this.

And as we begin, I want to thank all of you. And I wish the American people could see the level of dedication of the veterans service organizations. You represent millions of members of families who have put their faith in you. And the organizations here today, the persons who provided the different organizations' provided statements are so helpful. And so, you are the persons who have the background, and you are the people who use the systems we are talking about. It is also significant that it does not cost the taxpayers any money, so you are the correct example of stewardship.

Yesterday, we had an extraordinary hearing with Dr. Clifford Stanley and Dr. Jonathan Woodson. And Dr. Stanley is special to me. He is a graduate of South Carolina State University, one of the great universities of South Carolina. And so I really am frustrated that, with their capabilities, that the President has named a military health-care czar, the former Governor of Maine, John Baldacci.

We don't need a health-care czar. We have veterans service organizations that can provide this information. And as stewards of the taxpayers—this is not the government's money; it is the taxpayers' money—\$164,000, plus expenses, I think are being diverted from the military health-care system. It could be done without any expense. And I really think the first thing that the Governor should do is step down. He could then create a savings of almost \$200,000 by way of efficiencies.

With that, indeed, we have people here today. And this is going to be tough. Each of you have 30 seconds to tell us how you would provide for an efficiency, beginning, obviously, with Mr. Strobridge.

Mr. STROBRIDGE. Sir, I think there are a lot of opportunities for efficiencies.

We have engaged with the Defense Department, to a pretty significant degree, on the mail-order pharmacy system. Despite what DOD has done so far, there has been really only a relatively modest shift.

And what we have advised the Defense Department is they have probably gotten most of what they are going to get from people who are motivated by the money savings. Our surveys indicate people who aren't shifting so far are doing so because they are worried about one aspect or another, they are deterred from taking that step.

And we have talked to the Department of Defense about giving people that information ahead of time. They haven't done that so far, but we have been trying to work with them to get the most frequently asked questions, get those answers to those people, which will reduce their inhibitions about calling to try it. Because once people try the mail-order system, they are pretty satisfied with it.

We think that is a huge potential savings.

Mr. WILSON. Thank you.

Mr. BARNES. Mr. Chairman, I would echo Steve's comments with regard to the mail-order pharmacy.

As I noted in our statement, we also note that GAO has identified several opportunities for significant savings, including command structure reorganization, which could save estimates of in excess of \$260 million to over \$400 million annually within the Department.

There are also opportunities with regard to greater interaction and coordination with the Department of Veterans Affairs with regard to electronic medical records. The AHLTA [Armed Forces Health Longitudinal Technology Application] and VistA [Veterans Health Information Systems and Technology Architecture] systems do not interact, despite significant resources that have been committed to both departments to those programs over the years. It is kind of mind-boggling. FRA has questioned why the VistA system was not the basis for developing the AHLTA system given the fact that we need to take care of our wounded warriors that transition from DOD to VA health care.

So those are just a couple areas that we would recommend. Thank you.

Mr. WILSON. Thank you.

Mr. JONES. Exactly right. I echo both of those thoughts, particularly the AHLTA thing.

AHLTA comes in with rave reviews from defense contractors, but the doctors seem to say it is a burdensome system. It is incompatible with VA, and DOD and VA have been working on finding a way to combine the electronic system for years. Charles Percy, Senator from Illinois, long ago, 1982, began the process. He said, we need to pull this electronic health record together.

Mr. WILSON. Right.

Mr. JONES. I would also point out that there are opportunities for this sort of combination of joint working between VA and DOD.

In South Carolina, for example, in Charleston, South Carolina, there is a major veterans pharmaceutical distribution system right across the street from the hospital. We have sent people down

there. And they had an oversight hearing last year, the Department, at the House Veterans' Affairs Committee, where there were problems in the mail order and distribution of pharmaceuticals. But it was pointed out that all you had to do was walk across the street to connect with VA to get this job done. So that is a major problem.

Procurement reform is necessary in DOD. GAO pointed out several issues this past week in procurement reform. These are major issues and areas that we need to look at. And, of course, to incentivize the health-care mail-order system is important, as well. It can save a lot of money for beneficiaries, in particular, who we represent.

Mr. WILSON. And, to be fair—and I apologize. We need to go immediately to Ms. Davis. I am subject to the 5 minutes, too, obviously.

Mrs. DAVIS. Thank you, Mr. Chairman.

So, why don't I let the rest of you finish with my time? Go ahead.

Mrs. HOLLEMAN. Quickly, of course I agree with the suggestions already made.

I think there should also be more of a focus on treating chronic illnesses. It has been discussed, it was discussed briefly, as all things were, yesterday, concerning the medical home and that pattern and that structure. Certainly, the government is looking at that. But that should really be a major, major focus, as it has been shown it saves money and it accomplishes the purpose of the health-care system. And USFHP is a prime example of how that works and how it saves money and improves lives.

Mrs. MOAKLER. We, of course, agree with all the previous efficiencies that have been introduced. But we would like to re-emphasize that establishing a unified joint medical command structure would certainly introduce many efficiencies. As you know, we are a purple organization, and we feel that families would be best served by a joint command, a joint medical command.

We also encourage the inclusion of recommendations of the Task Force on the Future of Military Health Care in this year's NDAA [National Defense Authorization Act]: restructuring TMA [TRICARE Management Activity] to place greater emphasis on its acquisition role; examining and implementing strategies to ensure compliance with the principles of value-driven health care; reassessing requirements for purchased care contracts to determine whether more cost-effective strategies can be implemented; and removing the systemic obstacles to the use of more efficient and cost-effective contracting strategies.

Mr. HANSON. Medical and dental readiness continues to be having a big impact on Reserve Component mobilization. And as Dr. Heck pointed out at yesterday's hearing, if Reserve dentists and doctors were permitted to treat fellow reservists, this would save health dollars and help our Nation's readiness.

Ms. COOKE. And I would echo the comments of my colleague, Mrs. Holleman. The best way to decrease health-care costs is to eliminate the medical conditions that diminish quality of life and contribute disproportionately to rising health-care trends. So I would suggest an upfront investment in prevention in programs to

minimize and eliminate chronic conditions as a long-term efficiency.

Mrs. DAVIS. Thank you so much. I appreciate everybody.

Maybe I just want to really focus on your comments, Ms. Cooke, earlier especially, because I think, as it was explained to us yesterday, there is a difference in the capitated care, and so we are trying to really understand.

I know prevention saves money. I believe that. When we have been looking at health care for the country, we have made that point repeatedly. Unfortunately, it doesn't score when you are trying to figure out what some of those best methods are. And that is a great frustration, even though you know that you are going to be able to do that.

Can you explain a little bit better, then, how your plan actually saves money? And how has that been documented over the years?

Ms. COOKE. Yes. Thank you for the opportunity.

I will comment that the comments yesterday suggesting that there was a difference in cost, again, seem to us to be inconsistent with the law. And so we look forward to CBO's [the Congressional Budget Office's] scoring what this proposal would be, in that, by law, our costs cannot exceed what the government would pay.

But with regard to managing chronic conditions, you know, the health-care industry faces the problem of, how do you quantify non-events? How do you quantify the fact that certain people would have gotten diabetes and otherwise today do not?

Throughout the six programs, we have over 40 disease management and care management programs. And so I will give an example of Johns Hopkins. We are very focused on research. We have one program that is called Guided Care that embeds clinical staff nurses in primary-care sites and provides them a panel of military retirees based on the chronic conditions that they have.

And so there has been assessment that, because of that program, which focuses on not only engaging the member but visiting the member's home, engaging the family, understanding what community resources are, and actually developing a care plan for the military beneficiary that they keep on their refrigerator, with the clinical nurse sometimes accompanying them to specialty care services, has shown a decrease in costs with regard to repeat inpatient admissions and has also shown an increase in satisfaction with the member and the provider.

Mrs. DAVIS. My time is up, but perhaps in the next round we will have a chance to come back or someone else could ask about how, given all that—and I appreciate what you are saying, because I believe that, but I also want you to show us how you could reduce costs, if needed.

Ms. COOKE. Okay.

Mr. WILSON. Thank you very much, Ms. Davis.

We now have Dr. Joe Heck of Nevada.

Dr. HECK. Thank you, Mr. Chairman.

You know, what we heard when the other panel was here was this analogy or the comment made about that they are talking about the working-age retirees. So, potentially, somebody enlisted at the age of 18, retired at the age of 38, and what is going to happen from age 38 to, let's say, 65. And that individual may go on

to a second career, maybe a very successful career, and be very well-off, and whether or not there should be some responsibility on that person's part or their new employer's part to provide some of their health-care coverage.

I would like for you to address the counterargument and why that analogy doesn't really hold water.

Mr. STROBRIDGE. Yes, sir. I think we would like very much to address that.

That is one of the problems I think we have with some of the DOD descriptions. You know, when they talk about working-age retirees, there is almost an implication there that, if you go out and get a job, then, you know, you didn't really earn your health care. And from the perspective of the military people, they spend 20 or 30 years on Active Duty being told that if you put up with these conditions that other Americans aren't willing to put up with, then you will be provided a package of retirement benefits, including health care. And nobody in there said, "Oh, but that doesn't apply if you go get a civilian job."

That is what gets military retirees so upset, because they fulfill all the conditions, all the extra sacrifices that the government imposes. And the government imposes no cap on the amount of sacrifices that they will extract. Once that service is rendered, all of a sudden some folks in the Administration want to seem to say, you know, that service has no value anymore, that, you know, if you get a civilian job, DOD has no employer responsibility to you even though you served as a DOD employee under those conditions for 20 or 30 years.

To us, that is very important. That is why I mentioned in my oral statement, we think it is very important to have some statement in law, where there is none now, that states explicitly that military health care is one of the crucial offsets to the adverse conditions of service that is, in fact, an upfront and very substantial premium payment.

And that would help defeat some of these arguments, I think, upfront that people want to devalue the service and only compare cash to cash, which to us is an apple-to-orange comparison.

Mr. HANSON. One of the arguments that we made for the existence of TRICARE Reserve Select was to improve the hire-ability of members of the Guard and Reserve by having a health-care plan that is exportable. That would help small employers know that, when they bring an individual in, that they are bringing a health-care plan with them.

And this is one of the incentives that we have in place, because we are beginning to see problems with re-employment of people that have been deployed.

And this same argument can be taken over to TRICARE for the Active Duty retirees, as well, because here is an experienced working pool that is needed by this Nation's economy, and if they have a TRICARE health to bring with them, as well, that means they can be hired by individuals who maybe couldn't afford equivalent people in the normal working place that didn't have a military background.

Mr. JONES. Mr. Heck, Robert Gates, the Secretary of Defense, says these working retirees, as you described, are beneficiaries who

were employed full-time while receiving full pensions, often foregoing their employer's health plan to remain on TRICARE.

Well, it is apparent that some may find it very hard to understand, but the simple fact is that these men and women earned a retirement benefit, and they actually look forward to using it. It is a breach of moral contract to stump that promise that has been made to these folks.

Mr. BARNES. Dr. Heck, I would add that this issue goes to military service being unlike any other career occupation. And there is a propensity to constantly focus on the dollar, the bottom line, and not on the commitment that was made and those that served in the past.

Also, with regard to the enlisted force, those retired from the enlisted service, many of them do not have the high-paying jobs or the resources that are assumed when these discussions or when these points are brought forward.

Also, approximately 1 percent of the population is shouldering the responsibility for defending our Nation. And the total amount of defense spending as a percentage of GDP [gross domestic product] is historically low during a wartime period compared to past periods of conflict. So, a couple observations to add to the discussion here.

Thank you.

Mr. WILSON. Thank you, everyone.

Indeed, Ms. James is really tough on this 5 minutes. And I tell you, she punches me. You all don't see this.

Congresswoman Niki Tsongas of Massachusetts.

Ms. TSONGAS. Thank you all for appearing before our committee today. It is an important issue, and I appreciate the insight that I am receiving from each of your testimonies.

Yesterday, in the first of this series of hearings, I said that before Congress could increase TRICARE fees for working-age retirees, any proposal on the table would have to be proven to minimize impact. It would be inexcusable, in my mind, to deprive our retired heroes of the health benefits they have earned.

I also question the disparate impact of any increases on servicemembers who accrue less annual retirement benefits than others. As you all know, retirement benefits vary greatly depending on a number of factors, such as how long a person served and whether they were decorated for extraordinary heroism. The key metric, however, is the rank they hold, or held. Retired generals can earn robust six-figure sums in annual retirement benefits, whereas enlisted personnel may only earn benefits in the teens.

Yesterday, in the first part of this series, I asked Under Secretary Stanley and Assistant Secretary Woodson if the Department had seriously reviewed any proposals for a stepped increase of TRICARE Prime fees for working-age retirees determined on the basis of rank at the time of retirement and retiree benefits earned.

Assistant Secretary Woodson answered that the Department did not consider this proposal because it would be difficult to administer since the Department would want to take into consideration retirees' other streams of revenue—a statement I do not agree with.

More importantly, though, he stated that it was unnecessary in this case because the fee increases that were proposed are modest. But he stated that, quote, "If we were proposing large fee increases, I would agree with you strongly."

My question, then, to all of you is, do you agree or disagree with Dr. Woodson's assessment?

And if we could begin with you, Mr. Strobridge.

Mr. STROBRIDGE. Yes.

The Department, in fact, did propose tiering fee increases previously. The Military Coalition has been unanimous in opposing means-testing of military benefits. We don't have that for Federal civilian health care. The President pays the same as the lowest GS employee.

One of the concerns, I think, is creating a situation where, the longer you serve and the more successfully you compete for promotion, you know, the less your benefit is. And we don't think that is a good incentive.

But more and more, as I said in my oral statement, the military benefit package is considered the offset for the adverse conditions of service. You earn the package mainly by your service.

And I would have to agree with the answer that was given yesterday; once you start trying to split it, basically what you are saying is, who can afford to do what? And I think they were accurate. Once you start to say who can afford to do what, you have to look at all of your income, and it ultimately drives you to looking at last year's tax return.

And, to us, we don't think that ought to be based on what kind of job you get as a civilian. We don't think it ought to be based on your spouse's income or how much you inherited from a parent. Your benefit derives from your service, not from your grade.

Mr. BARNES. I would agree with Steve's comments.

Also, I think the comparison issue between military benefits and Federal civilian benefits is a real strong, compelling example with regard to that concept.

There are also a number of variables, I think. And I was not at the hearing yesterday, but, from your description, it sounds like the Department is referencing the complexities of administering that, with regard to just retirement income or total household income or what have you, with calculating that.

So I go back to the equity issue, the connection, and looking at Federal benefits. And that has been our position, and we concur with the Coalition's position.

Mr. HANSON. The Reserve Officers Association doesn't support a tiered approach based on rank because it should be pointed out that reservists and Guards members have an income in their retirement that is 25 percent to 30 percent of what an Active Duty member does because of the fact that they are part-time warriors. So it would be very unfair to charge someone in the Reserves the same amount based on tiering that you would do an Active Duty member.

Mr. WILSON. And we are at the 5-minute situation.

Colonel Allen West of Florida.

Mr. WEST. Thank you, Mr. Chairman, Madam Ranking Member.

And, a few years ago, there was an Army commercial that said, "We do more before 0900 than most people do all day." So thank you, Mr. Chairman, for bringing that commercial back to life.

With that being said, you know, this panel and this briefing today is very important to me and it is very personal to me. I had a father who served in World War II; he was a disabled American veteran. My older brother in Vietnam; also a DAV [disabled American veteran]. I did a couple years in the Army, myself, and now my young nephew is following in my footsteps. My father-in-law served two tours in Vietnam, and my two brothers-in-law served also in the United States Air Force.

So when I sit here today, I think about a quote from George Washington, and I am paraphrasing, when he said that future generations of a nation will judge itself based upon how well we treat our veterans.

So I think it is very important that we understand that what we are talking about here is not a benefit; it is something that people have been willing, when they raised their hand, that they were going to give their lives for. And I think that this Nation owes them that.

However, I will ask this question to you. You know, when I first retired, I would, you know, spend my Fridays going down to the VFW [Veterans of Foreign Wars] post. But I found myself not being able to endure that too much longer because, you know, myself, being a very avid distance runner, the cigarette smoke was just absolutely choking me.

So my question to each and every one of you today: We are talking about what has to be done on this side, but I think there is a responsibility, also, for those of us who have retired. And so, how do we develop initiatives that incentivize healthy living in our military retirees?

I think that is very important, so I would like to get your thoughts on that. Thank you.

Mrs. MOAKLER. I think that the military health-care system has already introduced some preventive-care programs within the MTFs. And some of those can be focused on diabetes, helping those who are prediabetic to keep from having full-blown diabetes. There are also programs aimed at weight loss and controlling obesity. And as a beneficiary myself, I have seen those programs offered within the MTFs. And, also, some the TRICARE contractors are creating those programs, as well.

As with any benefit offered to our military servicemembers, our retirees, our survivors, it is communicating the availability of these programs and ensuring that our families and our servicemembers can take advantage of those programs.

Mrs. HOLLEMAN. I thoroughly agree.

The military life, everyone thinks of it as a healthy life, and it is not; it is a fit life. People are fit, but they aren't all that healthy in some of the habits they develop, in large part because of the pressures of that life—smoking, alcohol consumption, other things that can really affect long-term health requirements.

And I firmly agree that the MTF programs, the contractors' programs, the programs, again, mentioned for the U.S. Family Health Plan, that sort of thing, should be a focus. And, as Kathy Moakler

said, it should be widely publicized. Because how many times do they say you have to say something before it gets in my head? I think seven, for ads. At least, that is what Crest seems to run on. And I think we have to do the same thing.

Mr. STROBRIDGE. Congressman West, I think one of the frustrating things is that there has been a lot of effort tied to that, sometimes to no avail. We actually had to get this subcommittee to pass legislation to get DOD to run a pilot program to have TRICARE pay for smoking-cessation programs. And even then we don't include Medicare eligibles in a lot of those incentive programs that we have, because, as Ranking Member Davis points out, you know, you end up with the scoring problems for Medicare eligibles and those kinds of things. So the budget rules actually inhibit us doing things that will encourage healthy life sometimes.

Something else we think that needs to be done is eliminate the co-pays for those maintenance medications for people with chronic conditions. There are all kinds of studies out there that show that even a modest co-pay deters people from taking their medication.

So there are lots of disincentives built into the system that I think we can still do. Unfortunately it seems too often take a law change to get DOD to do those.

Mr. WILSON. We are precisely at 5 minutes, as I have been gently reminded by Ms. James. And our subcommittee is so fortunate to have people with experience. So we have a former sergeant in the Army, a former major of the Marine Corps, Congressman Mike Coffman of Colorado.

Mr. COFFMAN. Thank you, Mr. Chairman.

I have got a question about TRICARE fees. And why don't I start at this end for those groups who represent beneficiaries and go the other way. And here is my question. Would your organization support the proposed increase, \$30 for individuals, \$60 for family annually, if it were tied to a retired pay cost-of-living adjustment vice Medicare? And for those who say no, what if the increase didn't impact current retirees? What if it were grandfathered in and didn't start for 2 years? Just different iterations of the same question.

But the primary thing is going to this about limiting the adjustment to whether or not there is a cost-of-living increase. So if the cost-of-living increase were 1 percent, or there wasn't one, then it would be limited to the 1 percent if that were the case as opposed to whatever medical inflation was.

Let us start with the Reserve Officers Association.

Mr. HANSON. Thank you, Congressman.

In short, a combination of the modest increases this year with an index base on COLA is something that ROA could not object to.

The one concern that I have with how you phrase things is the setting up of generational differences in benefits to where one group is grandfathered and the next is charged more. That should be uniform across all people who serve.

Mrs. MOAKLER. I agree with Marshall Hanson on that. Our association has agreed to the increase in fees even when they were first—the principle of increase in fees, even when they were introduced 4 years ago, and we have always maintained that they should be tied to COLA. And I also agree that creating a popu-

lation of haves and have-nots is never a good thing with a military benefit.

Mrs. HOLLEMAN. This question has been discussed in great detail and with some drama in my organization recently. After much discussion, TREA has found that we could agree to a COLA increase if that was absolutely necessary. Our people are dedicated. They are patriotic. They see the problems that are happening. But they see their problems, and they see their situations, and this is a very hard thing for them to make the conclusion.

Mr. JONES. Mr. Coffman, thank you very much for your question. The 13-percent increase is modest in some people's eyes, but there is concern in our group that that increase is too steep. A 13-percent increase in Chinese military, as reported last week, can that be described as modest? I think the others would look at that in the same way we are looking at a 13-percent increase.

We participate in retiree activity days across the Nation and overseas. We travel and meet with retirees at these opportunities that are on bases across the country. And what we have heard is the word "grandfather." The grandfather word might be something that we would be attracted to, and we would certainly give it our very serious consideration. Thank you, sir.

Mr. BARNES. Mr. Coffman, thanks for the question. I believe there is less opposition to what you are—or less concern in our association to what you are proposing than the current DOD proposal. But I have to state again that the oversight responsibility on this issue is key. DOD currently has the authority to adjust these fees apart from the USFHP part of this, which requires a legislative change. That goes back to 1995 when TRICARE was established. So I think key to that, to answering this question, is consideration of those key aspects. Thank you.

Mr. STROBRIDGE. Congressman, I think we would have a hard time objecting to what you propose. We would put the caveat in there that we think it is important to put those principles in legislation to specify that the benefits or the health care package and retirement package is to offset the conditions of service, and that those, in fact, constitute an upfront premium, and that is why the COLA adjustment is reasonable. Is that a better deal than civilians get? Yes, it is. But civilians don't have to pay that upfront premium.

Mr. COFFMAN. Thank you, Mr. Chairman. I yield back.

Mr. WILSON. Thank you very much.

I thank all of you. And I want to thank Congresswoman Vicky Hartzler of Missouri, who had been here, but she had a 9 o'clock meeting. So she has just been a very valuable member of this subcommittee.

As we proceed, in agreement with the ranking member, we will go through another round, and we will be asking a question each.

The question I have for all of you—and we will begin in the reverse order with Ms. Cooke—and that is the proverbial question of pharmaceuticals. Should they be mail order, or should they be by pharmacy? I know that I found it very helpful to have a one-on-one contact with the local pharmacist. So not only could you let me know what you think about the mail order, but are there ways to reduce costs by using the local pharmacy?

Ms. COOKE. I think there is a role for mail order. I think for beneficiaries who are on several routine maintenance medications, it may be more convenient for them to have those medications delivered to their home. But there are circumstances certainly for urgent conditions where having a relationship with the local pharmacist and being able to access those medications on a timely basis are critical.

So I think there is not a one size fits all. I think to the extent that home delivery for maintenance medications is something that really should be considered, because I think it would save the Department money, but it could not necessarily offset people's right to receive urgent medications or exercise their options to receive it at the retail. So I think there is room for both.

Mr. HANSON. The military coalition has worked hard with DOD Health Affairs to try and get beneficiaries to shift over to the mail-order system, and they are finding immediate savings by accomplishing this. So ROA, of course, supports this type of move. And to personalize it, both of my parents, who are in their late eighties, love the system because it saves them trips and constantly reminds them for refills.

But as was pointed out in both my testimony and by my compatriot to my left, having some type of way that individuals aren't penalized when they have to go to a retail side with higher co-payments is something we have to explore and, I think, include in any type of system that we go to so that young families that have to do a late-night run to stop an ear infection don't pay higher prices just because they want to take people who have maintenance drugs and move them over to mail order.

Mrs. MOAKLER. One of the things that we have discussed—of course, I agree with the statements of the two previous panelists, but one of the things we have discussed is education of the beneficiaries on how easy it is to use the mail-order pharmacy. Because people are reluctant. They are worried that they are not going to have enough pills. It can be difficult to make that initial start, especially if you are getting your prescription from a medical-treatment facility. But we do believe that not penalizing those servicemembers and family members who need that urgent medication or need a narcotic that they couldn't get sent through the mail order, they shouldn't be penalized with increased fees. But we do believe that the fees will promote greater efficiencies overall if more people use the mail-order pharmacy for their recurring medications.

Mrs. HOLLEMAN. I agree with everything that the previous three people have said.

I will also say that speaking to a pharmacist can be very helpful, particularly with an initial prescription. It is helpful if you are at the MTF. It is helpful if you are at a retail pharmacy. So I think it is obvious that we need both in the system. But for continuing maintenance drugs that you are taking for years and years, of course the home delivery is a very useful option.

Mr. JONES. Home delivery is a useful option, and it saves the beneficiary and the Department of Defense taxpayers money. However, one of the things that could save money for the Defense Department and we feel is a primary reason for the higher costs in

the pharmaceutical program is the lack of aggressiveness in pursuit of the Federal pricing schedule for the drugs they used in the Department.

Some years ago we offered the opportunity for Federal pricing. It was projected to return \$1.6 billion annually. Well, the lack of aggressive nature of the Defense Department in securing Federal pricing has resulted in one-third of that amount being received—well, \$600 million. So we need a little more aggressive action on the part of the Defense Department and a little less blame on retirees.

Mr. WILSON. And I apologize, Mr. Barnes, but my time is up. So I now proceed to Mrs. Davis.

Mrs. DAVIS. Thank you.

Why don't you just turn to some of the transition programs really quickly, because I know that a number of programs have been developed to respond to wounded warriors and their families. But when I speak to people, I always have the feeling that something is not quite connecting. If you could specify as quickly as possible, where do you see that gap? What is the problem?

I think that we have also identified—I think a number of you did—in the data systems and being able to go from the DOD to the VA. But I am just wondering, is there something about the way the service could be improved that would enable that transition to be much smoother when it comes to our families?

Mr. STROBRIDGE. Are you talking about the transition between DOD and VA or—

Mrs. DAVIS. Transition back to the community.

Mr. STROBRIDGE. Back to the community.

One of the things that we have talked about consistently that is a chronic problem is mental health/behavioral health. DOD has made great strides—I mean, everybody and his brother is trying their best to do these kinds of things and to try to find ways that it can be done and delivered in a way that the beneficiaries are comfortable with.

There is a lot of fear on this issue. The servicemember is concerned that if they identify themselves, they are going to hurt their career, in many cases with good reason. The family members are reluctant to come forward for fear of the impact on the servicemember, for fear of being stigmatized. There are programs under way to try to do those in ways that are not reported back to the Defense Department. Those get more participation, but they don't identify the problem to DOD.

So there is a chronic issue, and I have to think that the key is going to be the destigmatization effort. And I think we have a problem with the senior leaders talking destigmatization, but when it comes to the unit, if you come forward, you are stigmatized. And until that changes, until the action matches that rhetoric, I think we are going to continue to have a problem.

Mr. BARNES. Congresswoman, excellent question. I would echo Steve's concern. And I will tell you from my experience when I was on Active Duty, having something about counseling in my record, it was like you just don't go there. And the stigma issue is huge, and it is going to take a long time to turn that around.

Another aspect of this is family readiness, awareness of programs. Despite significant resources being committed to these across the services in the Department, we still hear story after story about spouses, family members and sometimes servicemembers that are not aware of programs and services that are available to them.

Going back to the seamless transition issue, which I have to plug here, the bureaucratic challenges associated with the Department of Defense and the Department of Veterans Affairs for these wounded warriors and what they have to deal with is still very challenging. The special oversight committee is faltering. Great concept, but oversight is needed continually on this, and there needs to be a lot more done to effect seamless transition and take care of these wounded warriors and their families.

Mr. HANSON. One challenge that we have, ma'am, is the duration that individuals are placed in these transitional programs. In some cases individuals are discharged as being fit when not all of their problems are recognized and recorded. In other cases you have individuals who are kept on medical hold because of the duration it takes to go through medical evaluation boards and physical evaluation boards. So these are things that need to have oversight and review, because it is not doing justice to our young warriors.

Mrs. MOAKLER. We would also like to look at some bridge programs for our servicemembers and families who are being medically retired or medically discharged. Our association has promoted the idea of a 3-year Active Duty benefit for those servicemembers who are medically retired. We know they are still eligible for TRICARE as a retiree, but it would be similar to the survivor benefit. It would help them in those transitioning years with costs, with letting them use a system that they are familiar with as they transition into the community.

I know we haven't talked about families with special needs, but perhaps providing 1 year of an ECHO [extended care health option] benefit for those families with disabilities, be they a wounded family that is being medically retired or even a retired family after 20 years who hasn't been able to settle in the community where they are going to make their final retirement.

Mr. WILSON. Thank you all.

And Congressman Allen West of Florida.

Mr. WEST. Thank you, Mr. Chairman.

I would like to go back to the question that I had previously asked, because I know there were some people that wanted to respond to that, because I think that when you look at the nature of military service, it really is Pavlovian in nature. I mean, we do reward people for the right type of behavior. So I really believe that if we are, you know, serious about how we can lower the cost for military retiree health care, then how can we make sure the military retirees are healthy? So I know that there were some people that still want to chime in on that. So, please.

Mr. JONES. Yes, sir. It is an excellent question, and we appreciate the quotation from Washington. We used the quotation in our testimony. And the thought that the perception was so key, that we all should be able to recognize that. Those who will be coming into

service tomorrow do reflect on how today's veterans in the military are being treated.

You asked a question about how do we encourage individuals to maintain their public health, maintain their individual health. And you mentioned smoking and running and those sorts of things, which are key. Well, we do that not necessarily by government, but we do that necessarily by example and by appreciation. We note a lack in our communities of a community sense, of a community spirit. We see it with the litter on the highway. We see it with the lack of appreciation for people who excel. We see it for all sorts of things.

What we are looking for is something like what was given—apologies to Niki Tsongas of Massachusetts. Some years ago, Michael Strahan retired from football, the New York Giants. They had just won the Super Bowl, beating the previously undefeated Patriots. And Strahan was speaking with George Mara, the president of the Giants, and Mara said that Strahan thanked him and thanked the organization for all they had done for him. And Mara simply said, it is not the organization that you should be thanking. He said, I think you have done more than we can ever do for you. That is the example of excellence, and that is the example we need to have reflected in our communities.

We know that there are, what, 20 percent of Americans today that are not ready physically to become a servicemember. We need to incorporate physical education in our schools. We once did. In my youth certainly; I am not sure in your youth, sir.

Mr. WEST. Yes. Okay.

Mr. JONES. But in my youth we had physical education, and it was a regimen. People enjoyed it. Dodgeball was a fun game.

Mr. WEST. Unless you got hit in the head.

Mr. JONES. You get hit in the head, you learn the game better. You always learned how to play the game a little bit better.

But these are the things that the community—a sense of community and understanding and example. And you set a fine example, and there are so many other Americans today who are setting that example. And we try to do that with our preventative care in the hospital system, to encourage people to take the right course. Certainly we save a lot of money in insulin and diabetes and those sort of things if we can capture it early.

And I appreciate you giving me the opportunity to speak on this issue. It is very important. We do it by example, not necessarily by government.

Mr. BARNES. Congressman, I would thank for your service and thank you for the question.

A couple of observations here with regard to your description of the VFW hall and the smoking is indicative of a demographic issue. We in our association are working to communicate with three generations, in essence: those currently serving, and those in between, and those that go back through a number of conflicts, into World War II and some before that. And communicating to them education awareness is key.

The communications aspect of this, this goes to the use of the mail-order pharmacy issue, too. Awareness is a great deal of anxiety in certain demographics about trying something new and

whatever. I will tell you I am enrolled in the medical home in Bethesda, and there are new efforts that are trying to be implemented, communications electronically and what have you, to help address some of these things. But I think the starting point is understanding the demographics and the perceptions of these different groups and trying to communicate and educate them about the importance of healthy lifestyles and changing some bad habits.

Mr. WEST. Well, thank you.

And, Mr. Jones, I will absolutely agree with you, it is leadership by example. That is the key thing. So next time I will ask Mr. Chairman if he will join me at 5:00 in the morning for a 6-mile PT [physical training] run.

But thank you very much, and I yield back.

Mr. WILSON. Well, I am willing to take you up for a 5-mile walk. I have got my pedometer.

And we will be concluding with a question from Congressman Mike Coffman from Colorado.

Mr. COFFMAN. Thank you, Mr. Chairman.

Maybe you all could give me some—if we were to focus on the delivery process, and I will include family health care, individual in there as well. What specific changes do you think we can make to contain the costs? In other words, is there room to maneuver in terms of saying that there has got to be some kind of primary-care gatekeeper that one has to see before accessing a higher-priced specialist, particularly those people outside the network? And that might be sort of the Kaiser model of a nurse practitioner or a physician's assistant. I mean, are we doing enough in terms of cost containment at that level, particularly in primary care? Let me start with the U.S. Family Health Care Plan.

Ms. COOKE. From a delivery process, I think it is less about the gatekeeper; it is integration. So almost 100 percent of beneficiaries enrolled in our plan have a primary-care manager, and it is the credibility and trust of the relationship. So it eliminates duplication of services. So that is one cost-cutting measure. There is a relationship there, so there is not a knee-jerk reaction to send the beneficiary off for specialty care or to send them off for urgent care when, in fact, they have the primary-care physician that understands their medical history and can provide that care. So I think that is critical.

Also, there is a value in understanding the complete picture of the beneficiary, not just having access to their inpatient or primary-care claims. It is really understanding what medications the beneficiary is on, utilizing health-risk assessments, engaging the beneficiary in their health.

Mr. COFFMAN. I am sorry to interrupt you, but time is short. If I am a beneficiary—and I will be soon. I just received my letter for TRICARE. And so let us just say I make a decision that I think I have got diabetes, or there is something wrong where I want to see an endocrinologist, and I make that assessment. Can I do that? Can I make that decision myself and access a specialist?

Ms. COOKE. Not according to the TRICARE Prime benefits. You would have to receive a referral. But again, if you were enrolled in a program that has a diabetes care management, disease-management program, even if you didn't raise your hand, you would be

identified and sought out for active participation and have that managed.

Mr. COFFMAN. Because I think that is one of the issues in terms of escalating health care costs is when you don't have a primary-care gatekeeper there, and people are making decisions that have direct access to specialty care without going through some type of gatekeeper process that says we can really do this at a lower cost here at this level instead of seeing a higher-cost specialist.

Does anybody else want to comment on that?

Mr. HANSON. As Ms. Cooke pointed out, TRICARE Prime across the board with all the contractors has primary-care managers that try and control this. We have been briefed by DOD that the real costs that they are facing isn't so much the care that comes out of that program, but by the fact that so many people who are beneficiaries go directly to emergency care, which pops the care way up, and they are trying to find ways of bringing urgent-care centers and other ways of doing it to reduce the care there.

Mr. COFFMAN. Okay. Good point.

Mrs. MOAKLER. I think it is also interesting, our association, of course, is a big promoter of TRICARE Prime, but TRICARE Prime is not the entry to the benefit. We have so many of our beneficiaries who are not enrolled in TRICARE Prime either because of geographic reasons, or they choose not to be, but who are on TRICARE Standard. And I think it might be interesting to contrast those who are in TRICARE Standard who may be cobbling together their medical care and contrast their costs, mostly which are out of pocket but there is a cost to DOD, with those who are in managed care and have primary-care managers.

Mr. STROBRIDGE. Congressman Coffman, I think one of the big problems, you know, that we have sort of touched around here is the Department of Defense spends a lot of time on TRICARE Prime. We have talked before about this subcommittee's effort to put something in law requiring DOD to establish these healthy care kind of programs, which they did for TRICARE Prime, but they don't have those kind of chronic-condition programs for TRICARE Standard or the people over 65 under TRICARE for Life, yet we know who the diabetics are, we know who the high-cost people are. To us, there is a great opportunity to reach out to those people not to control their care, but to urge them to participate in these kinds of management programs.

Mr. COFFMAN. Thank you.

And I just want to assure Lieutenant Colonel West that what happens in the VFW hall stays in the VFW hall.

I yield back, Mr. Chairman.

Mr. WILSON. Thank you very much. I thank all of you.

And at this time, Mrs. Davis, if there is no further. Oh, pardon me. Please.

Mrs. DAVIS. Thank you, Mr. Chairman.

I think that you have a lot more to say about this issue and how we work some of this and some of the questions to ask. So we certainly welcome you to, if you would like to put some of that in writing, to do that or to communicate with us in whatever way you prefer in our offices.

I really appreciate the fact that we have to work through this. And I feel as if I don't have as good of information from the DOD as we might like to understand better the real impacts on some of this and whether or not we actually are not so much comparing apples to oranges as much as understanding the impacts that some of these changes may bring about, and, in fact, whether we are doing all that we can in terms of this prevention issue.

If we are doing what I think Ms. Cooke has said, and if we are trying to bring about many of those economies of care and making for healthier people through this, then it ought not cost so much more. We ought to find a better way to do that. And I am hoping that we can work through this as we move forward. Thanks a lot.

Mr. WILSON. Thank you.

And I want to join in with Mrs. Davis. All of the members of the subcommittee are available and want to hear from you, meet with you.

Also I want you to know what an extraordinary resource we have with Jeanette James. She herself has been a nurse. So we are very grateful for her service as the professional staff working with John Chapla. What a great team. VMI graduate. So we are very grateful.

And at this time, we shall adjourn.

[Whereupon, at 9:28 a.m., the subcommittee was adjourned.]

A P P E N D I X

MARCH 16, 2011

PREPARED STATEMENTS SUBMITTED FOR THE RECORD

MARCH 16, 2011

Statement of Chairman Joe Wilson (R-South Carolina)
House Subcommittee on Military Personnel
Hearing on
Military Health System Overview and Defense Health Program
Cost Efficiencies: A Beneficiary Perspective
March 16, 2011

This morning the subcommittee meets to hear testimony on the Military Health System and the Department of Defense's proposed cost saving initiatives from the beneficiary perspective. I understand this is an unusually early time for the Military Personnel Subcommittee to hold a hearing and I appreciate everyone's willingness to be here this morning to discuss this important subject.

For several years the Department of Defense has raised concerns about the rising cost of health care and the challenge of maintaining the viability of the military health system over the long term. We must seek reasonable solutions for ensuring the availability of world-class military health care, not only to our returning wounded and injured and their families, but to future generations of brave young men and women who answer the call to serve our nation.

The Department of Defense has proposed several measures aimed at reducing the cost of providing health care to our servicemembers and their families and military retirees. The plan is a more comprehensive approach than previous cost-cutting efforts. That being said, these proposals will affect not only beneficiaries, they will also affect the people who support the military health care, such as pharmacists, hospital employees and contractors.

We are joined today by an outstanding panel consisting of representatives of several military service organizations and a representative of organizations that support the military health system. I look forward to hearing your views on the Department of Defense proposals; what do you support, what do you oppose and do you recommend alternatives to the proposals that we may consider.

Statement of
Representative Susan Davis
Military Health System Overview and Defense Health Program Cost Efficiencies:
A Beneficiary Perspective
March 16, 2011

Thank you, Mr. Chairman. Let me also welcome our beneficiary representatives – Colonel Steve Strobbridge, Master Chief Joseph Barnes, Rick Jones, Deirdre Parke Holleman, Kathleen Moakler, and Marshall Hansen. I would also like to welcome Mary Cooke, who is representing the US Family Health Plans.

As you all know, yesterday the subcommittee heard from Under Secretary of Defense for Personnel and Readiness, Dr. Stanley, Assistant Secretary of Defense for Health Affairs, Dr. Woodson, and the Surgeons General on their views on the status of the military health care system, and their efforts to improve the care being provided to our service men and women, retirees, survivors and their families.

Today, we will hear first-hand from those who are the beneficiaries of the system, and the experiences that they are having with the military health care system and their thoughts on the health care proposals put forth by the Department of Defense.

Our country is facing difficult economic times and we are now faced with making hard decisions that will impact the lives of those who are currently serving and those who have served. I know that our beneficiary representatives here today, understand the challenges we face, as several have previously made sacrifices when they served in uniform, or are family members of those serving or who have served.

We need to work together to find a way forward that will continue to ensure the best quality of care for those currently serving, especially those in harm's way, and to ensure that the benefit being provided remains sustainable into the future.



STATEMENT OF
THE MILITARY OFFICERS ASSOCIATION OF AMERICA

Before the
HOUSE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

March 16, 2011

Presented by
Colonel Steve Strobbridge (USAF-Ret)
Director of Government Relations

MR. CHAIRMAN, RANKING MEMBER DAVIS, AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE, thank you for the opportunity to comment on the Defense Department's TRICARE fee proposals in the FY2012 budget.

The Military Officers Association of America (MOAA) does not receive any grants or contracts from the federal government.

MOAA appreciates the Subcommittee's consistent support in recent years to protect beneficiaries from disproportional health care fee increases.

MOAA has not taken the position that TRICARE fees should never rise. If retired pay doubles or triples due to cost-of-living adjustments over a lifetime, we believe it would be unrealistic to expect that fees would not rise by even \$1.

However, we assert that the statute should provide reasonable guidelines for setting and adjusting TRICARE fees.

Statutory formulas govern nearly all other major military compensation elements. In this regard, there are formulas for setting and adjusting military retired pay, pay raises, survivor benefits, and more.

But current law leaves much of the TRICARE fee-setting-and-adjustment process to the discretion of the Secretary of Defense. For many years, no secretary proposed any increase in TRICARE fees, leading beneficiaries to believe there would be no increases. In 2007 and 2008, beneficiaries were shocked when a new secretary proposed tripling or quadrupling fees.

In a very real sense, the military health care package symbolizes the mutual commitment between career military families and the government they serve.

The government puts no cap on the sacrifices it demands of servicemembers and their families. In contrast, current law leaves their crucial career healthcare package subject to dramatic swings with year-to-year leadership and/or budget changes.

MOAA is encouraged that the administration's FY 2012 budget proposal avoids the draconian fee changes proposed in past years and more appropriately acknowledges career military families' pre-payment of very large premiums of service and sacrifice over the course of a 20-30-year career in uniform.

We particularly appreciate the proposed elimination of co-pays for the mail-order pharmacy system and the exemption of survivors and military disability retirees from the TRICARE Prime fee increases.

But we object strongly to the Department's proposed linkage of future TRICARE Prime fee adjustments for non-disabled beneficiaries under age 65 to an as-yet-unspecified measure of health cost growth for the broader population that DoD actuaries assume would grow at an average of 6.2% per year.

The attached chart shows the dramatic adverse compounding effect this index would exert on the Prime enrollment fee over time versus the proposal by MOAA to cap annual increases at no more than the retired pay COLA percentage (which the DoD Actuary projects at 3% per year for purposes of managing the military retirement trust fund).

MOAA believes opportunities for far greater cost savings are missed by continuing shortfalls in Defense Department efforts to pursue:

- More effective promotion of the mail-order pharmacy
- Consolidation of redundant/competing service and contractor systems
- More effective management of chronic conditions and use of technology
- More efficient and effective contracting and acquisition systems

To restore important career benefit stability and limit future adverse retention consequences, MOAA believes Congress should establish in law the following principles:

- *The military retirement and healthcare package is the primary offset for the many unique and extraordinary demands and sacrifices inherent in a military career.*
- *Those decades of service and sacrifice constitute a very large, pre-paid premium for career military members' and families' healthcare coverage in retirement, over and above the fees they pay in cash. This large, up-front and in-kind premium must be acknowledged in statute to explicitly reject inappropriate, "apple-to-orange" comparisons focused on cash fees paid by military beneficiaries vs. civilians.*
- *The way to incorporate this inherently unquantifiable military-unique premium of service and sacrifice in the fee adjustment process is to limit the percentage increase in TRICARE fees in any year to the percentage increase in military retired pay.*

Monetary Impact of DoD-Proposed Fee Adjustment Methodology

Year	Cap at Retired Pay COLA* Percentage	DoD Proposal (tied to HC inflation)**	Difference (loss of purchasing power)	Year	Cap at Retired Pay COLA* Percentage	DoD Proposal (tied to HC inflation)**	Difference (loss of purchasing power)
2011	\$460	\$460	\$0	2029	\$859	\$1,446	\$586
2012	\$520	\$520	\$0	2030	\$885	\$1,535	\$650
2013	\$536	\$552	\$17	2031	\$912	\$1,631	\$719
2014	\$552	\$586	\$35	2032	\$939	\$1,732	\$793
2015	\$568	\$623	\$55	2033	\$967	\$1,839	\$872
2016	\$585	\$661	\$76	2034	\$996	\$1,953	\$957
2017	\$603	\$702	\$100	2035	\$1,026	\$2,074	\$1,048
2018	\$621	\$746	\$125	2036	\$1,057	\$2,203	\$1,146
2019	\$640	\$792	\$153	2037	\$1,089	\$2,339	\$1,251
2020	\$659	\$841	\$183	2038	\$1,121	\$2,485	\$1,363
2021	\$678	\$894	\$215	2039	\$1,155	\$2,639	\$1,483
2022	\$699	\$949	\$250	2040	\$1,190	\$2,802	\$1,612
2023	\$720	\$1,008	\$288	2041	\$1,225	\$2,976	\$1,750
2024	\$741	\$1,070	\$329	2042	\$1,262	\$3,160	\$1,898
2025	\$764	\$1,137	\$373	2043	\$1,300	\$3,356	\$2,056
2026	\$787	\$1,207	\$421	2044	\$1,339	\$3,564	\$2,225
2027	\$810	\$1,282	\$472	2045	\$1,379	\$3,785	\$2,406
2028	\$834	\$1,361	\$527	2046	\$1,421	\$4,020	\$2,600

* Uses DoD actuaries' 3% long-term COLA assumption for military retirement trust fund

**DoD proposal assumes a 6.2% annual cost inflation factor

Colonel Steve Strobbridge (USAF-Ret)

Director, Government Relations, Military Officers Association of America (MOAA); and
Co-Chairman, The Military Coalition

Steve Strobbridge, a native of Vermont, is a 1969 graduate from Syracuse University. Commissioned through ROTC, he was called to active duty in October 1969.

After several assignments as a personnel officer and commander in Texas, Thailand, and North Carolina, he was assigned to the Pentagon from 1977 to 1981 as a compensation and legislation analyst at Headquarters USAF. While in this position, he researched and developed legislation on military pay, health care, retirement and survivor benefits issues.

In 1981, he attended the Armed Forces Staff College in Norfolk, VA, en route to a January 1982 transfer to Ramstein AB, Germany. Following assignments as Chief, Officer Assignments and Assistant for Senior Officer Management at HQ, U.S. Air Forces in Europe, he was selected to attend the National War College at Fort McNair, DC in 1985.

Transferred to the Office of the Secretary of Defense upon graduation in June 1986, he served as Deputy Director and then as Director, Officer and Enlisted Personnel Management. In this position, he was responsible for establishing DoD policy on military personnel promotions, utilization, retention, separation and retirement.

In June 1989, he returned to Headquarters USAF as Chief of the Entitlements Division, assuming responsibility for Air Force policy on all matters involving pay and entitlements, including the military retirement system and survivor benefits, and all legislative matters affecting active and retired military members and families.

He retired from that position on January 1, 1994 to become MOAA's Deputy Director for Government Relations.

In March 2001, he was appointed as MOAA's Director of Government Relations and also was elected Co-Chairman of The Military Coalition, an influential consortium of 33 military and veterans associations.



Statement of
The Fleet Reserve Association
on
Military Health Care

Presented to:
Subcommittee on Military Personnel
House Armed Services Committee

By

Master Chief Joseph L. Barnes, USN (Ret.)
National Executive Director
Fleet Reserve Association

March 16, 2011

THE FRA

The Fleet Reserve Association (FRA) is a leading advocate on Capitol Hill for enlisted active duty, Reserve, retired and veterans of the Navy, Marine Corps, and Coast Guard. It is Congressionally Chartered, recognized by the Department of Veterans Affairs (VA) as an accrediting Veteran Service Organization (VSO) for claim representation and entrusted to serve all veterans who seek its help. In 2007, FRA was selected for full membership on the National Veterans' Day Committee.

FRA was established in 1924 and its name is derived from the Navy's program for personnel transferring to the Fleet Reserve or Fleet Marine Corps Reserve after 20 or more years of active duty, but less than 30 years for retirement purposes. During the required period of service in the Fleet Reserve, assigned personnel earn retainer pay and are subject to recall by the Secretary of the Navy.

FRA's mission is to act as the premier "watch dog" organization in maintaining and improving the quality of life for Sea Service personnel and their families. The Association also sponsors a National Americanism Essay Program and other recognition and relief programs. In addition, the newly established FRA Education Foundation oversees the Association's scholarship program that presented awards totaling nearly \$120,000 to deserving students last year.

The Association is also a founding member of The Military Coalition (TMC), a 33-member consortium of military and veteran's organizations. FRA hosts most TMC meetings and members of its staff serve in a number of TMC leadership roles.

FRA's motto is: "Loyalty, Protection, and Service."

CERTIFICATION OF NON-RECEIPT OF FEDERAL FUNDS

Pursuant to the requirements of House Rule XI, the Fleet Reserve Association has not received any federal grant or contract during the current fiscal year or either of the two previous fiscal years.

OVERVIEW

The Fleet Reserve Association (FRA) is an active participant and leading organization in the Military Coalition (TMC) and strongly supports the extensive recommendations addressed in the TMC testimony prepared for this hearing. The intent of this statement is to address issues of particular importance to FRA's membership and the Sea Services enlisted communities.

INTRODUCTION

Mr. Chairman, the Fleet Reserve Association salutes you, members of the Subcommittee, and your staff for the strong and unwavering support of programs essential to active duty, Reserve Component, and retired members of the uniformed services, their families, and survivors. The Subcommittee's work has greatly enhanced care and support for our wounded warriors, and improved access to health care for all beneficiaries. This support is critical to military readiness and invaluable to our uniformed services engaged throughout the world fighting the global War on Terror, supporting other operational requirements and fulfilling commitments to those who've served in the past.

FRA supports a defense budget of *at least* 5 percent of GDP that will adequately fund both people and weapons programs. The current level of defense spending (4.7 percent including supplemental spending in FY 2010) is significantly lower than past wartime periods as a percentage of GDP and the Association is concerned that the Administration's five-year spending plan of one percent above inflation may not be adequate to sustain the war effort and other operational commitments.

The Association thanks this distinguished Subcommittee for ensuring adequate funding for the Defense Health Program (DHP) in order to meet readiness requirements, fully fund TRICARE, and improve access for all beneficiaries regardless of age, status or location. Sufficiently funding health care and benefits for all beneficiaries is part of the cost of defending our Nation. As stated in Sec. 2: Findings and Sense of Congress from The Military Healthcare Protection Act (S. 604) in the 110th Congress, (3) The demands and sacrifices are such that few Americans are willing to bear or accept them for a multi-decade career; and (4) A primary benefit of enduring the extraordinary sacrifices inherent in a military career is a range of extraordinary retirement benefits that a grateful Nation provides for those who choose to subordinate much of their personal life to the national interest for so many years.

TRICARE

Ensuring adequate funding the Military Health System (MHS) and VA health care is FRA's top legislative priority and important to every segment of our membership, Auxiliary and widows. This is reflected in responses to the Association's 2011 online survey completed in February, which revealed that over 90 percent of all active duty, Reserve, retired, and veteran respondents cited health care access as a critically important quality-of-life benefit associated with their military service.

It's important to note that higher health care costs are not unique to the military, and FRA appreciates the Subcommittee's opposition to past proposals to drastically increase TRICARE fees and pharmacy co-pays. Our membership believes there are management efficiencies and cost saving initiatives that can significantly offset higher costs – something first referenced in FRA's 2006 testimony on these issues before the Senate Armed Services Personnel Subcommittee. An example of these is the expanded use of the more economical pharmacy home delivery option for prescriptions, which saved the department over \$30 million in 2010.

FRA also notes recommendations in recent Government Accountability Office (GAO) testimony before the House Committee on Oversight and Government Reform which identified federal programs, agencies, offices and initiatives that have duplicative goals or activities. Number two on a list of 81 areas for consideration is realigning DoD's military medical command structures and consolidating common functions to increase efficiency which would result in projected savings of from "\$281 million to \$460 million" annually. In addition, GAO cites opportunities for DoD and the Department of Veterans' Affairs (VA) to jointly modernize their respective electronic health record systems, and also control drug costs by increasing joint contracting.

FRA also believes that identifying a permanent solution to pending cuts in Medicare physician reimbursement rates is integral to ensuring access to care for all beneficiaries seeking care outside the MHS or under TRICARE for Life. Congress has repeatedly punted on this matter and the latest extension preventing cumulative reimbursement rate cuts now totaling 29.5 percent expires on December 31, 2011. The Association supports a further two-year extension included in the Administration's 2012 Budget, however, a permanent fix is sorely needed.

HEALTH CARE FEES PROPOSAL

Regarding the Administration's 2012 health care fees proposal, the Association believes first and foremost that military service is unlike any other civilian career or occupation. Associated with this reality and maintaining readiness, are commitments to provide health care and other benefits for career personnel after their service careers. As stated in the Senate testimony referenced above, "Providing and funding health care benefits for all beneficiaries is part of the cost of defending our Nation." It's also important to remember that only about one percent of the population is currently serving in the uniformed services to defend our freedoms and prosecute the continuing war efforts.

The Department of Defense's lax management of health care fees since TRICARE was established in 1995 led to drastic fee hike proposals from 2006 to 2008 including a TRICARE Standard enrollment fee which would not enhance access to care for beneficiaries in that program.

Bipartisan legislation was subsequently introduced in successive Congresses that would shift oversight responsibilities from DoD to Congress (the most recent was H.R. 816 sponsored by Reps. Chet Edwards and Walter Jones in the 111th Congress), and a Senate bill in the 110th Congress (S.604 referenced above sponsored by Senators Lautenberg and Hagel). If enacted, the Senate bill would have prohibited health care fee adjustments from exceeding the annual Consumer Price Index (CPI), which determines military retired pay adjustments and other federal benefits pegged to inflation. FRA supported these bills in previous Congresses.

Compared to past proposals, the 2012 TRICARE fee changes are more reasonable – however, the 2012 adjustments characterized by DoD as "modest" are only part of the plan and the Association is very concerned about the yet-to-determined annual

adjustment index for TRICARE Prime fees in 2013 and beyond.

FRA supports other aspects of the proposal including the elimination of co-pays for generic drugs dispensed via TRICARE's Home Delivery pharmacy program to encourage expanded use of this program – and survivors and medically retired personnel are not impacted by the proposal. There are also no active duty fee increases, no changes to TRICARE Standard - and something especially important to Medicare eligible retirees – no additional TRICARE for Life fees.

HEALTH CARE INFLATION

As noted above, the Bureau of Labor Statistics' Consumer Price Index (CPI) is the basis for annual retired pay adjustments and absent a baseline statutory measure for determining health care costs, this index is integral to examining proposals to adjust TRICARE Prime enrollment and other health care related fees.

DoD cites a 6.2 percent assumption with regard to adjustments for 2013 and beyond while acknowledging a number of health care inflation indexes. FRA's research found that one-year Standard & Poor's (S&P) Healthcare Economic Indices through November 2010 ranged from 2.71 percent (S&P Healthcare Hospital Medicare Index) to 6.27 percent (S&P Healthcare Economic Composite Index), to 9.04 percent (S&P Healthcare Economic Commercial Index). And a January 20, 2011 press release on this data states that "Average per capita cost of healthcare services covered by commercial insurance and Medicare programs rose 6.27 (percent)," which is perhaps the benchmark DoD actuaries used in conjunction with projected multi-year savings associated with annual health care fee adjustments for military retirees.

USFHP AND COMMUNITY HOSPITALS REIMBURSEMENTS

The plan also would require new Uniformed Services Family Health Plan (USFHP) beneficiaries to enroll in Medicare Part B and shift to Medicare as primary provider at age 65 – a change that would impact future enrollees to this highly regarded program which serves approximately 115,000 beneficiaries in six areas throughout the U.S.

Although the FRA does not have expertise on the proposed adoption of Medicare payment rules at over 400 Sole Community Hospitals over four years, we understand that perhaps 20 of the facilities are near military bases and request consideration and/or analysis of the impact of these changes with regard to ensuring future access to care for TRICARE beneficiaries at these hospitals.

CONTINUED ATTENTION TO IMPROVED SERVICE AND COST EFFICIENCIES

FRA continues its strong advocacy regarding the need to improve service, streamline operations and further identify and implement cost saving measures within DoD, all of which are essential to maintaining readiness and fulfilling commitments made to all beneficiaries. The Association notes the elimination of 780 contract positions in conjunction with streamlining TRICARE Management Activity functions along with increasing inter-service cooperation and co-locating medical headquarters operations.

WOUNDED WARRIOR CARE

FRA appreciates the extraordinary efforts by this Subcommittee to help our wounded warriors. Last year this Subcommittee authorized a monthly stipend under the DoD family caregiver program for catastrophically injured or ill wounded warriors that is equal to the caregiver stipend provided by the Department of Veterans' Affairs (VA). Unfortunately, this program of which the Veterans' Affairs Committees have jurisdiction, has yet to be implemented.

A recent Navy Times survey on wounded warrior care (November 29, 2010) indicates that 77 percent of caregivers have no life of their own; 72 percent feel isolated; and 63 percent suffer from depression. The new program will help many caregivers, however, the enactment and implementation of the legislation is only the first step and effective oversight and sustained funding are also critical to ensuring future support for these caregivers.

FRA supports additional changes detailed in the full TMC statement which include establishing a permanent independent office for the DoD/VA Interagency program with expanded authority to include oversight of all components of achieving a true seamless transition; authorizing active duty TRICARE benefits, regardless of accessibility of VA care, for three years after medical retirement to help ease transition from DoD to VA; and extending and making permanent the charter of the "Special Oversight Committee" to ensure improved and enduring coordination with DoD and VA initiatives to help wounded warriors.

DES

In response to the Dole/Shalala commission report a pilot program was created (NDAA-FY 2008 – Public Law 110-181) known as the Disability Evaluation System (DES). The pilot provides a single disability exam conducted to VA standards that will be used by both VA and DoD and a single disability rating by VA that is binding upon both Departments. This is a common-sense approach that FRA believes will reduce bureaucratic red-tape and help streamline the process and warrants expansion to the entire disability rating system. Despite jurisdictional concerns, the Association urges the Subcommittee to provide oversight as the DES is implemented. According to a recent GAO report the new system takes 10 months to traverse as compared to the current system that on average takes about 18 months.

Achieving an effective delivery system between DoD and VA to guarantee seamless transition and quality services for wounded personnel, particularly those suffering from Post Traumatic Stress (PTS) and Traumatic Brain Injuries (TBI) is very important to our membership. DoD should also make every effort to de-stigmatize mental health conditions that should include outreach, counseling, and mental health assessment for all service members returning from the combat zone.

SUICIDE RATES

FRA is deeply concerned about military suicide rates. Active duty suicides have been reduced or at least leveled off, but suicides for non-active duty Reserve Component are increasing.

For example, the Marine Corps ended calendar year 2010 with suicides at a three-year low. The service reported 37 confirmed or suspected suicides in 2010 as compared to 52 in 2009, and 173 Marines attempted suicide in 2010, which is nine more than the previous year. And the Navy reports a decline from 46 per 100,000 personnel in 2009 to 38 in 2010. Despite this, attempted suicides have increased since 2006.

Intervention has been helpful for active duty personnel but suicides for the Reserve Component (RC) not on active duty are increasing. Regarding these, (all services and Guard), 145 suicides were reported for 2010 which reflects a significant increase from 80 suicides the previous year.

RC members returning from deployment face stressful and seemingly insurmountable problems including home foreclosures, divorce, debts, and loss of employment. To help address these issues, FRA supports legislation (HR 208) sponsored by Rep. Thomas Rooney that authorizes reimbursement for mental health counseling under TRICARE.

CONCLUSION

FRA is grateful for the opportunity to present these recommendations to this distinguished Subcommittee.

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MASTER CHIEF JOSEPH L. BARNES, USN (RETIRED)
National Executive Director, Fleet Reserve Association

Joseph L. (Joe) Barnes is a retired Navy Master Chief and serves as the Fleet Reserve Association's (FRA's) National Executive Director. He is a member of FRA's National Board of Directors, chairs the Association's National Committee on Legislative Service, and is responsible for managing the organization's National Headquarters in Alexandria, VA. In addition, he is president of the newly established FRA Education Foundation, which oversees the Association's scholarship program that presents awards totaling nearly \$100,000 to deserving students each year.

Barnes joined FRA's National Headquarters team in 1993 and prior to assuming his current position in 2002, he served as FRA's Director of Legislative Programs. During his tenure, the Association realized significant legislative gains, and was recognized with a certificate award for excellence in government relations from the American Society of Association Executives (ASAE).

In addition to his FRA duties, Barnes is Co-Chairman of the Military Coalition (TMC) and co-chairs TMC's Personnel, Compensation and Commissaries Committee. He is also a member of the Defense Commissary Agency's Patron Council and an ex-officio member of the U.S. Navy Memorial Foundation's Board of Directors.

He received the U.S. Coast Guard's Meritorious Public Service Award and was appointed an Honorary Member of the U.S. Coast Guard by then Commandant of the Coast Guard Adm. James Loy, and former Master Chief Petty Officer of the Coast Guard Vince Patton.

While on active duty, he was the public affairs director for the U.S. Navy Band in Washington, DC, and directed marketing and promotional efforts for national tours, network radio and television appearances, and major special events in the nation's capital. His awards include the Defense Meritorious Service and Navy Commendation Medals.

Barnes holds a bachelor's degree in education and a master's degree in public relations management from The American University, Washington, DC. He earned the Certified Association Executive (CAE) designation from ASAE in 2003 and is an accredited member of the International Association of Business Communicators (IABC).

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**Testimony of
The National Association for Uniformed Services**

presented by

**Rick Jones
Legislative Director**

before the

**Subcommittee on Military Personnel
Committee on House Armed Services**

**Thursday, March 16, 2011
2212 Rayburn House Office Building**



Introduction

Chairman Wilson and Members of the Subcommittee, the National Association for Uniformed Services thanks you for the opportunity to present testimony before the House Armed Services Subcommittee on Military Personnel to consider A Beneficiary Perspective on the Department of Defense Military Health Care System.

The Defense Blueprint for Military Health Care Raises Serious Concern

In recent years, the Department of Defense (DoD) has continually pressed Congress for TRICARE fee increases on military retirees and their families. To date, Congress has rejected these proposed raids on earned medical benefits. Members of the National Association for Uniformed Services deeply appreciate your work to secure these earned benefits.

This year, once again, DoD has proposed increased fees. On February 14, DoD presented its formal request to lawmakers for higher TRICARE fees as part of the President's fiscal year 2012 Budget. As you know, President Obama's fiscal 2012 defense budget contains a plan to raise TRICARE fees on certain military retirees and their families. The plan targets what the Pentagon calls "working age" retirees, defined as those between the ages of 38 and 64 who are enrolled in TRICARE Prime.

In sum, DoD intends to collect \$450 million over the next five years from the pockets of "working age" retirees by raising TRICARE Prime enrollment fees in the first year by 13 percent and in following years by the rate of medical inflation, which is projected by economists to run several points higher than general inflation at a minimum annual pace of 6.2 percent and as high as 10 to 14 percent over the next five-years.

In addition, the defense budget proposes to boost the co-pay for prescription drugs to \$5 for generics, \$12 dollars for brand name, and \$25 for non-formulary medications at retail pharmacies. The current charge for such prescriptions is \$3 for generics, \$9 for brand name and \$22 for non-formulary medications.

The plan is to drive more retirees to use the TRICARE Home Delivery program by posting a "zero" charge for generic medications received by mail. Non-formulary medications obtained through Home Delivery, however, would also increase to \$25 from \$22. These increases for pharmaceuticals would apply to all beneficiary groups under the Pentagon plan.

The proposed fee increases are part of a broad offensive by Defense Secretary Gates to come up with \$178 billion in savings over the next five years. The Secretary proposes that \$7

billion of that figure would come through increased TRICARE premiums and other changes within the military health system.

NAUS does not discount the challenging fiscal situation, nor are we blind to the rising cost of providing for our defense. We have encouraged Congress at every opportunity to prioritize spending and eliminate fraud, waste and abuse in all areas of the government. And we have cautioned against cuts that could weaken our national defense or adversely affect the brave men and women who provide the blanket of security that allows us to live our lives united in freedom.

Unlike past Pentagon plans requesting doubling or tripling fees, this year's recommendation is different. NAUS observes the latest DoD proposal has, regrettably, divided the military association community. Some organizations have come out in opposition, others in full favor, and many others are still "studying" the proposals and remain silent on their position.

At first look, the plan for TRICARE increases may indeed seem "modest," as the Department has described its proposal. However, it is clear that the plan is "a nose under the tent," a Trojan Horse designed to divide the voice of retirees and start the roll-out for substantial increases in TRICARE fees and copays.

The plan begins small as Defense Comptroller Robert Hale recently said, "We are hopeful that by starting slowly ... we will get their (Congress and military associations) agreement." After a first year increase of a "modest" 13 percent, what really matters, according to Hale, is that the earned benefit increase would be compounded year after year by the rate of growth in medical costs. Comptroller Hale accurately described the impact saying fees "will keep growing" because of indexing "so if you go out 10 or 20 years, it will have a major influence on controlling costs."

The National Association for Uniformed Services also finds it very difficult to hear top officials suggest military retirees' earned benefits are responsible for undercutting our nation's ability to defend itself. Defense officials say the fastest growing part of the Pentagon budget is health care, and they cite its growth over the past decade—growing from \$19 billion in fiscal year 2001 to \$52 billion in the 2012.

While it is true costs for military health care have increased over the past decade, the cause is not, repeat, not military retirees using their earned benefits. The true accelerant for rising costs is the War.

The cause for dramatically higher medical costs is the need to care for our wounded warriors, a requirement to carry forward our medical wartime research and the importance of paying our related wartime expenditures. Higher survival rates of wounded warriors and the larger proportion of troops diagnosed with mental health disorders and trauma in the current conflicts push costs of military health care higher than in previous wars.

Nevertheless, to achieve its plan, Pentagon officials begin by citing the costs of military health care in 2001, a pre-war date, and conclude by projecting costs into 2012 and, of course,

to even higher levels in the years beyond. Once ballooning costs are outlined, the Pentagon asserts "the costs of military health care is eating us alive." At that point, Pentagon officials attack one of the most important non-cash benefits earned in a military career—TRICARE—as the cause of the escalating expense of military health care.

Mr Chairman, the costs of military health care always increase during wartime. And they always will, unless our nation decides to leave our wounded behind, which will never happen while today's veterans and military retirees and generations to follow breathe American air. Again, the blame for the dramatic rise in military health care costs is the War.

In a recent TRICARE Cost Survey, members of the National Association for Uniformed Services responded with appeals to hold the line on TRICARE fees for retirees and active duty families. More than half—62 percent—of members said they were not willing to pay even a "modest" TRICARE cost increase, though 25 percent said they might be willing to pay more. A vast majority of members—84 percent—agreed that TRICARE is an earned benefit and no fee or cost increases should be expected from those who completed a career in uniform. And practically all members—93 percent—said keeping costs as they are is a way for the government to honor its promises of lifetime health care, particularly when the country is at War.

Our members are seriously concerned about stories in the national media that depict the cost of retiree benefits as responsible for threatening available funding for our national security. Not too long ago, one Pentagon undersecretary said that the costs of earned benefits "have gotten to the point where they are hurtful. They are taking away from the nation's ability to defend itself."

Our members tell us that it is hard to imagine anything being said with more callousness as a declaration from top-government officials that the benefits earned in honorable military service threaten our national security. It raises serious concern about the direction we are taking on the way forward because we know that the brave men and women who served this country are not the enemy of national security.

The National Association for Uniformed Services finds it very difficult to hear top officials seeming to say to those who wore the uniform only a few years ago that they now have to pay more for the promises made for a career in uniform. It is especially hurtful now that their job is done and they are out of our military.

A USAF retired Master Sergeant from Maryland said, "I sacrificed a lot to serve my county. I remember \$50 paychecks for two weeks, and having the commissary clerk subtotal my food costs several times because I couldn't afford it all. I had a car with tires that never matched and a bed with a mattress that did not match the box spring. My carpets were bound remnants and never measured a full 8 x 12. Now they want to change the rules and take more from me. Can we please turn the clock back to 1966 and give me another shot at this?"

Faced with the possibility of added costs for earned benefits, the Sergeant is looking back at his honored service with a sense of regret. He understands the recommendation does not match up to expectation.

The assertion behind the proposals, of course, is to have working-age retirees and family members pay a larger share of TRICARE costs or use civilian health plans offered by employers. Frankly, we are deeply troubled that DoD would aim to discourage retirees from using their earned benefits with the military medical system.

These benefits were earned the hard way. They are different from private sector and regular federal health benefits. They were promised to a set of brave men and women in return for a career of service in America's armed forces.

And for those outside of this room who wish to compare military fees to other government programs or who do not understand the risk inherent in military service allow me to point out that there is a stark difference between running in Reeboks, Rockports, Bostonians or Bass Weejuns to catch a carpool and running in combat or desert boots to catch protective cover.

The National Association for Uniformed Services is certainly not comfortable with defense leadership actually suggesting to the public that the price we pay is more than the value our nation received from those who served 20 years or more.

What we see and hear disturbs us, because it is inconceivable that the Department of Defense would propose "starting slowly" for certain military retirees under TRICARE as a means to help meet the costs of providing for our national defense. Again, this is a "nose under the tent."

Certainly there are a number of lower priority programs that can be reduced. If cuts are needed to tighten the defense budget, there are other things big and small that can be done.

We believe the TRICARE increases should not, repeat, not be taken at this time. If this plan is enacted, it would demonstrate that the promised earned benefits of a military career are not viewed as a priority.

It is imperative that the Subcommittee do the right thing. To do otherwise would send the wrong signal to those who now serve and have served in America's Armed Forces, especially in a time of War.

Our members understand sacrifice and they know what it means to be at the point of the spear. But they are troubled with always being first in line for sacrifice, when they witness resources continuing to go to lower priority programs such as they have seen in the past—money to the Professional Golf Association, a museum for the Ground Hog Puxatawney Phil, a Cowboy Museum, the Bridge to Nowhere and other projects too numerous to list. Money was even directed to subsidize the GRAMMY Foundation, an organization run by millionaire record producers, recording "artists" and record manufacturers.

And beyond these special projects our members read yearly about federal employees delinquent or refusing to pay taxes. In 2009, the Internal Revenue Service (IRS) found nearly 100,000 civilian federal employees were delinquent on their federal income taxes, owing over \$1 billion in unpaid federal income taxes.

And it is our understanding that more than \$120 billion is wasted through improper payments to fraudsters in medical and social security programs for payment of nonexistent delivery of supplies, multiple billings for the same patient, for prosthetic arms for people who don't need prosthetics and for general lack of effort to root out this type of thievery.

In the past decade, Washington sent over \$1 billion of American tax dollars to dead people. Washington paid for dead people's prescriptions and wheelchairs, subsidized their farms, helped pay their rent, and even chipped in for their heating and air conditioning bills.

Incredibly, there are additional questionable spending priorities as we discuss targeting the earned benefits of military health care.

What signal, for instance, is being sent when our government directs our nation's hospitals to pay the medical care costs for treating illegal aliens? Is it right to squeeze resources for the Pentagon that result in military retirees paying more for their earned benefits, while giving budget priority to those here illegally in the United States? Does illegal alien health care trump the healthcare benefit provided those who gave a lifetime protecting American freedom and preserving our way of life?

The National Association for Uniformed Services has faith in our leaders, but we are not blind. Before we begin whacking at our military's earned benefits, let us make certain that we use our best wisdom to select our most important programs over our lesser important ones. And let us not forget, we are at War.

If our defense budget is insufficient to cover our national security requirements, as defense observers say it is, then why do we continue to spend billions on non-defense, non-federal and non-essential programs and projects. Our members ask members of Congress to sort out the matter and to use common sense in reaching a balanced and reasonable analysis of the situation, especially when our courageous troops are engaged in battle overseas.

In this regard, it is important to point out that the current defense budget, at this point of the Wars in Iraq and Afghanistan, represents only a little more than 4 percent of the gross domestic product. This compares with 37.8 percent during World War II, 10.2 percent during the height of the Cold War and 6.2 percent as recently as 1986. In fact, the defense budget averaged 5.7 percent of GDP in the *peacetime* years between 1940 and 2000.

The National Association for Uniformed Services Asks Rejection of the DoD Proposed Increase

Mr. Chairman, the National Association for Uniformed Services asks Congress to reject the DoD proposed increases. We propose that adequate funding is provided to maintain the value

of the healthcare benefit provided those men and women willing to undergo the hardships of a military career.

And the National Association for Uniformed Services is not alone in its call to hold the line. While we do not speak for them, we are pleased to stand with the millions of veterans who form the American Legion, the Veterans of Foreign Wars, the AMVETS, the Air Force Sergeants Association, and the Jewish War Veterans to name a few of the major associations representing those men and women who actually served in the Armed Forces of the United States and who also reject the Pentagon plan to raise fees.

Our country has asked a great deal from these former soldiers, sailors, coastguardsmen, airmen, and Marines tasked to secure the blessings of freedom and protect our nation's interests. In return, these courageous men and women have kept faith and kept a strong defense. And today we are better for it.

All we ask for is what is best for our former service men, women and their families and survivors. We believe that the way we treat them reflects well on those currently serving and those thinking about future service.

Defense Secretary Robert M. Gates defends the plan to raise TRICARE fees on "working retirees" by 13 percent beginning in 2012. Secretary Gates says that "many of these beneficiaries are employed full time while receiving full pensions, often forgoing their employer's health plan to remain with TRICARE." While some may find it hard to understand, the simple fact is that those men and women who have earned a retirement benefit actually look forward to using it.

It should also be pointed out that many of our military retirees are on fixed retirement incomes and many cannot afford even a "modest" 13 percent increase in monthly expense. And many are not Generals and Admirals working for defense contractors, but Sergeants and Petty Officers who face higher unemployment than their non-veteran peers. Also, please consider, those military retirees who would be affected received no, repeat, no COLA increase these past two years. Lifetime health care is the single most important earned, repeat, earned benefit a retired service member and family have.

Today, the military's pay and benefits are good. The promise of health care is an essential commitment to those who spent a career in the military. We should not tamper with it in an effort to balance the Pentagon budget.

Mr. Chairman, at an earlier time in our history, one of our most revered leaders said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the veterans of earlier wars were treated and appreciated by their nation." It is indeed interesting today to note how perceptive George Washington's observations were. If we measure today's national defense and the promises made to those who have served in the context of Washington's remarks, I think every thinking American would be uneasy.

The National Association for Uniformed Services urges you to confirm America's solemn, moral obligation to keep the faith with our military retirees. They have kept their promise to our Nation, and now it's time for us to keep our promise to them.

TRICARE Pharmacy Programs

The DoD budget proposal also requests a 67 percent increase in retail formulary pharmacy fees for all members and families eligible for military health care. Officials at the Pentagon rationalize this increase as being justified because it costs the government twice as much for a drug through the TRICARE Retail Pharmacy program (TRRx) than it does for the same drug through the TRICARE Home Delivery program. DoD believes the rise in the TRRx co-payments will increase revenue and forcefully migrate beneficiaries to the Home Delivery program, where costs for prescriptions are lower.

However, we feel that one of the primary reasons for the higher cost to the Department of Defense in the retail sector is due to the neglect of DoD to aggressively pursue the Federal Pricing schedule for TRRx. Nor has DoD negotiated other discounts or price breaks with any pharmaceutical companies, which could save considerable resources.

We also find DoD slow in developing a concerted marketing or education plan to encourage beneficiaries to use the mail order program. Considerable savings can be found for the beneficiary as well as the Department in developed use of Home Delivery.

The National Association for Uniformed Services urges the Subcommittee to direct DoD to develop and use an active marketing plan for beneficiary use of the mail order program.

Expectations About the Benefit Package Affects Retention

The United States provides a robust benefits package to the men and women who serve. These benefits are well-deserved and serve as a counterbalance to the sacrifices made throughout a full career in the military. They are a calculated part of the overall compensation package.

The members of the National Association for Uniformed Services tell us that they view the proposed increases as an erosion of their benefits.

For many of those currently serving service members well into their career at their tenth year or more in service, the DoD strategy of "starting slowly with a modest proposal" to increase fees, poses a substantial diminishment in their expectation about the package they would earn at the close of their career. They remember when recruiters told them that if they stayed in service the government would provide them lifetime health care.

In discussion with key Pentagon officials, the National Association for Uniformed Services is plainly told that there are more plans for collecting additional shares from military retirees. The Pentagon plan is clearly devised as a "nose under the tent." When our members easily recall recent comments from a "health care economist" that Congressional passage of

TRICARE for Life “was a mistake,” we are concerned. And it should concern others as well. Our troops and our military retirees now more clearly see the promise of earned benefits may in fact cost them more than they ever anticipated.

The National Association for Uniformed Services urges the Subcommittee to ensure that every effort is taken to reassure experienced servicemembers that their promised benefits will be delivered by a grateful nation.

The National Association for Uniformed Services Appreciates the Opportunity to Testify

Mr. Chairman, the National Association for Uniformed Services thanks you for extending the opportunity to appear before you today and we thank you for your support of those who serve and have served in the uniformed services. We believe the price is not too great for the value received.

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 Established in 1968



Richard A. "Rick" Jones
 Legislative Director
 National Association for Uniformed Services (NAUS)

Richard A. "Rick" Jones joined NAUS as Legislative Director on Sept. 1, 2005. As legislative director, he is the primary individual responsible for promoting the NAUS legislative, national security, and foreign affairs goals before the Departments of Defense and Veterans Affairs, and the Congress of the United States.

Rick presently serves as co-director of the National Military and Veterans Alliance (NMVA) and co-chairman of the Alliance for Military and Overseas Voting Rights (AMOVR). NMVA is composed of 31 military associations and veterans organizations with a combined membership of over 3.5 million members. AMOVR, a working alliance of 36 military and overseas advocacy groups, elected officials, and voting rights advocates, is formed to ensure that our military men and women are afforded their right to vote and to ensure their votes are counted.

Rick is an Army veteran who served as a medical specialist during the Vietnam War era. His assignments included duty at Brooke General Hospital, San Antonio, Texas; Fitzsimons General Hospital, Denver, Colorado; and Moncrief Community Hospital, Columbia, South Carolina.

Rick completed undergraduate work at Brown University prior to his Army draft and earned a Master Degree in Public Administration from East Carolina University in Greenville, North Carolina, following military service.

Prior to assuming his current position, Rick served five years as National Legislative Director for AMVETS, a major veterans service organization. He also worked nearly twenty years as a legislative staff aide in the offices of Senator Paul Coverdell, Senator Lauch Faircloth, and Senator John P. East. He also worked in the House of Representatives as a committee staff director for Representative Larry J. Hopkins and Representative Bob Stump.

In working for Rep. Stump on the House Committee on Veterans' Affairs, he served two years as minority staff director for the subcommittee on housing and memorial affairs and two years as majority professional staff on funding issues related to veterans' affairs budget and appropriations.

Rick and his wife Nancy have three children and reside in Springfield, Virginia.

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TESTIMONY OF

Deirdre Parke Holleman

Executive Director

Of

THE RETIRED ENLISTED ASSOCIATION

Before a

HEARING

Of the

HOUSE ARMED SERVICES COMMITTEE'S

Subcommittee on Military Personnel

On

**Military Health System Overview and Defense Health Cost Efficiencies: A
Beneficiary Perspective**

On

March 16th 2011

The Retired Enlisted Association does not receive any grants or contracts from the federal government.

Chairman Wilson, Ranking Member Davis and distinguished members of the Subcommittee it is an honor and deep responsibility to speak to you about the Military medical system and its future funding on behalf of the members of TREA and all beneficiaries.

Proposed Defense Health Cost Efficiencies

When asked to look at this subject the obvious first step is to look at the Administration's FY2012 DoD budget proposals. These include the suggested increase in yearly enrollment fee for Military retirees from \$230 to \$260 for an individual and \$460 to \$520 for a family; the yearly INDEXING of future enrollment fees to a level of medical inflation that seems, for now to be calculated at 6.2% a year; the change in the pharmacy benefit; the exclusion of medical retirees and survivors from this year's proposals, the proposal of aging out enrollees in the US Family Health Plan etc. And when compared to other ideas floating around this town the first instinct is to say- "well that's not so bad."

This year's proposals are certainly not as appalling as earlier ones were. And for that we are grateful. But then we must ask why are DoD's health care costs rising and why should retirees shoulder the burden for the increasing costs- whatever they happen to be. It should be clear that DoD's health care system's purpose is not to create a health care employee benefit program for beneficiaries. **The primary purpose of the system is clearly to support Readiness.** That is a crucial, honorable and necessary focus. But it is clearly not focused on economic efficiencies. It is focused on doing that essential job. And that is the job of the entire Nation. First remember we are approaching the 11th year of a war without an end in sight. Of course medical costs and everything else are more expensive during a war.

How much of the increased costs are due to the cost of war time treatment?

How much is due to the need to send more TRICARE beneficiaries downtown for civilian care because the MTFs are short of military medical personnel because are serving our warriors in war zones?

MTF's have the right of refusal to take a broad range of interesting cases so the medical training programs will qualify for licensing and internship and residency programs (otherwise most of what the military doctors and nurses in training would see are healthy people who have had accidents and babies being born.)

These are just a few examples of the numerous unique methods of DoD healthcare practice that would never be a concern or a cost to a program like Blue Cross/ Blue Shield. Of course military retirees and their families and survivors have a responsibility to help pay for such costs but they have the duty of a tax payer- but not more than any other tax payer. They should not be required to pay for these types of costs through their enrollment fees, co-pays etc.

We should also question if we really have any idea how much health care is actually costing the Department of Defense. DoD is arguing that its health care budget has doubled in the last decade going from \$24 billion to \$50 billion. They are predicting that by 2026 it will take up 13% of the budget. But how do we know? Last year Senator Chuck Grassley (IA) concluded that the DoD IG is incapable of auditing the Department of Defense. The 2010 NDAA calls for "Audit Readiness of Financial Statements of the Department of Defense" by September 30th 2017. With these problems it seems hasty, at best, to transfer costs to those who have already served our Nation in the hardest and most dangerous places in the world.

These retirees have paid for this benefit by 20 or more years of exhausting, dangerous and tense service. It is not a general nationwide healthcare insurance program. It is not Medicare or Medicaid. They have not earned this benefit by simply being an American citizen and paying their taxes. This is a crucial part of the complete financial package that America pays to maintain an all volunteer military. These retirees took on decades of risk and dedication. Their families have at different times in their lives both been separated from them and moved around the world to be able to be with them. It is a benefit they have earned. It should rightly be looked at as a pre-paid enrollment fee.

It should also be noted that the active duty force is well aware of what is happening to their retired brothers and sisters. One of the reasons Congress created and passed TRICARE for Life (TFL) in 2000 was that the active duty saw what was happening to military retirees over the age of 65, and their negative reactions were harming retention.

Additionally, we should always remember what a difficult life these men and women have agreed to take on. What a strain the duties put on both their physical and mental health. The military is a fit style of life but it is not a healthy one. And it is the duty of a grateful Nation to provide the medical care a military career truly requires.

The proposed indexing as now designed would dramatically cut the retirement package that the career military has earned. While the retiree or survivors retired/ survivors payment would only rise by a Cost of Living Allowance (COLA); the enrollment fee for TRICARE Prime would rise by one of several considered Medical Inflation Indexes. The present calculation depends on a 6.2% increase. As time went on this would seriously lower the retirement package that military retirees have been promised and planned on.

The present target of these proposed increases are the recent retirees (between the ages of 38 and 64) who have been carrying the brunt of this ongoing 10 year war and will be continuing to do so for the foreseeable future. These are the men and women who volunteered to protect

the rest of us. They have been the first in line but they don't want to push, or be pushed to the front of the sacrifice line again.

TRICARE Pharmacy Plan

We have been told again and again how much the government saves when TRICARE Pharmacy beneficiaries receive their prescriptions either by using an MTF or Home delivery rather going to a retail pharmacy. Below please see DoD's proposal to push all TRICARE Pharmacy beneficiaries into using Home Delivery. While there are many things we like about this plan it does not take into account that there are many drugs that one should get immediately. In this situation Home Delivery is not a sensible option. We see no reason to penalize beneficiaries by increasing **those** retail co pays. However we must say that the \$0 co-pay for Mail Order generics is an extremely elegant physiological move.

	Retail	Home Delivery (Mail Order)
Generic	\$5 (+\$2)	Zero (-\$3)
Brand Name	\$12 (+\$3)	\$9 (no change)
Nonformulary	\$25 (+\$3)	\$25 (+\$3)

U.S. Family Health Plan

Another Department of Defense proposal is to require beneficiaries of the U.S. Family Health Plan to age out of the program when they turn 65 and move into TRICARE for Life (TFL). TREA is opposed to such a proposal. That is true even though we strongly believe that TRICARE for Life is a wonderful program. However, USFHP is a small distinct program within the TRICARE Prime programs that is extremely effective for the 115,000 beneficiaries enrolled in its 6 sites. It was created by Congress in 1981 centered on some former U.S. Public Health Hospitals. It provides first class care for its enrollees and indeed is very similar to the Medical Home model that DoD is presently attempting to stand up throughout its system.

TREA is at a loss to understand why DoD thinks it would save as much as it expects from aging out the enrollees and requiring them to take TFL. However we can certainly see that there would be savings for the Department of Defense with their plan.

Medicare is first payer for TFL and pays approximately 80% of the medical costs with DoD picking up the remaining 20%. DoD continues to pay USFHP a capitated yearly rate for every beneficiary over the age of 65- so DoD would see a savings but the United States government would not. It would just transfer some of the costs to Medicare. But to get that saving on their books from this plan the beneficiary would have to lose his or her continuity of care and continued enrollment in this first rate plan. If there is some way to convince Medicare and/or

the relevant Congressional Committees to have Medicare start paying the cost they would normally be responsible for that would be wonderful if unlikely.

But this is a first rate program that provides unique first rate care. If one was just starting to create all the TRICARE programs you might not create this. But when you consider how hard it is to stand up and run *any* first rate program it is extremely foolish to turn your back on it.

MHS Overview

TREA fully supports The Military Coalition's wise and detailed analysis of the whole Military Health System. In the short time we have we would only like to reemphasize the need to develop a smoother transition for our wounded warriors from Department of Defense's medical treatment to the treatment provided by the Department of Veterans Affairs. We urge DoD to provide all equivalent care that the patient can receive at the VA. There should be no gaps or holes between the 2 Departments where the wounded veteran can be delayed or lost. It should be seamless. We urge you to continue your years of work to make it happen.

Conclusion

TREA again, wishes to thank you for allowing us to discuss these very important proposals with you. We know the difficult balancing act that all of you are facing. But please remember that the retirees' whose benefits are presently being analyzed and recalculated are the men and women, families and survivors who have been carrying the daily burden of our 10 year war. They are the ones who will fly when needed into disaster zones like Japan across the world. They were promised a solid and predictable retirement. And really, they have earned it.

Biography of Deirdre Parke Holleman, Esq.

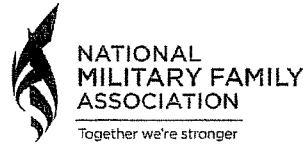
Executive Director
The Retired Enlisted Association

Deirdre Parke Holleman, Esq. is the Executive Director of The Retired Enlisted Association. She is also the Co-Director of the National Military and Veterans Alliance (NMVA) and the Co-Chairman of The Military Coalition's (TMC) Survivors Committee. In all three capacities and as a member of TMC's Health Care Committee Mrs. Holleman focuses on healthcare, financial and benefit matters for the Military's retirees, the active duty, the National Guard and Reserves and all their families and survivors.

Prior to joining TREA Mrs. Holleman was the Washington Liaison for The Gold Star Wives of America, Inc. There she represented the concerns of active duty widows and widows of Military members who die of service connected disabilities Before Congress, the Department of Defense, the Department of Veteran Affairs and other Veteran Service Organizations.

Mrs. Holleman is an attorney licensed to practice in the State of New York and before all Federal Courts. She argued many cases before all the Appellate Courts of New York including the New York Court of Appeals, the highest appellate court in the state. She successfully argued **In the Matter of Marie B.**, a case that struck down a New York statute as unconstitutional. For years she was a civil trial attorney in New York primarily handling Domestic, Family and Juvenile cases. She was the Associate Director of The Legal Aid Society of Mid-New York, Inc. This charity represents people who cannot afford to hire counsel in civil matters over nine counties in Upstate New York. She has a B.A. in History and Journalism from George Washington University and a J.D. from Vanderbilt University School of Law.

She lives in Rosslyn Virginia with her husband Christopher Holleman, an Administrative Judge for the Small Business Administration.



Statement of

Kathleen B. Moakler
Government Relations Director

NATIONAL MILITARY FAMILY ASSOCIATION

Before the

Subcommittee on
Military Personnel

of the

UNITED STATES HOUSE OF REPRESENTATIVES
ARMED SERVICES COMMITTEE

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The Committee

Military families serve our country with pride, honor, and quiet dedication. The National Military Family Association is the leading nonprofit organization committed to strengthening and protecting the families of the men and women currently serving, retired, wounded or fallen. We provide families of the Army, Navy, Marine Corps, Air Force, Coast Guard, and Commissioned Corps of the USPHS and NOAA with information, work to get them the benefits they deserve, and offer programs that improve their lives. Our over 40 years of service and accomplishments have made us a trusted resource for military families and the Nation's leaders.

Association Representatives in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteer Representatives are our "eyes and ears," bringing shared local concerns to national attention.

The Association does not have or receive federal grants or contracts.
Our website is: www.MilitaryFamily.org.

Kathleen B. Moakler, Government Relations Director

Mrs. Moakler has been associated with the National Military Family Association since 1995 as a member of the headquarters staff. She was permanently appointed to Government Relations Director in October 2007. In that position, she monitors the range of issues relevant to the quality of life of the families of the seven uniformed services and coordinates a staff of 4 deputy directors. Mrs. Moakler represents the interests of military families on a variety of advisory panels and working groups, including the DoD/VA Survivors Forum, and the State Department Interagency Roundtable. Mrs. Moakler is co-chair of the Survivor Programs Committee for the Military Coalition (TMC), a consortium of 34 military and veteran organizations and serves on the Retiree Committee. She is often called to comment on issues pertaining to military families for such media outlets as the NY Times, CNN, NBC News, NPR and the Military Times. She writes regularly for military focused publications.

An Army spouse of over 28 years, Mrs. Moakler has served in various volunteer leadership positions in civilian and military community organizations in that time. She has worked with many military community programs including hospital consumer boards, commanders' advisory boards, family readiness groups, church councils, youth programs, and the Army Family Action Plan at all levels. She believes that communication is paramount in the efficient delivery of services and the fostering of a rich community life for military families. She holds a Bachelor of Science degree in Business Administration from the State University of New York at Albany. Mrs. Moakler has been awarded the Army Commanders Award for Public Service and the President's Volunteer Service Award.

Mrs. Moakler is also a military mom. Her daughter, Megan is an Army nurse who has served two tours in Iraq and is presently stationed at Ft. Sill, Oklahoma, and son, Matthew is an Army major stationed at Ft. Belvoir, Virginia. Her oldest son, Marty, works for Hulu.com and is an aspiring writer/actor in Los Angeles, California. Mrs. Moakler and her husband, Colonel Martin W. Moakler, Jr. USA (retired), reside in Alexandria, Virginia.

Chairman Wilson and Distinguished Members of the Subcommittee, the National Military Family Association thanks you for the opportunity to present testimony on the quality of life of military families – the Nation's families. The military health care benefit is an important component of that quality of life for our active duty, reserve component, and retired service members, their families, and survivors. Your recognition of the sacrifices of these families and your response through legislation to the increased challenges facing them has been greatly appreciated.

We endorse the recommendations contained in the statement submitted by the Military Coalition. In this statement, our Association will expand on several issues of importance to military families as they relate to Family Health. We will expand on other aspects of the quality of life of military families in our statement for the record for the Subcommittee's hearing on Military Personnel issues scheduled for March 17, 2011.

Family Health

Family readiness calls for access to quality health care and mental health services. Families need to be assured the various elements of their military health system are coordinated and working as a synergistic system. The direct care system of Military Treatment Facilities (MTFs) and the purchased care segment of civilian providers under the TRICARE contracts must work in tandem to meet military readiness requirements and ensure they meet access standards for all military beneficiaries.

Improving Access to Care

Our Association continues to monitor the experience of military families with accessing care within both the direct care and purchased care segments of the Military Health System (MHS). We are concerned our MTFs are stressed from ten years of provider deployments, which directly affects the quality, access, and cost of health care. We have consistently heard from families that their greatest health care challenge has been getting timely care in both the direct and the purchased care systems. Their main challenges with the direct care system are:

- access to their Primary Care Managers (PCM)
- availability of after-hours care
- having appointments available in MTFs for 60, 90, or 120-day follow-ups recommended by their providers

Their main challenges with purchased care system, according to TRICARE's *Health Care Survey of DoD Beneficiaries 2009 Annual Report* are difficulty in accessing personal doctors and specialty care.

Our Association hears frequent complaints by families regarding the referral process. Families who are unfamiliar with the process at their facility and in their TRICARE region report not being able to obtain an appointment within access standards. Often, they find that a provider on the TRICARE Managed Care Support Contractor's (MCSC) list is no longer taking TRICARE or taking new patients. The difficulties sometimes cause the beneficiary to give up on the referral process and never obtain the specialty appointment their PCM believes they need. Our Association is concerned with the impact these delays or the lack of even getting the referral is having on the quality of care and beneficiary outcome. We cannot stress enough how continuity of care is important to maintain our families' quality of care. We recommend Congress require the Department of Defense (DoD) report on the management of the referral process—both within the direct care system and between the direct care and purchased care sectors—and the impact on beneficiaries' access to care.

We see even more issues ahead that could affect beneficiary access. The TRICARE Management Activity (TMA) will roll out the new TRICARE Third Generation (T3) contract in the TRICARE North Region beginning April 2011. At that time, the remaining two TRICARE Regions will still be operating under the existing TRICARE Next Generation (T-Nex) contract. Because of the recent announcement of a T3 award change in the South Region and subsequent protest filed, full T3 implementation will remain in a holding pattern, preventing contractors' renegotiation with approximately 66 percent of our civilian TRICARE providers. With the demands and uncertainties to providers in regards to health care reform's added requirements and expenses along with looming Medicare reimbursement rate changes, we are concerned about providers' long-term willingness to remain in the TRICARE network and about the contractors' ability to recruit new providers. Thus, the combination of factors may result in a decreased access to care for military families.

National Guard and Reserve Member Family Access to Care

We remain especially concerned about access to care for our National Guard and Reserve families. These families also need increased education about the multiple types of TRICARE health care benefits in which they are eligible to participate. We recommend Congress request a report to assess the coordination and continuity of health care services for our National Guard and Reserve families as they frequently move from activated TRICARE Prime coverage to non-activated status and TRICARE Reserve Select (TRS) or their employer civilian health care insurance plans. We also believe that paying a stipend to a mobilized National Guard or Reserve member for their family's coverage under their employer-sponsored insurance plan while the service member is deployed may work out better for many families in areas where the TRICARE network may not be robust.

TRICARE Reimbursement

Our Association is concerned that continuing pressure to lower Medicare reimbursement rates will create a hollow benefit for TRICARE beneficiaries. We are appreciative Congress passed the *Medicare and Medicaid Extenders Act of 2010* (P.L.111-309), which provided a one-year extension of current Medicare physician payment rates until December 31, 2011. As the 112th Congress takes up Medicare legislation this year, we ask you to consider how this legislation will impact military health care, especially our most vulnerable populations, our families living in rural communities, and those needing access to mental health services.

While we have been impressed with the strides TMA and the TRICARE contractors are making in adding providers, especially mental health providers to the networks, we believe more must be done to persuade health care and mental health care providers to participate and remain in the TRICARE system, even if that means DoD must raise reimbursement rates. We frequently hear from providers who will not participate in TRICARE because of what they believe are time-consuming requirements and low reimbursement rates. National provider shortages in the mental health field, especially in child and adolescent psychology, are exacerbated in many cases by low TRICARE reimbursement rates, TRICARE rules, or military-unique geographic challenges, such as large military beneficiary populations in rural or traditionally-underserved areas. Many mental health providers are willing to see military beneficiaries on a voluntary status. We need to do more to attract mental health providers to join the TRICARE network. Increasing reimbursement rates is just one way of enticing them.

We recommend Congress require a DoD report on the impact on beneficiaries of the MEHS referral process. We ask Congress also to require a report assessing the coordination and continuity of health care services for National Guard and Reserve families as they transition from one TRICARE status to another. Lastly, we ask for a legislative change to allow reserve component families to be given the choice of a stipend to continue their employer-provided care during the deployment of the service member.

Pharmacy

For several years now, our Association has cautioned about DoD generalizing findings of certain civilian beneficiary pharmacy behaviors and automatically applying them to the military population. As part of the President's FY 2011 Budget proposal, DoD recently announced it would adjust certain pharmacy co-payments. DoD's intent is to drive beneficiaries away from Retail pharmacies and toward TRICARE Mail Order Pharmacy (TMOP) utilization, which should lower government costs and increase DoD savings. Our Association has long championed a zero co-payment for generic Tier 1 medications in TMOP and we applaud DoD's proposal to implement this as one of their cost-saving measures. While we believe the rationale behind the proposed changes is sound, we request that Congress require DoD to report on how these changes impact beneficiary behavior and health care quality outcomes.

We do have some concerns with the proposed increase in co-pays for retail formulary and non-formulary medications and the impact this increase will have on beneficiaries who have no choice but to rely on the retail pharmacy for urgent non-maintenance medications. For example, the young families of deployed National Guard or Reserve members or recruiters usually do not live close to an MTF pharmacy. When their child needs an antibiotic for an urgent medical condition, such as pneumonia or an ear infection, they have no other option than the retail pharmacy. Currently, they would pay \$3 for a course of a generic antibiotic treatment; under DoD's proposal, they would now pay \$5. Beneficiaries who need certain medications not suited for TMOP because they are a narcotic or their chemical compound is not suitable for home delivery would also pay more under DoD's proposal.

We are also concerned about the effect of the proposed co-pay changes on our wounded, ill, and injured service members and those already medically retired. This population may be adversely affected because of the frequent alteration to their medication protocols by their health care providers in order to achieve optimum medical benefits for their often-changing medical conditions. Their medications may appear to be a maintenance drug, but are actually intended to be used only for short-term relief. Sending them to the mail order for a 90-day supply just because the co-payment is less may in fact cost the beneficiary and the government more because of frequent changes in doses. Many of the prescriptions needed by the wounded are for newly FDA-approved medications, which will most likely place them in non-Formulary Tier 3 status. This may place an unfair financial burden on this population because they tend to utilize a higher number of medications.

Beneficiaries who have no choice in where they must obtain their medications should not be subjected to co-payment increases aimed at changing the behavior of those who do have choices. DoD must consider the possible effects of its co-payment changes as it plans for implementation and may need to devise alternative co-payment adjustments to protect beneficiaries during these situations. We look forward to discussing potential options with Members of Congress and DoD.

In addition to the elimination of the TMOP co-payment for generic drugs as an enticement for beneficiaries to switch maintenance medications from retail to TMOP, we believe there are additional ways DoD could experience increased pharmacy savings. These include:

- Make all medications available through TRICARE Retail pharmacy also available through TRICARE Mail Order Pharmacy (TMOP)
- Provide medications treating chronic conditions, such as asthma, diabetes, and hypertension at the lowest level of co-payment regardless of brand or generic status

- Implement *The Task Force on the Future of Military Health Care* recommendation to include over-the-counter (OTC) drugs as a covered pharmacy benefit, thus eliminating the need for more costly pharmaceuticals that have the same efficacy as over-the-counter options.

The new T3 contract will provide TRICARE MCSC and Express-Scripts, Inc., the ability to link pharmacy data with disease management. This will allow for better case management, increase adherence/compliance, and decrease cost, especially for beneficiaries suffering from chronic illness and multiple conditions. However, this valuable tool will only be available this year in the TRICARE North Region because the T3 contract still remains under protest in the remaining two Regions.

We applaud the proposed changes to co-pays for TMOP participants as a way to drive more beneficiaries to TMOP to increase DoD efficiencies. We support the rationale behind proposed changes to the co-payments for the Retail pharmacy, but caution that beneficiaries should not be penalized for the purchase of urgent, non-maintenance drugs or those drugs not available via mail order.

National Health Care Proposal

Our Association is cautious about all the changes proposed in the *Patient Protection and Affordable Care Act* (P.L. 111-148) and their potential impact on TRICARE and CHAMPVA. We thank Congress for including a provision in the NDAA FY11 to allow TRICARE to provide coverage for TRICARE eligible young adult beneficiaries up to the age of 26. Our families have been asking for this added benefit. We await its implementation and are appreciative that DoD is working hard to ensure TRICARE Young Adult (TYA) Standard/Extra coverage is made available before our beneficiaries' college age students graduate this May. We appreciate the inclusion of a TRICARE Young Adult Prime option by Congress and look forward to its implementation this fall, as well. We understand DoD is addressing the issue of access to MTFs for those eligible TYA Prime non-ID card holders. However, we still need Congressional action to allow CHAMPVA to allow young adults up to the age of 26 to participate.

Congress needs to act to provide health care coverage to young adults, up to the age of 26, who are eligible for CHAMPVA.

Cost Saving Strategies in the 2012 Budget

We appreciate DoD's continued focus on cost savings strategies in the 2012 budget. DoD's proposed TRICARE changes include a change in enrollment fees for TRICARE Prime for under age 65 retirees and a change in pharmacy co-pays. DoD should also incur savings through better management of health care costs. Our Association has always supported a mechanism to provide for modest increases to TRICARE Prime enrollment fee for retirees under 65. TRICARE Prime, the managed care option for military beneficiaries, provides guaranteed access, low out of pocket costs, additional coverage, and more continuity of care than the basic military health benefit of TRICARE Standard. The annual enrollment fee of \$230 per year for an individual retiree or \$460 for a family has not been increased since the start of TRICARE Prime in 1995.

We agree that DoD's proposed increase of \$5 per month per family and \$2.50 per month per individual plan is indeed modest. We applaud DoD for deciding not to make any changes to the TRICARE benefit for active duty, active duty family members, medically retired service members, and survivors of service members and for not making any changes to the TRICARE Standard and TRICARE for Life (TFL) benefit.

We have some concerns regarding DoD's selection of a civilian-based index in determining TRICARE Prime retiree enrollment fee increases after 2012. Our Association has always supported the use of Cost of Living Allowance (COLA) as a yearly index tied to TRICARE Prime retiree enrollment fee increases.

We believe if DoD thought the rate of \$230 for individual and \$460 for family was appropriate in 1995, then yearly increases tied to COLA would maintain that same principle. Our concern over the utilization of a civilian index is based on our concern that civilian health care experts cannot agree on an accurate index to base civilian health care yearly cost increases. The *Task Force on the Future of Military Health Care* “strongly recommended that DoD and that Congress accept a method for indexing that is annual and automatic.” However, the Task Force recommended “using a civilian-only rather than total cost (including civilian and MTF costs for Prime beneficiaries) because the Task Force and DoD have greater confidence in the accuracy of the civilian care data and its auditability.” We ask Congress to adopt the Task Force’s DoD accountability recommendation and require DoD to become more accurate and establish a common cost accounting system across the MHS. Until it can do so, however, we believe increases tied to COLA are the most fair to beneficiaries and predictable for DoD.

We do not support DoD’s budget proposal to change the U.S. Family Health Plan (USFHP) eligibility, asking newly enrolled beneficiaries to transition from USFHP once they become Medicare/TRICARE for Life eligible. Our Association believes USFHP is already providing TMA’s medical home model of care, maintaining efficiencies, capturing savings, and improving patient outcomes. Every dollar spent in preventative medicine is captured later when the onset of beneficiary co-morbid and chronic diseases are delayed. It is difficult to quantify the long-term savings not only in actual cost to the health care plan—and thus to the government—but to the improvement in the quality of life for the beneficiary. Removing beneficiaries from USFHP at a time when they and the system will benefit the most from their preventative and disease management programs would greatly impact the continuity and quality of care to our beneficiaries and only cost shift the cost of their care from one government agency to another. Almost all USFHP enrollees already purchase Medicare Part B in case they decide to leave the plan or spend long periods of time in warmer parts of the country. There must be another mechanism in which beneficiaries would be allowed to continue in this patient-centered program. USFHP also meets the *Patient Protection and Accountability Care Act’s* definition of an Accountable Care Organization. They certainly have the model of care desired by civilian health care experts and should be used by DoD as a method to test best-practices that can be implemented within the direct care system.

Our Association understands the need for TRICARE to align itself with Medicare reimbursement payments. DoD’s proposal to implement reimbursement payment for Sole Community Hospitals is another example of its search for efficiencies. According to TMA, 20 hospitals that serve military beneficiaries could be affected by this change. We appreciate the four-year phased-in approach. However, our Association recommends Congress encourage TMA to reach out to these hospitals and provide waivers if warranted and provide oversight to ensure beneficiaries aren’t unfairly impacted by this proposal.

Other Cost Saving Proposals

We ask Congress to establish better oversight for DoD’s accountability in becoming more cost-efficient. We recommend:

- Requiring the Comptroller General to audit MTFs on a random basis until all have been examined for their ability to provide quality health care in a cost-effective manner
- Creating a committee, similar in nature to the Medicare Payment Advisory Commission, to provide oversight of the DoD Military Health System (MHS) and make annual recommendations to Congress. *The Task Force on the Future of Military Health Care* often stated it was unable to address certain issues not within their charter or within the timeframe in which they were commissioned to examine the issues. This Commission would have the time to examine every issue in an unbiased manner.

- Establishing a Unified “Joint” Medical Command structure. This was recommended by the Defense Health Board in 2006 and 2009 and included in the U.S. House Armed Service Committee’s NDAA FY11 proposal and passed by the House of Representatives.

We are supportive of TMA’s movement toward a medical home model of patient and family-centered care within the direct and purchase care systems. An integrated health care model, where beneficiaries will be seen by the same health care team focused on well-being and prevention, is a well-known cost saver for health care expenditures. Our concern is with the individual Services’ interpretation of the medical home model and its ability to truly function as designed. Our MTFs are still undergoing frequent provider deployments; therefore, the model must be staffed well enough to absorb unexpected deployments to theater, normal staff rotation, and still maintain continuity of providers within the medical home.

Our Association believes right-sizing to optimize MTF capabilities through innovating staffing methods; adopting coordination of care models, such as medical home; timely replacement of medical facilities utilizing “world class” and “unified construction standards;” and increased funding allocations, would allow more beneficiaries to be cared for in the MTFs. This would be a win-win situation because it increases MTF capabilities, which DoD asserts is the most cost effective. It also allows more families, who state they want to receive care within the MTF, the opportunity to do so. The Task Force made recommendations to make the DoD MHS more cost-efficient, which we support. They conclude the MHS must be appropriately sized, resourced, and stabilized and make changes in its business and health care practices. We encourage Congress to include the recommendations of the *Task Force on the Future of Military Health Care* in this year’s NDAA FY12. These include:

- Restructuring TMA to place greater emphasis on its acquisition role
- Examining and implementing strategies to ensure compliance with the principles of value-driven health care
- Incorporating health information technology systems and implementing transparency of quality measures and pricing information throughout the MHS (This is also a civilian health care requirement in the recently passed *Patient Protection and Affordable Care Act*.)
- Reassessing requirements for purchased care contracts to determine whether more cost effective strategies can be implemented
- Removing systemic obstacles to the use of more efficient and cost-effective contracting strategies.

We approve of DoD’s modest increase to TRICARE Prime enrollment fees for working age retirees. We recommend that future increases to TRICARE Prime enrollment fees for working age retirees be indexed to retired pay cost of living adjustments. We recommend that Medicare-eligible beneficiaries using the USFHP be allowed to remain in the program. Our Association recommends Congress encourage TMA to reach out to Sole Community hospitals serving large numbers of military beneficiaries and provide waivers if warranted.

Behavioral Health Care

Our Nation must help returning service members and their families cope with the aftermath of war. DoD, the Department of Veterans Affairs (VA), and State agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs, especially during Permanent Change of Station (PCS) moves. Partnering will also capture the National Guard and Reserve member population, who often straddle these agencies’ health care systems.

Full Spectrum of Care

As the war continues, the call for families who need a full spectrum of behavioral health services—from preventative care and stress reduction techniques, to counseling and medical mental health services—is

growing louder. The military offers a variety of psychological health services, both preventative and treatment, across many agencies and programs. However, as service members and families experience numerous lengthy and dangerous deployments, we believe the need for confidential, preventative psychological health services will continue to rise. More importantly, this need will remain high even after military operations scale down.

The rise in suicides among our active duty and reserve component service members demonstrates the need for these mental health services are at dangerous levels. Our Association commissioned the RAND Corporation to conduct a study on the impact of the war on caregivers and children, *Children on the Homefront: The Experience of Children from Military Families*. The study found military children reported higher anxiety signs and symptoms than their civilian counterparts. A recent study by Gorman, et. al (2010), *Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints*, found an 11 percent increase in outpatient mental health and behavioral health visits for children from the ages of 3-8 during 2006-2007. There was an 18 percent increase in pediatric behavioral health and a 19 percent increase in stress disorders when a parent was deployed. They also found an 11 percent decrease in all other health care related visits. Additional research has found an increase in mental health services by non-deployed spouses during deployment. A study of TRICARE claims data from 2003-2006 published last year by the *New England Journal of Medicine* showed an increase in mental health diagnoses among Army spouses, especially for those whose service members had deployed for more than one year.

Our research also found the mental health of the caregiver directly affects the overall well-being of the children. Therefore, we need to treat the family as a unit as well as individuals. Communication is key in maintaining family unit balance, especially during the deployment phase. Our study also found a direct correlation between decreased communication and an increase in child and/or caregiver issues during deployment. Research is beginning to validate the high level of stress and mental strain our military families are experiencing.

Access to Behavioral Health Care

The body of research focusing on the increased levels of anxiety and utilization of mental health services and medication causes our Association to be even more concerned about the overall shortage of mental health providers in TRICARE's direct and purchased care network. DoD's *Task Force on Mental Health* stated timely access to the proper psychological health provider remains one of the greatest barriers to quality mental health services for service members and their families. The Army Family Action Plan (AFAP) identified mental health issues as their number three issue for 2010.

While TMA reports significant progress by the TRICARE contractors in adding to the numbers of mental health providers in the networks, these numbers do not automatically translate into a corresponding increase in access. A recently published report in the March 2011 issue of *Military Medicine*, "Access to Mental Health Services for active duty and National Guard TRICARE Enrollees in Indiana," found that only 25 percent of mental health providers listed in the TRICARE contractor's provider list were accepting new TRICARE beneficiaries. Researchers stated the number one barrier to active duty and reserve component service members, and their families in obtaining mental health care in Indiana was the accuracy of the TRICARE mental health provider list. Our Association often hears from families about the number of times they contact a network provider using the TRICARE provider list only to find the provider cannot meet access standards, is no longer taking TRICARE, or is not taking new TRICARE patients. This study validated what the *Task Force on Mental Health* heard from families during their investigation. It is important provider lists must be up-to-date in order to handle real time demands by military families.

While families are pleased more military mental health providers are available in theater to assist their service members, they are disappointed with the resulting limited access to providers at home. Families report they are being turned away from obtaining appointments at their MTFs and clinics and told to seek services elsewhere. The military fuels the shortage by deploying its mental health providers, even its child and adolescent psychology providers, to combat zones. Many providers have returned home after completing a combat tour, only to be overwhelmed by treating active duty members. This concerns us because it can lead to provider compassion fatigue and create burnout, which only exacerbates the provider shortage problem. Our Association would like to be assured DoD is allowing these providers adequate dwell time to get fully rested and reintegrate with their families before returning to work. Our service members and their families rely heavily on this specialty care and they cannot afford for these providers to not be at the top of their game when providing beneficiary care. This situation could create a lose-lose situation, which our Nation cannot afford, especially after nearly ten years at war.

Family members are a key component to a service member's psychological well-being. They must be included in mental health counseling and treatment programs for service members. Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. We recommend an extended outreach program to service members, veterans, and their families of available mental health resources through DoD and VA with providers who inherently understand military culture. We appreciate the VA allowing family member access to Vet Centers; however, we encourage them to develop more family-oriented programs. DoD must also look beyond its own resources to increase mental health access by working with other government agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), especially SAMHSA's Military Families Strategic Initiative, and encourage State agencies to provide their already established services and programs to service members, veterans, and family members. DoD must also educate these other agencies about military culture to make the providers more effective in their support.

Frequent and lengthy deployments create a sharp need in mental health services by family members and service members as they get ready to deploy and after their return. Embedding mental health providers in medical home modeled clinics will allow easier access for our families. There is also an increase in demand in the wake of natural disasters, such as hurricanes and fires. DoD must maintain a flexible pool of mental health providers that can increase or decrease rapidly in numbers depending on demand on the MHS side. Currently, Military Family Life Consultants and Military OneSource counseling are providing this type of preventative and entry-level service for military families. The web-based TRICARE Assistance Program (TRIAP) offers another vehicle for non-medical counseling, especially for those who live far from counselors. The military Services, along with military family members, need to be more aware of resources along the continuum of mental health support. Families need the flexibility of support in both the MHS and family support arenas, as well as coordination of support between these two entities.

There are other barriers to access for some in our population. Many already live in rural areas, such as our Guard and Reserve, or they will choose to relocate to rural areas lacking available mental health providers. We need to address the distance issues families face in finding mental health resources and obtaining appropriate care. Isolated service members, National Guard and Reserve, veterans, and their families do not have the benefit of the safety net of services and programs provided by MTFs, military installation based support programs, VA facilities, Community-Based Outpatient Centers, and Vet Centers. We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture.

The Defense Centers of Excellence is providing a transition benefit for mental health services for active duty service members, called *inTransition*. Our Association recommends this program be expanded to provide the same benefit to active duty spouses and their children. Families often complain about the lack of seamless transition of care when they PCS. This program will not only provide a warm hand-off between mental health providers when moving between and within Regions, but more importantly, enable mental health services to begin during the move, when families are between duty stations and most vulnerable.

Communities and nongovernment organizations are stepping up to provide mental health services, but more needs to be done. Our Association recently developed a Community Toolkit outlining how community members such as health care providers, educators, and child and youth serving organizations can better support military families. We have been working closely with the White House and the First Lady Michelle Obama and Dr. Biden's military family initiative. We look forward to discussing this initiative with you further.

We recommend an extended outreach program to service members, veterans, and their families of available psychological health resources, such as DoD, VA, and State agencies. We encourage Congress to request DoD to include families in its Psychological Health Support survey and perform a pre and post-deployment mental health screening on family members (similar to the PDHA and PDHRA currently being done for service members). We recommend the use of alternative treatment methods, such as telemental health; increasing mental health reimbursement rates for rural areas; modifying licensing requirements in order to remove geographic practice barriers that prevent mental health providers from participating in telemental health services; and educating civilian network mental health providers about our military culture. Our Association recommends the "inTransition" program be expanded to provide the same benefit to active duty family members.

Wounded Service Members Have Wounded Families

Our Association asserts that behind every wounded service member and veteran is a wounded family. It is our belief the government, especially the DoD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded, ill, and injured service member must also consider the needs of the spouse, children, parents of single service members and their siblings, and the caregivers. DoD and VA need to think proactively as a team and one system, rather than separately; and addressing problems and implementing initiatives upstream while the service member is still on active duty status.

Reintegration programs become a key ingredient in the family's success. For the past three years, we have piloted our *Operation Purple® Healing Adventures* camp to help wounded, ill, and injured service members and their families learn to play again as a family. We hear from the families who participate in this camp, as well as others dealing with the recovery of their wounded service members, that, even with Congressional intervention and implementation of the Services' programs, many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/lover with an injury. Each member needs to understand the unique aspects the injury brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes all must focus on treating the whole family, with DoD and VA programs offering skill based training for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of deployment and the reintegration process.

DoD, the VA, and non-governmental organizations must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

DoD and the VA must do more to work together both during the treatment phase and the wounded service member's transition to ease the family's burden. They must break down regulatory barriers to care and expand support through the Vet Centers the VA medical centers, and the community-based outpatient clinics (CBOCs). We recommend DoD partner with the VA to allow military families access to mental health services throughout the VA's entire network of care using the TRICARE benefit. Before expanding support services to families, however, VA facilities must establish a holistic, family-centered approach to care when providing mental health counseling and programs to the wounded, ill, and injured service member or veteran.

We remain concerned about the transition of wounded, injured, and ill service members and their families from active duty status to that of the medically-retired. While we are grateful, DoD has proposed to exempt medically-retired service members, survivors, and their families from the TRICARE Prime enrollment fee increases, we believe wounded service members need even more assistance in their transition. We continue to recommend that a legislative change be made to create a three-year transition period in which medically-retired service members and their families would be treated as active duty family members in terms of TRICARE fees, benefits, and MTF access. This transition period would mirror that currently offered to surviving spouses and would allow the medically-retired time to adjust to their new status without having to adjust to a different level of TRICARE support.

We ask Congress to allow medically-retired service members and their families to maintain the active duty family TRICARE benefit for a transition period of three years following the date of medical retirement.

There are many other health care and behavioral care issues facing our service members, our wounded, ill and injured service members and their families. We will expand on other aspects of the quality of life of military families in our statement for the record for the Subcommittee's hearing on Military Personnel issues scheduled for March 17, 2011.

Kathleen B. Moakler
Government Relations Director
National Military Family Association

Mrs. Moakler has been associated with the National Military Family Association since 1995 as a member of the headquarters staff. She was appointed as Government Relations Director in October 2007. In that position, she monitors the range of issues relevant to the quality of life of the families of the seven uniformed services and coordinates a staff of 4 deputy directors.

Mrs. Moakler represents the interests of military families on a variety of advisory panels and working groups, including the DoD/VA Survivors Forum, and the State Department Interagency Roundtable.

Mrs. Moakler is co-chair of the Survivors Committee for the Military Coalition (TMC), a consortium of 34 military and veteran organizations and serves on the Retiree Committee. She is often called to comment on issues pertaining to military families for such media outlets as the NY Times, CNN, NBC news and the Military Times. She writes regularly for various military related and Association publications.

An Army spouse of over 28 years, Mrs. Moakler has served in various volunteer leadership positions in civilian and military community organizations in that time. Through the years, Mrs. Moakler has worked with many military community programs including hospital consumer boards, commanders' advisory boards, family readiness groups, church councils, youth programs, and the Army Family Action Plan at all levels. She believes that communication is paramount in the efficient delivery of services and the fostering of a rich community life for military families. She holds a Bachelor of Science degree in Business Administration from the State University of New York at Albany. Mrs. Moakler has been awarded the Army Commanders Award for Public Service and the President's Volunteer Service Award.

Mrs. Moakler is also a military mom. Her daughter is an Army nurse with two tours to Iraq and one son is an Army major stationed at Ft. Belvoir, Virginia. Her oldest son is an aspiring actor in Hollywood, California. Mrs. Moakler and her husband, Colonel Martin W. Moakler Jr. USA (retired), reside in Alexandria, Virginia.

Written Testimony on Health Care
Reserve Officers Association of the United States
And
Reserve Enlisted Association

for the

House Armed Services Committee
Subcommittee on Military Personnel

March 16, 2011



"Serving Citizen Warriors through Advocacy and Education since 1922."™



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The Reserve Officers Association of the United States (ROA) is a professional association of commissioned and warrant officers of our nation's seven uniformed services, and their spouses. ROA was founded in 1922 during the drawdown years following the end of World War I. It was formed as a permanent institution dedicated to National Defense, with a goal to teach America about the dangers of unpreparedness. When chartered by Congress in 1950, the act established the objective of ROA to: "...support and promote the development and execution of a military policy for the United States that will provide adequate National Security." The mission of ROA is to advocate strong Reserve Components and national security, and to support Reserve officers in their military and civilian lives.

The Association's 60,000 members include Reserve and Guard Soldiers, Sailors, Marines, Airmen, and Coast Guardsmen who frequently serve on Active Duty to meet critical needs of the uniformed services and their families. ROA's membership also includes officers from the U.S. Public Health Service and the National Oceanic and Atmospheric Administration who often are first responders during national disasters and help prepare for homeland security. ROA is represented in each state with 55 departments plus departments in Latin America, the District of Columbia, Europe, the Far East, and Puerto Rico. Each department has several chapters throughout the state. ROA has more than 450 chapters worldwide.

ROA is a member of The Military Coalition where it co-chairs the Tax and Social Security Committee. ROA is also a member of the National Military/Veterans Alliance. Overall, ROA works with 75 military, veterans and family support organizations.

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The Reserve Enlisted Association is an advocate for the enlisted men and women of the United States Military Reserve Components in support of National Security and Homeland Defense, with emphasis on the readiness, training, and quality of life issues affecting their welfare and that of their families and survivors. REA is the only Joint Reserve association representing enlisted reservists – all ranks from all five branches of the military.

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DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Reserve Officers and Reserve Enlisted Associations are member-supported organizations. Neither ROA nor REA have received grants, sub-grants, contracts, or subcontracts from the federal government in the past three years. All other activities and services of the associations are accomplished free of any direct federal funding.

INTRODUCTION

In answering the call-up, over 800,000 reserves have been mobilized cumulatively since the issuance President Bush's issued Executive Order 13223 on September 14, 2001.

ROA and REA thank the Military Personnel subcommittee for the chance to present testimony on behalf of the 1.1 million Ready Reservists affected by medical readiness, and for the retirees of the National Guard and Reserve who continue to be entitled to health care. Further we would like to thank the committee for expanding the pre-activation TRICARE coverage for recalled Guard and Reserve members prior to reporting for mobilization, and for passage of TRICARE Retired Reserve.

But as the topic of Health Care fees is a focus of today's hearing, let it be mentioned that while increases to retiree TRICARE Prime and Standard fees were prohibited in FY 2011, the premiums for both TRICARE Reserve Select and TRICARE Retired Reserve were overlooked, and increased by the Department of Defense (DoD).

We also commend your committee on working the health care issues for the young men and women who are deployed overseas, and stationed at home. But the transition between health plans is far from seamless. Oftentimes military leadership is encouraging Guard and Reserve members who are returning from mobilization to seek health coverage from the Department of Veteran Affairs rather than utilizing the transitional TRICARE benefit.

EXECUTIVE SUMMARY

Increasing the cost-share of DoD health care beneficiaries is admittedly an emotional issue. The nation and the Department of Defense are faced with ever increasing health care costs, but this is not simply a budgeting exercise. Because of the dynamics involved, this is an issue that should be resolved by involving all those who are concerned. Here is a summary of the key points as seen by the Reserve Officers Association (ROA) and the Reserve Enlisted Association (REA).

Currently the Secretary of Defense has the authority to make changes in TRICARE fees and copayments without Congressional approval. The prime example of this in FY-2011 was the increase of TRICARE Reserve Select and TRICARE Retired Reserve Premiums.

Congress must maintain an oversight over DoD health care, preventing capricious fee increases to beneficiaries.

TRICARE Prime:

- The proposed \$30 increase for individuals and \$60 for families is a modest proposal.
- If indexed, adjustments to the enrollment fee should be population based rather than industry-based.
- It is important to independently verify the current total cost of DoD health care benefits. Such an audit will permit Congress to validate proposals based on cost-sharing percentages.
- Annual increases should **not** be tied to the market-driven Federal Employee Health Benefits Plan (FEHBP) or a commercial plan.

On Pharmacy Co-payments:

- ROA and REA believe higher retail pharmacy co-payment should not apply on initial prescriptions, but on maintenance refills only.
- ROA and REA support DoD efforts to enhance the mail-order prescription benefit.

Sole Community Hospitals:

- Fee adjustments must be approached with caution because of inconvenience to beneficiaries.

US Family Health Plan – Medicare coverage:

- ROA and REA support continuation of the Medicare coverage as part of USFHP.
- To maintain the program, a mandatory Part “B” payment might be considered.

Reserve Health Care Initiatives:

- Improve continuity of health care for all drilling Reservists and their families by:
 - o Auditing the assumptions used for TRICARE Retired Reserve premiums
 - o Providing Continuing Health Benefit Plan to traditional Drilling Reservists who are beneficiaries of TRICARE Reserve Select but are separated from the Selected Reserve to provide COBRA protections.
 - o Permitting active members in the Individual Ready Reserve (IRR) to buy-into TRICARE Reserve Select.
 - o Allowing demobilized Retirees and Reservists involuntarily returning to IRR to qualify for subsidized TRS coverage.
 - o Providing TRS coverage to mobilization ready IRR members; levels of subsidy would vary for different levels of readiness.
 - o Improving post deployment medical and mental health evaluations and access to care for returning Reserve Component members.
 - o Providing an option for Reservists where DoD pays a stipend to employers.
- Extend military coverage for restorative dental care following deployment to 90 days.
- Permit beneficiaries of Federal Employee Health Benefit plan the option of subscribing to TRICARE Reserve Select.

DISCUSSION**MILITARY HEALTH CARE – a shaky foundation.**

The Global War on Terror is a protracted engagement that will not end with the withdrawal of troops from Iraq and Afghanistan. Overseas Contingency Operations (OCO) will continue, as will military response to crisis spots such as Libya. Yet, at the same time the Fiscal Year 2011 (FY-2011) Defense Budget may be reduced.

Included in the Budget release is a statement that the president has moved \$73 billion from the OCO to the base budget (pg 61). While the budget at \$553 billion appears as a gross increase of \$22 billion above FY-2010, this shift from OCO to the base budget is a de facto cut of \$51 billion with spending on certain items being trimmed down from the FY-2010 base budget.

In addition, the political atmosphere is focusing debate on correcting the growing National Deficit. "Our national debt is our biggest national security threat," said Admiral Mike Mullen, Chairman of the Joint Chiefs of Staff at a "Tribute to the Troops" breakfast, last summer."

And there are members on both sides of the aisle that are saying if cuts are made then Defense should not be exempt. Lawmakers are talking openly about TRICARE fees not having been increased since 1995.

For a number of years, the Pentagon has spoken out about the rising costs of health care and the need for reform. This can be noted by statements illustrating that military health costs have increased such as "DoD medical costs have shot up from \$19 billion in FY 2001 to \$52.5 billion in FY 2012," as made by Deputy Secretary of Defense William J. Lynn, III at a Senate Budget hearing this month, or hyped by statements such as "Healthcare costs are eating the Defense Department alive," as said by Secretary of Defense Robert M. Gates.

In February, Admiral Mullen told the House Armed Services Committee as a whole that people costs account between 60 to 70 percent of the Pentagon budget. The Hill newspaper also quotes Mullen as saying that "the military is 'on track to almost be immobilized' by healthcare and benefits costs. Yet it has been calculated that personnel costs will be \$244 billion in 2010, just under 40 percent of the \$636 billion appropriated to DoD.

Health care costs now consume nine percent of the DoD budget. Yet comparisons of health care costs are distorted by beginning with a peacetime starting point followed by a decade of war. Still judging from what has been said to both Congress and the press, it would seem that many in the Pentagon are attributing the increases in military health care to its retirees, especially those working second careers.

Unfortunately, many retirees are blaming much of this additional health care costs on National Guard and Reserve members for being included under TRICARE.

The Pentagon's public campaign for health care reform has undercut its credence by serving members, retirees and beneficiary associations in what has been said, what has been budgeted, and what still might be planned.

HEALTH CARE COST DISCUSSION

The Reserve Officers Association and the Reserve Enlisted Association are disappointed in how the Department of Defense Health Affairs has in the past attempted to address such an emotionally laden issue unilaterally. While this year, the Pentagon has made efforts to meet with beneficiary associations, these gathering have been more briefings rather than discussions to seek solutions. ROA and REA would like to thank Congress for its continued involvement on DoD health care issues and hope it remain a leading partner on these issues.

ROA and REA applaud the efforts by Congress to address the issue of increasing Department of Defense health care costs and its interest to initiate dialogue and work with both the Pentagon and

the beneficiary associations to find the best solution. The time has come to examine the cost of TRICARE and the level of beneficiary contribution.

It is important to sustain the DoD health care as a deferred benefit for our serving Active and Reserve Component members and their families. While retired, these beneficiaries have accepted risks and made sacrifices in their earlier military careers that have not been asked of the remaining 99 percent of the nation's population. TRICARE fulfills an on-going promise by the government for continued health care to those who have served or are serving.

ROA and REA are committed to our membership to sustain this health care benefit. We fear that Congress will be unable to continue prohibitions on health care fees. DoD, Congress and the beneficiary associations need to work together to find a fair and equitable solution that protects our beneficiaries and ensures the financial viability of the military health care system for the future. Some associations seek to continue a freeze on premium fees permanently; others are joining ROA and REA by admitting that some increases are necessary.

Conversely, the Department of Defense and this nation cannot afford to carry the full burden of health care costs. The operational Active and Reserve force and their families deserve the best, both while serving and into retirement. To preserve the top health care program in the nation as a DoD benefit, ROA and REA are open to discussions on cost-sharing.

Beneficiary medical expense totals have not yet been provided by DoD. Congress should ask the Pentagon for a financial breakdown. An independent audit by the Government Accountability Office (GAO) or another agency would allow Congress an opportunity to validate proposals based on financial benchmark.

ROA and REA agree that the proposed \$30 increase for individuals and \$60 for families is a modest proposal, and can accept this as a first step.

Of concern is a proposal to index future increases. Having some formula in place seems appropriate, following a similar approach to what was taken by Congress to calculate cost of living allowances (COLA) for social security and military retirement pay. But the challenge is, **What index to select?**

ROA and REA agree with other beneficiary associations that it should not be a Medicare Index, because a Medicare-based index penalizes those retirees under age 65 who don't suffer from the same ailments as retirees in the older age group.

ROA also found that contracted commercial indexes tend to maximize health care growth, likely justifying the higher premium increases associated with commercial health insurance and should not be used. Comparisons between commercial and military health care plans are not justified.

ROA is continuing to explore indices, but the challenge is that even government matrixes are based on an industry and not actual beneficiary health care costs.

ROA and REA share the concern that any process used should be a fair and equitable approach where retiree's won't be overburdened. Should an index be agreed upon, it should be codified.

HEALTH CARE REFORM DISCUSSION

The beneficiary associations were invited to the Pentagon for a meeting with Dr. Clifford L. Stanley, Under Secretary of Defense for Personnel and Readiness about the health reform proposals. At this meeting it was stated that the FY-2012 proposal was enough to cover what was needed in the FY-12 budget, and if more was needed the next year, DoD would submit additional proposals.

During the first week of March, the Pentagon also announced that John Baldacci, former governor of Maine, has been hired into in a newly created position to recommend to Dr. Stanley "necessary reforms for the military health care system."

Statements like these combined with the DoD public relations health care costs campaign makes both retirees and beneficiary associations nervous.

In anticipation of less modest proposals in the future ROA and REA include the following:

TRICARE:

- Catastrophic Cap of \$3000 should not be changed, nor indexed.

TRICARE Standard:

- ROA and REA do not endorse an annual enrollment fee for either DoD or VA beneficiaries.
- Should DoD suggest increasing deductible levels, the total cost of Standard needs to be evaluated, because...
- Standard has large co-payments of 25 percent after the deductible, and the cost of TRICARE standard automatically adjust to changes in medical costs.
- For individuals or families relying on Standard for medical treatment, it is a more expensive health plan than TRICARE Prime.

TRICARE Reserve Select (TRS)

- DoD should stop viewing TRS as a health insurance, but as a health program.
- TRICARE standard deductible increases should not be rolled over into TRS.

TRICARE Retired Reserve (TRR)

- Premiums are too high, and for TRR to be viable, premiums need to be reduced.

RESERVE COMPONENT HEALTH CARE DISCUSSION

The Pentagon views TRICARE as a health care plan, and Reserve TRICARE as a health care insurance. Because words create paradigm, Reserve health care is treated by DoD entirely different than active duty health care. The differences are easily noted: Active duty members enroll in a benefit with deductibles and co-payments; Guard and Reserve members "purchase" a premium based health plan. The following are suggested improvements.

1. ROA and REA hold concerns over the implementation of TRICARE for gray area retirees. Because DoD treated Reserve gray area retirees as a separate health care risk group, health care premiums proved higher than expected. Because of the expense, enrollment is low. It is likely just being used by those with health care problems, who can't afford health care from other sources. If the program is not changed it will have a similar success to mobilization insurance.

ROA and REA hope that the committee will request a Government Accountability Office review of the process that determined the published premium levels.

2. Seamless Transition. Service members should not have to navigate through bureaucracy to receive care or benefits. Every time a Reserve Component member transitions into a new category of health care, he or she is required to reenroll in the new program. Even those who are beneficiaries of TRICARE Reserve Select (TRS) need to do an administrative transition between TRS, TRICARE once mobilized, into Transitional Assistance Management Program (TAMP) and back onto TRS. And once retired, there is additional transition into TRICARE Retired Reserve, and the latter TRICARE retiree health care. Add to this the additional health care provided by the Department of Veteran Affairs, and there are gaps in health care as a Reserve Component or family member moves between programs.

3. Access to TAMP. It has come to ROA's attention that some Guard and Reserve members who have returned from deployment may not be provided TAMP coverage. In one particular case, an individual who was placed in a wounded warrior company, after being found fit, was told that she would not qualify for transitional health care upon discharge because of how her orders were written while a wounded warrior.

ROA and REA feel that all members being separated from Active Duty should qualify for TAMP.

4. Sustaining Reserve Health Care. *Continued Health Care Benefit Plan* continues to be shown as only allowing members of the Selected Reserve who have had a tour of active duty within the previous 18 months by DoD. This is denying COBRA protections for TRS beneficiaries who haven't be activated, and doesn't support the Secretary of Defense's directive to mobilize National Guard and Reserve members one year out of six, which would be a dwell time of 60 months. There is little cost as the beneficiary pays a premium of 102 percent of TRICARE Cost.

As even discharged active service members have the benefit of the Continuing Health Care Benefit Plan, those Guard and Reserve members who have signed up for TRICARE Reserve Select need to have protections when they leave the Selected Reserve.

ROA and REA encourage Congress to work with the Pentagon to open up Reserve Component member access to the Continued Health Care Benefit Plan to any TRICARE Reserve Select beneficiary separating from the Selected Reserve under conditions that are not punitive in nature.

5. Employer health care option: DoD pays a stipend to employers of deployed Guard and Reserve members to continue employer health care during deployment. G-R family members are eligible for TRICARE if the members' orders to Active Duty are for more than 30 days; but some families would prefer to preserve the continuity of their own health insurance. Being dropped from private sector coverage as a consequence of extended activation adversely affects family

morale and military readiness and discourages some from reenlisting. Many G-R families live in locations where it is difficult or impossible to find providers who will accept new TRICARE patients. This stipend would be equal to DoD's contribution to Active Duty TRICARE.

ROA and REA continue to support an option for individual Reservists where DoD pays a stipend to employers

6. Dental Readiness. Currently, dental readiness has one of the largest impacts on mobilization. The action by Congress in the FY-2010 NDAA was a good step forward, but still more needs to be done.

The services require a minimum of Class 2 (where treatment is needed, however no dental emergency is likely within six months) for deployment. Current policy relies on voluntary dental care by the Guard or Reserve member. Once alerted, dental treatment can be done by the military, but often there isn't adequate time for proper restorative remedy.

ROA and REA continues to suggest that the services are responsible to restore a demobilized Guard or Reserve member to a Class 2 status to ensure the member maintains deployment eligibility.

Because there are inadequate dental assets at Military Treatment Facilities for active members, active families, and reservists, **ROA and REA further recommend that dental restoration be included as part of the six month TAMP period following demobilization.** DoD should cover full costs for restoration, but it could be tied into the TRICARE Dental program for cost and quality assurance.

7. Utilization of TRS: ROA and REA support efforts by the Pentagon to encourage enrollment in TRICARE Reserve Select. We share a concern that the numbers being published by the Pentagon understate the actual level of participation by Guard and Reserve members who are eligible. A survey should be taken of TRICARE contractors to compare their participation measures with those of DoD.

8. IRR Access to TRS: Not everyone who drills is eligible for TRS. All services offer drilling for points without pay. These members are in the IRR. The Navy has Voluntary Training Units. The Air Force and Army have non-paid Individual Mobilization Augmentees (IMA). The Army also has a group within the IRR body that has agreed to mobilization during their first two years.

The Army, the Marine Corps and the Navy have mobilized Reservists out of the Individual Ready Reserve. Under current law, unless these RC members are given an opportunity to join the Selected Reserve, they are not eligible to purchase TRS.

ROA and REA feel that IRR members should be eligible for TRS. They could qualify if they sign an agreement of continued service and complete a satisfactory year of training and satisfy physical standards. A satisfactory year could be defined either by points or by training requirements, as defined by each Reserve Chief.

ROA and REA recommend legislation to allow IRR buy-in to TRICARE Reserve Select.

CONCLUSION

ROA and REA reiterate their profound gratitude to the subcommittee for addressing the health care issues. The process that we develop and what we decide upon this year for TRICARE fees and sustained benefits reflects not only our recognition of retired members for their service to the nation, but is a dedication to the warriors of the future.

Service members deserve the best medical care that the nation can offer. Health care services are vital to keeping the nation's military force strong and ready. As a deferred benefit, it serves as a recruiting as well as a retention tool, as the willingness of the young to serve will depend on how they perceive the treatment and appreciation given to earlier veterans.

When a nation puts members of its military at physical risk from disease and traumatic injury it absolutely owes them health care not health insurance.

ROA and REA strongly urge that when all cost-sharing is finally taken into account, our beneficiaries must receive the DoD provided health care to which they are entitled.

Captain Marshall Hanson, USNR (Ret.)
ROA Director, Legislative and Military Policy

Captain Marshall Hanson became the Legislative Director of the Reserve Officers Association on 12 September 2005, two years after joining the ROA staff as the Naval Services Director. Not new to Washington DC, he brings to the ROA team experience and success as the full time Director of Legislation for two other associations, Naval Reserve Association and the National Association for Uniformed Services. Marshall brings to the ROA extensive expertise, working with the House and Senate Armed Services Committees, and with Defense Appropriations. He has gone through more than eleven legislative cycles. In 2000, Marshall participated with the Reserve Officers Association in a Roles and Missions study that submitted a white paper to Congress and the Pentagon.

CAPT Hanson has testified before the House and Senate Armed Services committees, the Senate Appropriations subcommittee on Defense, the House Veterans Affairs committee and Senate Finance committee, and before the National Reserve Force's Policy Board on Guard and Reserve issues.

He has been chairman of the Navy Marine Corps Council, co-director of the National Military and Veteran's Alliance, and chairman for the Tax Committee in The Military Coalition. In 1999, he moved to Alexandria, VA from Seattle, Washington to join the NRA staff. Marshall has worked to develop a new adhoc committee, Associations for America's Defense (A4AD), coordinating eleven other associations on national security, force planning and equipment issues, which were normally not covered by either the Coalition or the Alliance.

Captain Hanson was born in Darby, Pennsylvania and raised in Glen Rock, New Jersey and Seattle, Washington. A 1972 Graduate of the University of Washington, he was commissioned by the U of W NROTC. He earned an MBA from the University of Washington in 1978, and is a 1990 graduate with distinction of the Naval War College. With a Fleet Support designator, he is a qualified, specialist in strategic operations, analysis and planning.

CAPT Marshall Hanson retired from the Naval Reserve in August of 2002. With over three years of active duty and twenty-seven years with the Reserves, Hanson's had seven commands, and has collectively commanded over 200 people. Marshall's seagoing assignments include active duty on *USS Niagara Falls* (AFS-3) as an underway Officer of the Deck (I) and Damage Control Assistant. He has spent additional training periods aboard *USS Kansas City* (AOR-3), *USS Blue Ridge* (LLC-19), JMDS *Isoyuki* (DD-127), and various Canadian Naval Reserve Ships; and he has been the Chief of Staff for a Convoy Commodore, and staff-watch commander at Esquimalt Naval Base in Canada.

Upon retirement CAPT Hanson was awarded the Meritorious Service Medal; he was also awarded the Military Outstanding Volunteer Service Medal in 1997 for community activities in the greater Puget Sound Area. He has twice been awarded the overseas ribbon, and has the Vietnam Campaign Medals and National Defense Service Medal. Prior to his move to Washington D.C., he was a Materials Manager for a Seattle manufacturing company in his civilian career. He and his wife, Deborah, reside in Alexandria, VA and have two daughters, Loren Louise, age 18 and Sydney Emilia, 12 years.



Written Statement for the Record of

THE US FAMILY HEALTH PLAN ALLIANCE

FOR

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

March 16, 2011

Introduction

Mr. Chairman, Representative Davis, and distinguished members of the House Armed Services Personnel Subcommittee, thank you for the opportunity to provide you with testimony regarding the Uniformed Services Family Health Plan (US Family Health Plan) and our concern about a proposal contained in the President's Budget Request for Fiscal Year 2012 that, if enacted, would preclude us from caring for many of our nation's heroes and their families. As a longstanding partner with the Military Health System, the US Family Health Plan represents a stable and well-managed health care plan providing substantial value for uniformed services beneficiaries and for the Department of Defense (DoD).

The US Family Health Plan is a DoD-sponsored health plan, made available by nonprofit healthcare providers in six service areas across the country. The US Family Health Plan has over 30 years experience in providing healthcare to military beneficiaries. We offer the TRICARE Prime benefit to active duty family members, including activated Guard and Reserve family members, and retirees and their family members, including those age 65 and older. The six not-for-profit healthcare organizations administering the US Family Health Plan include:

- **Brighton Marine Health Center:** Serving Massachusetts and Rhode Island
- **CHRISTUS Health:** Serving southeastern Texas and western Louisiana
- **Johns Hopkins Medicine:** Serving Maryland, Washington DC, parts of Pennsylvania, Virginia, Delaware, and West Virginia
- **Martin's Point Health Care:** Serving Maine, New Hampshire, Vermont and Upstate and Western New York, and Northern Pennsylvania
- **Pacific Medical Centers:** Serving the Puget Sound area of Washington State
- **St. Vincent's Catholic Medical Centers of New York:** Serving New York City, Long Island, Southern Connecticut, Southeastern Pennsylvania, and New Jersey

Longstanding Partnership with DoD

The US Family Health Plan grew out of a longstanding relationship that DoD has had with several former U.S. Public Health Service facilities. The program had its origins in 1981 when Congress, in Section 987 of Public Law 97-34, authorized the transfer of ten US Public Service hospitals and clinics to public or private not-for-profit health care entities. Congress required at the time that these facilities continue to be used for health care purposes. Later that year, Congress adopted an amendment to the FY 1982 Military Construction Authorization Act (Public Law 97-99, Section 911) that designated these former Public Health Service facilities as "treatment facilities of the uniformed services." As a result, military beneficiaries who were eligible to receive care at military treatment facilities, including those age 65 and over, were entitled to care at what became known as the Uniformed Services Treatment Facilities (USTFs).

In 1993, the USTFs were mandated to provide services through a fully at risk managed care health plan.

With the introduction of the TRICARE Program, the FY 1997 Defense Authorization Act (the "Act") made the entities that owned the USTFs, now described as TRICARE Designated Providers, a permanent part of the MHS. The Designated Providers were explicitly authorized to offer the TRICARE Prime option for military beneficiaries in their service areas, other than active duty, but including those aged 65 and older. The Act made the fully at risk managed care model of the program (now known as the US Family Health Plan) permanent as well.

The Act provided the basis on which the relationship of the Designated Providers and DoD has gone forward in a constructive partnership that has worked very successfully to promote high quality and effective care for uniformed services beneficiaries. Today, the US Family Health Plan provides the TRICARE Prime benefit to nearly 115,000 military beneficiaries in 16 states and the District of Columbia.

The US Family Health Plan is a fully at risk managed care program that receives payment from DoD on a per member-per month (capitated) basis. From a financial point of view, the US Family Health Plan represents for DoD a fixed and predictable annual budget, which varies only by the number and demographics (e.g., age, sex) of our enrolled population, not our cost of providing services. There are no retroactive adjustments. The US Family Health Plan carries the full liability of the beneficiaries' care throughout their enrollment in the Plan.

Further, by statute, total capitation payments for health services to an enrollee of the US Family Health Plan cannot exceed an amount equal to the cost that the Government would have incurred if the enrollee had received such health care services through alternatives to US Family Health Plan, whether they be Military Treatment Facilities, TRICARE, or Medicare.

As a partner with the Military Health System, we have aligned ourselves with the stated goals of the System outlined in the Quadruple Aim strategy. The Quadruple Aim strategic imperatives focus on readiness, experience of care, population health, and per capita cost. The US Family Health Plan is doing its part to ensure these common goals are met in the following ways:

- **Readiness:** We understand the vital link between combat readiness and family readiness that has been espoused widely by DoD leadership. Keeping the military families we serve healthy is a key factor in family readiness, and we have actively engaged our beneficiaries in prevention and wellness programs designed to meet these family readiness needs. Further, we have a longstanding partnership with the National Military Family Association and together we created a series of public service announcements educating the general public on how they can support military families. These have reached over seven million people nationwide.
- **Experience of Care:** US Family Health Plan delivers accountable care through an integrated delivery system. It provides patient-centered and coordinated care with the overall goal of improving the patient's experience of care. The US Family Health Plan

has embraced the Patient Centered Medical Home concept as outlined in DoD policy. We are providing patient-centric, coordinated and integrated health care in NCQA-certified medical home programs to almost 30,000 beneficiaries at four of our sites.

Our patient-centered approach is clearly successful from the beneficiary point of view. The US Family Health Plan has conducted enrollee satisfaction surveys via independent firms since 1994. Each year, US Family Health Plan members are surveyed by an independent, NCQA certified vendor. In this year's survey, 91% of those surveyed rated the US Family Health Plan overall as 8 or higher on a ten-point scale on which 10 is the highest or best. In comparison only 62% of members in commercial managed care plans rated their plans at 8 or higher. In addition to overall satisfaction, the US Family Health Plan scores significantly higher than this national benchmark in claims processing, customer service, courteous and helpful office staff, how well doctors communicate, getting care quickly and getting needed care, rating of doctor and rating of health care. Overall, the US Family Health Plan has a strong customer service focus and a network of member services functions designed to address member concerns and health care needs in a timely manner.

We realize that the US Family Health Plan is one of a series of options available to our beneficiary population and thus must continue to strive to meet our enrollees' expectations. We understand that member loyalty develops when health plans consistently meet or exceed the expectations of their members, and that loyal members remain with a health plan, allowing it to recoup its up-front investment in enrolling, orienting and transitioning members into care. In our 2010 survey, over 82% of our beneficiaries indicated that they did not plan on switching to another health plan, and would recommend the US Family Health Plan to family and friends.

- **Population Health:** With the patient as the focal point, US Family Health Plan is focused on quality and improved health outcomes. With over 40 active care and disease management programs available to our beneficiaries, we are providing the full spectrum of care from prevention and wellness to intensive case management. With prevention and wellness as a key focus, two of our plans, Martin's Point Health Care and CHRISTUS Health, were selected by DoD as demonstration sites for the Congressionally mandated Military Health Risk Management Demonstration Program. This demonstration project will assess the effects of providing incentives along with wellness programs and healthy behaviors and lifestyle practices among military beneficiaries. We are very proud to be part of this important project that will inform prevention strategies for the future.

For those beneficiaries requiring more targeted clinical interventions, approximately 21% of our enrollees are currently participating in a care or disease management program. These programs are having demonstrated beneficial clinical outcomes, including reducing inpatient admissions, emergency room visits, and keeping our members healthier. This contributes to the high enrollee rate of satisfaction we experience.

With approximately one-third of our beneficiaries being aged 65 and over, we have developed special expertise in addressing the health care needs of these beneficiaries. Based on our experience with our 65 and over enrollees, we believe that a structured care environment like US Family Health Plan works most effectively for the overall management of these beneficiaries.

- **Per Capita Cost:** With a focus on quality and a longitudinal approach to health and wellness over the lifespan of our beneficiaries, the US Family Health Plan creates value for the Military Health System by managing the total cost of care over time, not just the cost of an individual health care activity. Because we are capitated, our beneficiaries receive all of their care within the US Family Health Plan and we necessarily focus financial and human resources on the health needs and requirements of our enrollees in a structured care environment. The alignment of financial incentives and health care risk under capitation clearly impacts greatly on the effectiveness of the medical management of the beneficiaries we serve. The acceptance of full risk by the six Designated Providers requires each of us to develop and implement accurate measurements of outcomes, both clinical and financial, and continuously to monitor and improve the care of our enrollees.

DOD Budget Proposal

We understand the fiscal challenges our country is facing. We also understand the impact of ever increasing health care costs on the DoD budget. We have partnered with DoD for 30 years and evolved into a program that can and will support the needs of DoD and its beneficiaries into the future. The patient-centered, longitudinal health management approach utilized by our plan members will continue to maintain the health and well being of our beneficiaries and control long-term costs for DoD.

The FY 2012 President's Budget Request includes a proposal that, as we currently understand it, would shift future US Family Health Plan members to Medicare when they reach the age of 65. The proposal would not save the government money overall, but would merely shift financial liability from DoD to Medicare for these beneficiaries.

Section 726(b) of the Act, which originated in the House Armed Services Committee's Subcommittee on Personnel, states that the capitation payments for health care services to a Designated Provider (US Family Health Plan sponsor) shall not exceed an amount equal to the cost that would have been incurred by the Government if the enrollee had received such health care services through a military treatment facility, the TRICARE program, or the Medicare program, as the case may be. The rates calculated based on this statutory limit are referred to as the "ceiling rates."

Based on this statutory requirement, DoD annually sets the ceiling rates for US Family Health Plan enrollees, both those under 65 years of age and those aged 65 and over. Recently, US Family Health Plan representatives were advised by the TRICARE Management Activity (TMA) Program Office that an independent audit of the ceiling rate process and methodology conducted in 2010 affirmed that the ceiling rate methodology was determined to be actuarially sound and consistent with the statutory requirement of Section 726(b).

By law and through the annual rate setting process, as validated by the recent study, US Family Health Plan rates cannot exceed the costs the Government would otherwise incur, through TRICARE and Medicare, for health services provided to these beneficiaries. In simplest terms, then, the DoD budget proposal would save the Government no money. Its only accomplishments would be to undermine the US Family Health Plan, initially by denying access for a vulnerable population - beneficiaries aged 65 and over - to an effective and successful program, and, ultimately, by depriving our Plan of the critical mass of enrollees necessary to run viable at-risk health services programs.

The DoD budget estimates shift liability from TRICARE to Medicare but do not give proper recognition to the requirement of Section 726(b) of the Act. And, in any event, the estimates are inconsistent and misleading. Most notably the detailed budget tables show the pay as you go (PAYGO) savings for 2012-2016 for DoD to be \$84M, but in the budget estimate this amount is offset by an increase in Medicare costs of only \$50M. Under the ceiling rate methodology established pursuant to Section 726(b), any reduction in DoD's costs would be entirely offset by increases in Medicare costs.

Without even considering the budgetary implications, DoD's proposal included in the FY 2012 President's Budget request is inconsistent with DoD's stated priorities of population health, improved health management and continuity of care. The members of TMA's policy staff who are knowledgeable about US Family Health Plan were not involved in or familiar with this budget proposal prior to its submission. The proposal seems to represent an exercise designed to create the appearance of savings, but all it would do is shift responsibility to Medicare without generating any reduction in Government costs, while at the same time, however, disrupting a highly effective program that DoD should promote as a model toward which the entire health care system should aspire.

Impact on Beneficiaries and the Future of US Family Health Plan

The DoD proposal would end US Family Health Plan care for those beneficiaries who need it most and is designed to destroy a highly effective program. One third of US Family Health Plan members are age 65 and over. If, in the future, US Family Health Plan is not allowed to serve such beneficiaries, it would compromise our highly effective disease management programs, undermine several of our Plans, and ultimately eliminate this program as an option for military families and retirees. In fact, DoD has previously revealed its intent to eliminate the US Family Health Plan. At a public briefing on July 31, 2009, before the Board of the Medicare Eligible Retiree Health Care Fund, a DoD representative stated the intent to "reduce to zero" the number of enrollees in US Family Health Plan, and emphasized the objective to "cease and desist with the US Family Health Plan as soon as possible."

While it may be seen as more politically palatable for DoD to craft a proposal appearing to affect only future enrollees, over time erosion of enrollment would occur due to the lack of confidence in the long-term stability of the Plan. Why would beneficiaries enroll in a plan that is not supported by DoD? Currently, US Family Health Plan earns the highest member satisfaction ratings in the Military Health System and provides the kind of innovative coverage that health policy leaders say all Americans should be able to access to help lower health costs. The DoD

budget proposal undermines the very foundation of a well-managed, highly satisfying and longitudinal approach to providing quality health care.

We urge the Congress to reject this proposal and protect the quality care that military families and retirees like, need, and deserve. We understand the challenges DoD and the Congress face in needing to reduce costs but would suggest that expansion, not elimination, of US Family Health Plan is more likely to achieve this result.

Conclusion

The US Family Health Plan is proud to be a partner in providing a high quality health care option for military beneficiaries. Our commitment to their long-term health and well being is clearly evident and recognized by ratings of high level satisfaction from our plan members. We look forward to continuing to assist in supporting both DoD's readiness requirements and life-long health care support for those we serve. We stand ready to work with DoD to further incorporate the highly successful tenets of our program throughout the Military Health System. We appreciate the long standing recognition and support of our program by so many distinguished members of the Congress.

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Ms. Cooke has held various positions in the health care industry and has a record of accomplishments in a variety of health care settings, including both the clinical and administrative aspects of inpatient and outpatient care, quality and risk management, contract administration, business operations, and health plan leadership and administration. She has worked for The Johns Hopkins Health System for the past 22 years.

Ms. Cooke is Vice President of the Johns Hopkins US Family Health Plan, a military managed health care plan, sponsored by the Department of Defense, and available to eligible military retirees, their families, and active duty family members residing in Maryland, Washington DC, and parts of Pennsylvania, Virginia, West Virginia and Delaware. Ms. Cooke is responsible for the strategic business planning and administrative leadership of the Johns Hopkins US Family Health Plan.

Ms. Cooke is serving her second term as the Chairman of the Board of Directors for the US Family Health Plan Alliance, LLC, whose member organizations include Brighton Marine Health Center, CHRISTUS Health, Johns Hopkins Medical Services Corporation, Martin's Point Health Care, Saint Vincent's Catholic Medical Centers New York, and Pacific Medical Centers. Ms. Cooke received her MSA in Health Administration from Central Michigan University and is currently a doctoral candidate.

DOCUMENTS SUBMITTED FOR THE RECORD

MARCH 16, 2011



**WRITTEN TESTIMONY FOR THE RECORD
OF
THE
ASSOCIATION of the UNITED STATES NAVY**

**Submitted to
U.S. House Armed Services Committee
Military Personnel SUBCOMMITTEE**

ON

March 16, 2011

Submitted By

Ike Puzon, Captain, USN, retired
Director of Government Affairs

The Association of the United States Navy

The Association of the United States Navy (AUSN) recently changed its name as of May 19, 2009. The association, formerly known as the Naval Reserve Association, traces its roots back to 1919 and is devoted solely to service to the Nation, Navy, the Navy Reserve and Navy Reserve officers and enlisted. It is the premier national education and professional organization for Active Duty Navy, Navy Reserve personnel, Veterans of the Navy, families of the Navy, and the Association Voice of the Navy and Navy Reserve.

Full membership is offered to all members of the U.S. Navy and Naval Reserve. Association members come from all ranks and components.

The Association has active duty, reserve, and veterans from all fifty states, US Territories, Europe, and Asia. Forty-five percent of AUSN membership is active reservists, active duty, while the remaining fifty-five percent are made up of retirees, veterans, and involved DoD civilians. The National Headquarters is located at 1619 King Street Alexandria, VA. 703-548-5800.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

AUSN does not currently receive, and has not received during the current fiscal year, or either of two previous years, any federal money for grants. All activities and services of the Association are accomplished free of any direct federal funding.

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United States Senate Military Legislative Assistant & Senior Military Advisor to Senator Max Cleland

Military Experience:

Joint Chief of Staff: Team Leader, J-8, Resource, Requirements, Assessments, Inspection Team Leader

Office of Secretary of Defense, Team Leader, Secretary of Defense Strategic Studies Group: Conducted national & international research and study on Information Technology and National Security Strategy for 2025.

Commanding Officer: Naval Air Station, Atlanta.

Office of Secretary of the Navy, Military Assistant, Assistant Secretary of the Navy (ASN), Manpower & Reserve Affairs:

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EDUCATION

- National War College, National Security Strategy, Washington, DC
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- Pepperdine University, Human Resource Management, Santa Ana, California
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Summary

Mr. Chairman, AUSN extends our thanks to you and the entire Subcommittee for your strong support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors. Your efforts have had a significant and positive impact in the lives of the entire uniformed services community.

This past year was more than arduous, with service members still at war on two separate fronts in southwest Asia and the nation slowly recovering from the recent economic crisis. Congress and the Administration have had difficult choices to make as they attempted to stimulate the economy while facing record-breaking budget deficits.

We are grateful that both the Defense Department and Congress placed top priority on personnel issues last year. As we enter the tenth year of intense wartime operations, and worldwide deployment of the US Navy, AUSN believes that this prioritization should continue for FY2012.

Despite the extraordinary demands, men and women in uniform are still answering the call – thanks in no small measure to the Subcommittee’s strong and consistent support – but only at the cost of ever-greater sacrifices.

Dramatic increases in suicide rates reflect the long-term effects of requiring the same people to return to combat again and again – and yet again.

In these times of growing political and economic pressures, AUSN relies on the continued good judgment of the Armed Services Committees to ensure the Nation allocates the required resources to sustain a strong national defense, and in particular, to properly meet the pressing needs of the less than one percent of the American population – service members and their families – who protect the freedoms of the 99 percent.

In this testimony, AUSN offers our collective recommendations on what needs to be done to meet these essential needs.

Executive Summary

Health Care Enrollment Fees

In response to member feedback on the Department of Defense proposal for TRICARE Prime fee increases, AUSN has embraced a policy that is congruent with a majority of its members.

Health care for our serving military and their families is a matter of absolute necessity to sustain a fighting force. It is an obligation of government with a constitutional basis much higher than other forms of public service. When a nation puts its citizens (the military) at physical risk from disease, traumatic injury and death it absolutely owes them health care not health insurance. The military is not a Public Service union looking for a benefit package and should never be so equated! An overwhelming majority of AUSN members believe this is where all discussion must start.

By extension, as a guiding principal, a primary entitlement for undertaking a career of unique and extraordinary sacrifices that few Americans are willing to accept is a range of exceptional retirement benefits that a grateful Nation provides for those who choose to dedicate a majority of their working lives to the national interest. DoD must work in partnership with associations, stakeholders, the Department of Veterans Affairs (VA) and other governmental agencies to ensure that our past, present and future military members and families receive cost effective, high quality health care. Before seeking increases in enrollment fees, deductibles or co-payments, the DoD and the Services should pursue any and all options to constrain the growth of health care spending in ways that do not disadvantage military members – past, present, and future – active duty, reserve and veteran, and provide incentives to promote healthy lifestyles. Such options should include addressing the duplicative overhead expense of Service unique health care programs.

Our members – active, retiree, veterans, reserve and family – strongly desire to do their part in controlling the fiscal debt of this country. Fiscal realities demand that they do. However, our members, along with other service

members, have already invested heavily in our nation. They have and continue to sacrifice in ways not recognized by the overwhelming majority of the American population. Military members and veterans earn, have earned, their health care and other benefits in a special way every day.

AUSN desires to negotiate realistically but we must be very careful in our terminology. Bureaucrats want to frame this conversation as a benefit package to recruit and retain to meet requirements. We must never forget the military and veterans are not civilian contractors with the right to quit if they don't like the orders. They are different and the Congress owes a very different debt to those citizens who can be ordered to potentially suffer serious losses, or die for their country. A nation that desires to provide guaranteed health care to all citizens and non-citizens alike surely can provide an extraordinary health care benefit to those who defend that very nation. The last dollar of Military Health Care should be funded before the first dollar is put into other social programs.

Therefore, with these guiding principals,

- AUSN membership believes the President's FY 2012 proposed enrollment fee increase can be accepted as a one time increase of 13%. However, AUSN strongly objects to any future open-indexing increases based on civilian health care indices in future years for any TRICARE program including TRICARE Prime for retirees. As a whole, military and former military members are by nature a healthier population.
- AUSN urges Congress to make the decisions on future increases based on what the Cost of Living Allowances are for veterans. We are asking Congress to reject the proposal of open-ended indexing for future increases and to control future increases, if any -- based solely on what the COLA is for retirees.

Health Care Fees —AUSN believes military beneficiaries from whom America has demanded decades of extraordinary service and sacrifice have earned health care that is the best America has to offer, consistent with their extraordinarily high pre-paid premiums of decades of service and sacrifice.

Congress needs to protect military beneficiaries against dramatic budget-driven fluctuations in this vital element of service members' career compensation incentive package.

Reducing the value of TRICARE for Life by \$3,000 per year (\$6,000 for a couple) as recommended by the Deficit Commission would be inconsistent with military beneficiaries' sacrifices and would undermine Congress' intent when it authorized TFL in 2001 — less than 10 years ago.

Reducing military retirement benefits would be particularly ill-advised when an overstressed force already is at increasing retention risk despite the current downturn of the economy and current recruiting successes.

AUSN believes:

- All retired service members earned exceptional health care by virtue of their service.
- Indexing to civilian medical care and means-testing has no place in setting military health care enrollment.
- Congress should direct DoD to pursue any and all options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries.

Wounded Warrior Care

DoD and VA Oversight —AUSN urges joint hearings by the Armed Services and Veterans Affairs Committees to assess the effectiveness of current seamless transition oversight efforts and systems and to solicit views and recommendations from DoD, VA, the military services, and non-governmental organizations concerning how joint communication, cooperation, and oversight could be improved. In addition, the hearings should focus on implementation progress concerning:

- Single separation physical;
- Single disability evaluation system;
- Bi-directional electronic medical and personnel records data transfer;
- Medical centers of excellence operations and research projects;
- Coordination of care and treatment, including DoD-VA federal/recovery care coordinator clinical and non-clinical services and case management programs; and
- Consolidated government agency support services, programs, and benefits.

Continuity of Health Care:

- Authorizing service-disabled members and their families to receive active-duty-level TRICARE benefits, independent of availability of VA care for three years after medical retirement to help ease their transition from DoD to VA.
- Ensuring Guard and Reserve members have adequate access and treatment in the DoD and VA health systems for Post Traumatic Stress Disorder and Traumatic Brain Injury following separation from active duty service in a theatre of operations.

Caregiver/Family Support Services –AUSN recommends:

- Providing enhanced training of DoD and VA medical and support staff on the vital importance of involving and informing designated caregivers in treatment of and communication with severely ill and injured personnel.
- Providing health and respite care for non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage while the injured member remains on active duty, commensurate with what the VA authorizes for medically retired or separated members' caregivers.
- Authorizing up to one year of continued residence in on-base housing facilities for medically retired, severely wounded service members and their families.

Active Forces and Their Families**Family Readiness and Support** –AUSN recommends that the Subcommittee:

- Encourage DoD to assess the effectiveness of programs and support mechanisms designed to assist military members and their families with deployment readiness, responsiveness, reintegration, and health care.
- Expand child care availability and funding to meet the needs of the total force uniformed services community.
- Monitor and continue to expand family access to mental health counseling.
- Promote expanded opportunities for military spouses to further educational and career goals, such as the My Career Advancement Account (MyCAA) program.
- Promote implementation of flexible spending accounts to enable military families to pay health care and child care expenses with pre-tax dollars.
- Ensure access to mental health care programs in remote areas

National Guard and Reserve**Health Care Access Options** –AUSN recommends:

- Requiring DoD to justify the sevenfold increase in TRICARE rates for individual TRR premiums for reservists who immediately enroll in TRR upon retirement from the Selected Reserve and have TRS coverage until separation.
- Seeking a GAO review of the TRR program premium rates and implementation
- Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60
- Permitting employers to pay TRS premiums for reservist-employees as a bottom-line incentive for hiring and retaining them.
- Authorizing an option for the government to subsidize continuation of a civilian employer's family coverage during periods of activation, similar to FEHBP coverage for activated Guard-Reserve employees of Federal agencies.
- Extending corrective dental care following return from a call-up to ensure G-R members meet dental readiness standards.
- Allowing eligibility in Continued Health Care Benefits Program (CHCBP) for Selected Reservists who are voluntarily separating and subject to disenrollment from TRS.
- Allowing beneficiaries of the FEHBP who are Selected Reservists the option of participating in TRICARE Reserve Select.

Yellow Ribbon Reintegration Program – AUSN urges the Subcommittee to hold oversight hearings and direct additional improvements in coordination, collaboration and consistency of Yellow Ribbon services between states and maintain this valuable program.

Reserve Family Support Programs – AUSN recommends:

- Ensuring programs are in place to meet the special information and support needs of families of individual augmentees or those who are geographically dispersed.
- Funding programs between military and community leaders to support service members and families during all phases of deployments, especially demob.
- Providing preventive counseling services for service members and families and training so they know when to seek professional help related to their circumstances.
- Authorizing and funding child care, including respite care, family readiness group meetings and drill time.
- Improving the joint family readiness program to facilitate understanding and sharing of information between all family members and commands.

Health Care

TRICARE Reimbursement Rates – AUSN urges reversal of the 30% cut in Medicare/TRICARE payments to doctors scheduled for January 2012 and a permanent fix for the flawed formula that mandates these recurring annual threats to seniors' and military beneficiaries' health care access.

TRICARE Cost Efficiency Options – AUSN continues to believe strongly that DoD has not sufficiently investigated options to make TRICARE more cost-efficient without shifting costs to beneficiaries several GAO reports indicate that DoD can find more efficiencies.

TRICARE Prime – AUSN urges the Subcommittee to:

- Require reports from DoD and the managed care support contractors on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.
- Require increased DoD efforts to ensure consistency between the MTF and purchased care sectors in meeting Prime access standards.
- Ensure timely notification of and support for beneficiaries affected by elimination of Prime service areas under the new TRICARE contracts.

TRICARE Standard – AUSN urges the Subcommittee to:

- Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation.
- Require a specific report on participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.
- Oppose establishment of a TRICARE Standard enrollment fee, since Standard does not entail any guaranteed access to care.
- Increase locator support to beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.
- Seek legislation to eliminate the limit when TRICARE Standard is second payer to other health insurance (OHI): e.g., return to the policy where TRICARE pays up to the amount it would have paid, had there been no OHI.
- Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future.

TRICARE For Life – AUSN urges the Subcommittee to:

- Resist initiatives to establish an enrollment fee for TFL, as many beneficiaries already experience difficulties finding providers who will accept Medicare patients.
- Seek ways to include TFL beneficiaries in DoD programs to incentivize compliance with preventive care and healthy lifestyles.
- Resolve the discrepancy between TRICARE and Medicare treatment of the shingles vaccine.

Survivors' Coverage – AUSN recommends restoration of TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

Pharmacy – AUSN urges the Subcommittee to:

- Advance the use of the mail order option by lowering or waiving copays, enhancing communication with beneficiaries, and using technological advances to ease initial signup.

- Require DoD to include alternate packaging methods for pharmaceuticals to enable nursing home, assisted living, and hospice care beneficiaries to utilize the pharmacy program. Packaging options should additionally include beneficiaries living at home who would benefit from this program because of their medical condition.
- Create incentives to hold down long-term health costs by eliminating copays for medications for chronic conditions, such as asthma, diabetes, and hypertension or keeping copays at the lowest level regardless of drug status, brand or generic.

Deficit Reduction Proposals

The National Commission on Fiscal Responsibility and Reform and several less publicized deficit-reduction panels have proposed a wide range of spending cuts, including proposed cutbacks in federal cost of living adjustments (COLAs); defense spending, including military pay and retirement; and federal health care programs, including TRICARE and TRICARE for Life.

AUSN agrees with the fiscal commission's key premise: "America cannot be great if we go broke." The rapidly growing debt problem facing our country is all too real, and there is no easy fix. Solving this problem for the long term will involve shared pain by all Americans.

Congress has improved retention and readiness by addressing a number of quality of life issues for the military community over the last decade, authorizing TRICARE For Life and TRICARE Senior Pharmacy coverage, establishing concurrent receipt for most severely disabled and combat-disabled retirees, improving pay and allowances for currently serving personnel, upgrading health coverage for the Guard and Reserve community.

Now, ironically, some critics decry the growth in personnel and health care spending since 2000. Twelve years ago, military leaders were complaining of retention problems as decades of pay raise caps had depressed military pay nearly 14 percent below private sector pay. Military retirees and their spouses were being unceremoniously dumped from military health coverage at age 65 and all disabled retirees were forced to fund their own VA disability compensation from their service-earned retired pay. Survivor Benefit Program (SBP) widows suffered a 34-percent benefit cut at age 62, and GI Bill benefits had eroded dramatically, among many other challenges.

Congress' actions to address those problems were spurred in no small part by national concern to protect the interests of military people whose severe and extended wartime sacrifices have been highlighted on every front page and every evening newscast for nearly a decade.

History demonstrates that public and congressional support for protecting military people programs can fade quickly in times of strained budgets or when a period of extended military conflict is (or is expected to be) coming to an end. That was true in the 1940s, '50s, '70s, '80s and '90s.

As Congress assesses how to fairly allocate necessary sacrifices among the various segments of the population, AUSN urges that you bear in mind that:

- Assertions about personnel and health cost growth since 2000 are highly misleading, because 2000 is not an appropriate baseline for comparison. As mentioned above, that was the nadir of the erosion of benefits era, when military pay was nearly 14% below private sector pay, currently serving members had suffered a major retirement cutback, older retirees and their families were being jettisoned from any military health coverage, disabled retirees and survivors were suffering dramatic financial penalties, and retention and readiness were suffering as a result. Congressional action (and spending) to fix those problems was a necessary thing, not a bad thing.
- No segment of the population has been called upon for more sacrifice than the military community. Currently serving military members have been asked to bear 100% of our nation's wartime sacrifice while the broader population was asked to contribute to the war effort by "going shopping."
- Retired service members, their families and survivors also have been no stranger to sacrifice. Hundreds of thousands of today's retirees served in multiple wars, including Iraq and Afghanistan, Gulf War I, Vietnam, Korea, and WWII eras, and the multiple conflicts and cold wars in between. Older retirees endured years when the

government provided them no military health coverage, and those under 65 already have forfeited an average 10% of earned retired pay because they retired under pay tables that were depressed by decades of capping military pay raises below private sector pay growth.

- There is a readiness element to military compensation and military health care decisions beyond the budgetary element. Regardless of good or bad budget times, a military career is a unique and arduous calling that cannot be equated to civilian employment. Sufficient numbers of high-quality personnel will choose to pursue a career in uniform only if they perceive that the extreme commitment demanded of them is reciprocated by a grateful nation, and the unique rewards for completing such a career are commensurate with the unique burden of sacrifice that they and their families are required to accept over the course of it.
- Military members' and families' sacrifices must not be taken for granted by assuming they will continue to serve and endure regardless of significant changes in their career incentive package.
- History shows clearly that there are unacceptable retention and readiness consequences for short-sighted budget decisions that cause service members to believe their steadfast commitment to protecting their nation's interests is poorly reciprocated.

Wounded Warrior Care

As the Pentagon marks a decade at war, seamless transition between the Departments of Defense (DoD) and Veterans Affairs (VA) continues to be problematic in many cases for our wounded, ill, injured troops; disabled veterans; and their family caregivers. AUSN acknowledges the significant progress that has been made in caring for our nation's heroes and thanks the Subcommittee for its leadership and oversight on these pressing issues, particularly in the last four years since the Walter Reed scandal that brought to light the flaws and inadequacies of both DoD and VA health care and benefits systems.

But complex challenges remain in overseeing and validating massive policy and program changes among the military services; the DoD; the VA; several Centers of Excellence; a multitude of civilian contractors and non-governmental agencies; and at least six congressional oversight committees.

DoD – VA Seamless Transition

DoD and VA Oversight – While many legislative changes have improved the care and support of our wounded warriors, AUSN is concerned that the sunset in law of the DoD-VA Senior Oversight Committee (SOC) poses significant risks for effective day-to-day leadership and coordination of DoD and VA seamless transition efforts. While an informal SOC exists, the Pentagon has relegated responsibility and authority to lower levels of the agency, making it difficult for senior official involvement and oversight on these matters and limiting the Department's ability to fully establish a synchronized, uniform and seamless approach to care and services.

AUSN urges joint hearings by the Armed Services and Veterans Affairs Committees to assess the effectiveness of current seamless transition oversight efforts and systems and to solicit views and recommendations from DoD, VA, the military services, and non-governmental organizations concerning how joint communication, cooperation, and oversight could be improved.

In addition, the hearings should focus on implementation progress concerning:

- *Single separation physical;*
- *Single disability evaluation system;*
- *Bi-directional electronic medical and personnel records data transfer;*
- *Medical centers of excellence responsibilities vs. authority, operations, and research projects;*
- *Coordination of care and treatment, including DoD-VA federal/recovery care coordinator clinical and non-clinical services and case management programs; and*
- *Consolidated government agency support services, programs, and benefits.*

Continuity of Health Care – Transitioning between DoD and VA health care systems remains challenging and confusing to those trying to navigate and use these systems. Systemic, cultural, and bureaucratic barriers often prevent the service member or veteran from receiving the continuity of care they need to heal and have productive and a high level of quality of life they so desperately need and desire.

Service members and their families repeatedly tell us that DoD has done much to address trauma care, acute rehabilitation, and basic short-term rehabilitation. They are less satisfied with their transition from the military health care systems to longer-term care and support in military and VA medical systems.

We hear regularly from members who have experienced significant disruptions of care upon separation or medical retirement from service.

One is in the area of cognitive therapy, which is available to retired members under TRICARE only if it is not available through the VA. Unfortunately, members are caught in the middle because of differences between DoD and VA authorities on what constitutes cognitive therapy and the degree to which effective, evidenced-based therapy is available.

Action is needed to further protect the wounded and disabled. The Subcommittee has acted previously to authorize three years of active-duty-level TRICARE coverage for the family members of those who die on active duty. AUSN believes we owe equal transition care continuity to those whose service-caused illnesses or injuries force their retirement from service.

National Guard and Reserve

Over 91,000 Guard and Reserve service men and women are serving on active duty (as of January 2011).

Since Sept. 11, 2001, more than 793,853 Guard and Reserve service members have been called up, including over 250,000 who have served multiple tours. There is no precedent in American history for this sustained reliance on citizen-soldiers and their families. To their credit, Guard and Reserve combat veterans continue to reenlist, but the ongoing pace of routine, recurring activations and deployments cannot be sustained indefinitely.

Guard and Reserve members and families face unique challenges in their readjustment following active duty service. Unlike active duty personnel, many Guard and Reserve members return to employers who question their contributions in the civilian workplace, especially as multiple deployments have become the norm. Many Guard-Reserve troops return with varying degrees of combat-related injuries and stress disorders, and encounter additional difficulties after they return that can cost them their jobs, careers and families.

Despite the continuing efforts of the Services and Congress, most Guard and Reserve families do not have access to the same level of counseling and support that active duty members have. In short, the Reserve components face increasing challenges virtually across the board, including major equipment shortages, end-strength requirements, wounded-warrior health care, and pre- and post-deployment assistance and counseling.

Guard and Reserve Health Care Access Options –AUSN is very grateful for sustained progress in providing reservists' families a continuum of government-sponsored health care coverage options throughout their military careers into retirement, but key gaps remain.

For years, AUSN has recommended continuous government health care coverage options for Guard and Reserve (G-R) families. Operational reserve policy during two protracted wars has only magnified that need. DoD took the first step in the 1990s by establishing a policy to pay the Federal Health Benefits Program (FEHB) premiums for G-R employees of the Department during periods of their active duty service.

Thanks to this subcommittee's efforts, considerable additional progress has been made in subsequent years to provide at least some form of military health coverage at each stage of a Reserve Component member's life, including:

- TRICARE Reserve Select (TRS) for actively drilling Guard and Reserve families, with premiums set at 28% of the actual program cost. The 2011 monthly premiums are \$53.16 for individual reservists in drill status and \$197.76 for member-and-family coverage.
- TRICARE Retired Reserve (TRR) for “gray area” reservists who have retired from active drilling status but have not yet attained age 60, with premiums set to cover 100% of program cost. Rates for 2011 are \$408.01 for member-only coverage, or \$1020.05 for TRR member-and-family coverage.
- TRICARE Standard/Prime for retired reservists with 20 or more years of qualifying service, once they attain age 60 and retired pay eligibility.
- TRICARE for Life as second-payer to Medicare for career reservists with 20 or more years of qualifying service at age 65 provided they enroll in Medicare Part B.

However, as noted earlier in this statement, early Reserve retirees who are in receipt of non-regular retired pay before age 60 are ineligible for TRICARE.

AUSN continues to support closing the remaining gaps to establish a continuum of health coverage for operational reserve families, including members of the Individual Ready Reserve subject to call-up.

AUSN recommends:

- *Requiring a GAO audit of TRR program*
- *Requiring DoD to justify the sevenfold increase in TRICARE rates for individual TRR premiums for reservists who immediately enroll in TRR upon retirement from the Selected Reserve and have TRS coverage until separation.*
- *Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60*
- *Permitting employers to pay TRS premiums for reservist-employees as a bottom-line incentive for hiring and retaining them.*
- *Authorizing an option for the government to subsidize continuation of a civilian employer's family coverage during periods of activation, similar to FEHBP coverage for activated Guard-Reserve employees of Federal agencies.*
- *Extending corrective dental care following return from a call-up to ensure G-R members meet dental readiness standards.*
- *Allowing eligibility in Continued Health Care Benefits Program (CHCBP) for Selected Reservists who are voluntarily separating and subject to disenrollment from TRS.*
- *Allowing beneficiaries of the FEHBP who are Selected Reservists the option of participating in TRICARE Reserve Select.*

Yellow Ribbon Reintegration Program – Congress has provided increased resources to support the transition of warrior-citizens back into the community. But program execution remains spotty from state to state and falls short for returning Federal Reserve warriors in widely dispersed regional commands. Military and civilian leaders at all levels must improve the coordination and delivery of services for the entire operational reserve force. Many communities are eager to provide support and do it well. But yellow ribbon efforts in a number of locations amount to little more than PowerPoint slides and little or no actual implementation.

DoD must ensure that state-level best practices – such as those in Maryland, Minnesota and New Hampshire – are applied for all operational reserve force members and their families, and that Federal Reserve veterans have equal

access to services and support available to National Guard veterans. Community groups, employers and service organization efforts need to be encouraged and better coordinated to supplement unit, component, Service and VA outreach and services.

AUSN urges the Subcommittee to hold oversight hearings and direct additional improvements in coordination, collaboration and consistency of Yellow Ribbon services between states.

Reserve Family Support Programs – We have seen considerable progress in outreach programs and services for returning Guard-Reserve warriors and their families. Family support programs promote better communication with service members. Specialized support and training for geographically separated Guard and Reserve families and volunteers are needed.

AUSN recommends:

- *Ensuring programs are in place to meet the special information and support needs of families of individual augmentees or those who are geographically dispersed.*
- *Funding programs between military and community leaders to support service members and families during all phases of deployments.*
- *Providing preventive counseling services for service members and families and training so they know when to seek professional help related to their circumstances.*
- *Authorizing and funding child care, including respite care, family readiness group meetings and drill time.*
- *Improving the joint family readiness program to facilitate understanding and sharing of information between all family members.*

Health Care

TRICARE Reimbursement Rates – Physicians consistently report that TRICARE is virtually the lowest-paying insurance plan in America. Other national plans typically pay providers 25-33% more. In some cases the difference is even higher.

While TRICARE rates are tied to Medicare rates, TRICARE Managed Care Support Contractors make concerted efforts to persuade providers to participate in TRICARE Prime networks at a further discounted rate. Since this is the only information providers receive about TRICARE, they see TRICARE as lower-paying than Medicare.

This is exacerbated by annual threats of further reductions in TRICARE rates due to the statutory Medicare rate-setting formula.

In this regard, unless Congress acts before the end of the year, current law will force a 30% reduction in Medicare and TRICARE payments as of January 1, 2012, which would cause many providers to stop seeing military beneficiaries.

AUSN urges reversal of the 30% cut in Medicare/TRICARE payments scheduled for January 2012 and a permanent fix for the flawed formula that mandates these recurring annual threats to seniors' and military beneficiaries' health care access.

TRICARE Cost Efficiency Options – AUSN continues to believe strongly that DoD has not sufficiently investigated options to make TRICARE more cost-efficient without shifting costs to beneficiaries. AUSN has offered for several years a long list of alternative cost-saving possibilities, including:

- Positive incentives to encourage beneficiaries to seek care in the most-appropriate and cost effective venue;

- Encouraging improved collaboration between the direct and purchased care systems and implementing best business practices and effective quality clinical models;
- Focusing the military health system, health care providers, and beneficiaries on quality measured outcomes;
- Improving MHS financial controls and avoiding overseas fraud by establishing TRICARE networks in areas fraught with fraud;
- Promoting retention of other health insurance by making TRICARE a true second-payer to other insurance (far cheaper to pay another insurance's co-pay than have the beneficiary migrate to TRICARE);
- Encouraging DoD to effectively utilize data from their electronic health records to better monitor beneficiary utilization patterns to design programs which truly match beneficiaries needs;
- Sizing and staffing military treatment facilities to reduce reliance on network providers and develop effective staffing models which support enrolled capacities;
- Reducing long-term TRICARE Reserve Select (TRS) costs by allowing service members the option of a government subsidy of civilian employer premiums during periods of mobilization;
- Encouraging retirees to use lowest-cost-venue military pharmacies at no charge, rather than discouraging such use by limiting formularies, curtailing courier initiatives, etc.
- Utilizing the current GAO reviews to implement changes to improve efficiencies

TRICARE Prime –There appears to be growing dissatisfaction among TRICARE Prime enrollees – which is actually higher among active duty families than among retired families. The dissatisfaction arises from increasing difficulties experienced by beneficiaries in getting appointments, referrals to specialists, and sustaining continuity of care from specific providers.

Increasingly, beneficiaries with a primary care manager in a military treatment facility find they are unable to get appointments because so many providers have deployed, have been gone PCS, or are otherwise understaffed or unavailable.

AUSN supports implementation of a pilot study by TMA in each of the three TRICARE Regions to study the efficacy of revitalizing the resource sharing program used prior to the implementation of the TRICARE-The Next Generation (T-NEX) contracts under the current Managed Care Support contract program.

AUSN supports adoption of the “Medical Home” patient-centered model to help ease such problems.

AUSN strongly advocates the transparency of healthcare information via the patient electronic record between both the MTF provider and network providers. Additionally, institutional and provider healthcare quality information should be available to all beneficiaries so that they can make better informed decisions.

We are concerned about the impact on beneficiaries of the elimination of some Prime service areas under the new contract. This will entail a substantive change in health care delivery for thousands of beneficiaries, may require many to find new providers, and will change the support system for beneficiaries who have difficulty accessing care.

To date, largely because of the delay in award of the new contracts, beneficiaries who live in the areas where Prime service will be terminated have not received any information on this and how it may affect them.

AUSN urges the Subcommittee to:

- *Require reports from DoD and the managed care support contractors on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in*

preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.

- *Require increased DoD efforts to ensure consistency between both the MTFs and purchased care sectors in meeting Prime access standards.*
- *Ensure timely notification of and support for beneficiaries affected by elimination of Prime service areas.*

TRICARE Standard –AUSN appreciates the Subcommittee’s continuing interest in the specific problems unique to TRICARE Standard beneficiaries. TRICARE Standard beneficiaries need assistance in finding participating providers within a reasonable time and distance from their home. This is particularly important with the expansion of TRICARE Reserve Select and the upcoming change in the Prime Service Areas, which will place thousands more beneficiaries into TRICARE Standard.

AUSN is concerned that DoD has not yet established benchmarks for adequacy of provider participation, as required by section 711(a)(2) of the FY2008 NDAA. Participation by half of the providers in a locality may suffice if there is not a large Standard beneficiary population, but could severely constrain access in other areas with higher beneficiary density. AUSN hopes to see an objective participation standard (perhaps based on the number of beneficiaries per provider) that would help shed more light on which locations have participation shortfalls of Primary Care Managers and Specialists that require positive action.

AUSN continues to oppose initiatives that would establish an enrollment fee for TRICARE Standard. If a beneficiary is to be required to pay an enrollment fee, the beneficiary should gain some additional benefit from enrollment. TRICARE Prime features an enrollment fee, but in return offers guaranteed access to care. In contrast, Standard offers no such guaranteed access, and beneficiaries typically are on their own in finding a participating provider who is accepting new patients.

A source of recurring concern is the TRICARE Standard inpatient copay for retired members, which now stands at \$535 per day. For each of the last several years, Congress has had to insert a special provision in the Defense Authorization Act to preclude increasing that by another \$115 per day or more. AUSN believes the \$535 per day amount already is excessive, and should be capped at that rate for the foreseeable future.

AUSN urges the Subcommittee to:

- *Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation.*
- *Require a specific report on participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.*
- *Oppose establishment of a TRICARE Standard enrollment fee, since Standard does not entail any guaranteed access to care.*
- *Increase locator support to TRICARE Standard beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.*
- *Seek legislation to eliminate the limit when TRICARE Standard is second payer to other health insurance (OHI): e.g., return to the policy where TRICARE pays up to the amount it would have paid, had there been no OHI.*
- *Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future.*

TRICARE For Life (TFL) – When Congress enacted TFL in 2000, it explicitly recognized that this coverage was fully earned by career service members’ decades of sacrifice, and that the Medicare Part B premium would serve as the cash portion of the beneficiary premium payment. AUSN believes that this remains true today.

Some have proposed establishing an enrollment fee for TFL. AUSN believes this is inappropriate, since beneficiaries have no guarantee of access to Medicare-participating providers.

AUSN is aware of the challenges imposed by Congress' mandatory spending rules, and appreciates the Subcommittee's efforts to include TFL-eligibles in the preventive care pilot programs included in the FY2009 NDAA. We believe their inclusion would, in fact, save the government money and hope the Subcommittee will be able to find a more certain way to include them than the current discretionary authority, which DoD has declined to implement.

AUSN also hopes the subcommittee can find a way to resolve the discrepancy between Medicare and TRICARE treatment of medications such as the shingles vaccine, which Medicare covers under pharmacy benefits and TRICARE covers under doctor visits. This mismatch, which requires TFL patients to absorb the cost in a TRICARE deductible or purchase duplicative Part D coverage, deters beneficiaries from seeking this preventive medication.

AUSN urges the Subcommittee to:

- *Resist initiatives to establish an enrollment fee for TFL, given that many beneficiaries already experience difficulties finding providers who will accept Medicare patients.*
- *Seek ways to include TFL beneficiaries in DoD programs to incentivize compliance with preventive care and healthy lifestyles.*
- *Resolve the discrepancy between TRICARE and Medicare treatment of the shingles vaccine.*

Survivors' Coverage – When a TRICARE-eligible widow/widower remarries, he/she loses TRICARE benefits. When that individual's second marriage ends in death or divorce, the individual has eligibility restored for military ID card benefits, including SBP coverage, commissary/exchange privileges, etc. – with the sole exception that TRICARE eligibility is not restored.

This is out of line with other federal health program practices, such as the restoration of CHAMPVA eligibility for survivors of veterans who died of service-connected causes. In those cases, VA survivor benefits and health care are restored upon termination of the remarriage. Remarried surviving spouses deserve equal treatment.

AUSN recommends restoration of TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

Pharmacy – AUSN supports a strong TRICARE pharmacy benefit which is affordable and continues to meet the pharmaceutical needs of millions of eligible beneficiaries through proper education and trust. The AUSN will oppose any degradation of current pharmacy benefits, including any effort to charge fees or copayments for use of military treatment facilities.

AUSN urges the Subcommittee to:

- *Advance the use of the mail order option by lowering or waiving copays, enhancing communication with beneficiaries, and using technological advances to ease initial signup.*
- *Require DoD to include alternate packaging methods for pharmaceuticals to enable nursing home, assisted living, and hospice care beneficiaries to utilize the pharmacy program. Packaging options should additionally include beneficiaries living at home who would benefit from this program because of their medical condition (for example beginning stages of Alzheimer's).*
- *Create incentives to hold down long-term health costs by eliminating copays for medications for chronic conditions, such as asthma, diabetes, and hypertension or keeping copays at the lowest level regardless of drug status, brand or generic.*

"A Veteran - AD, Reserve, NG, or Retired is someone who, at one point in their life, wrote a blank check made payable to "The United States of America," for an amount of "up to and including my life."

STATEMENT OF

AIR FORCE ASSOCIATION
AIR FORCE WOMEN OFFICERS ASSOCIATED
ARMY AVIATION ASSOCIATION OF AMERICA
ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES
ASSOCIATION OF THE US ARMY
COMMISSIONED OFFICERS ASSOCIATION OF THE US PUBLIC HEALTH SERVICE,
INC.
CHIEF WARRANT & WARRANT OFFICERS ASSOCIATION OF THE US COAST GUARD
ENLISTED ASSOCIATION OF THE NATIONAL GUARD OF THE UNITED STATES
IRAQ & AFGHANISTAN VETERANS OF AMERICA
NATIONAL GUARD ASSOCIATION OF THE UNITED STATES
SOCIETY OF MEDICAL CONSULTANTS TO THE ARMED FORCES
US ARMY WARRANT OFFICERS ASSOCIATION
US COAST GUARD CHIEF PETTY OFFICERS ASSOCIATION

Before the

HOUSE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL

March 16, 2011

MR. CHAIRMAN, RANKING MEMBER DAVIS, AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. This statement reflects the collective views of the organizations listed below concerning the Defense Department's TRICARE fee proposals in the FY2012 budget.

- Air Force Association
- Air Force Women Officers Associated
- Army Aviation Association of America
- Association of Military Surgeons of the United States
- Association of the US Army
- Commissioned Officers Association of the U.S. Public Health Service, Inc.
- Chief Warrant & Warrant Officers Association of the US Coast Guard
- Enlisted Association of the National Guard of the United States
- Iraq & Afghanistan Veterans of America
- National Guard Association of the United States
- Society of Medical Consultants to the Armed Forces
- US Army Warrant Officers Association
- US Coast Guard Chief Petty Officers Association

The signatory organizations do not receive any grants or contracts from the federal government, except that, In the past three years, the Air Force Association has received a \$100K grant to support and expand its National High School Cyber Defense competition.

The signatory organizations appreciate the Subcommittee's consistent support in recent years to protect beneficiaries from disproportional health care fee increases.

The signatory organizations have not taken the position that TRICARE fees should never rise. If retired pay doubles or triples due to cost-of-living adjustments over a lifetime, we believe it would be unrealistic to expect that fees would not rise by even \$1.

However, we assert that the statute should provide reasonable guidelines for setting and adjusting TRICARE fees.

Statutory formulas govern nearly all other major military compensation elements. In this regard, there are formulas for setting and adjusting military retired pay, pay raises, survivor benefits, and more.

But current law leaves much of the TRICARE fee-setting-and-adjustment process to the discretion of the Secretary of Defense. For many years, no secretary proposed any increase in TRICARE fees, leading beneficiaries to believe there would be no increases. In 2007 and 2008, beneficiaries were shocked when a new secretary proposed tripling or quadrupling fees.

In a very real sense, the military health care package symbolizes the mutual commitment between career military families and the government they serve.

The government puts no cap on the sacrifices it demands of servicemembers and their families. In contrast, current law leaves their crucial career healthcare package subject to dramatic swings with year-to-year leadership and/or budget changes.

The signatory organizations are encouraged that the administration's FY 2012 budget proposal avoids the draconian fee changes proposed in past years and more appropriately acknowledges career military families' pre-payment of very large premiums of service and sacrifice over the course of a 20-30-year career in uniform.

We particularly appreciate the proposed elimination of co-pays for the mail-order pharmacy system and the exemption of survivors and military disability retirees from the TRICARE Prime fee increases.

But we object strongly to the Department's proposed linkage of future TRICARE Prime fee adjustments for non-disabled beneficiaries under age 65 to an as-yet-unspecified measure of health cost growth for the broader population that DoD actuaries assume would grow at an average of 6.2% per year.

The attached chart shows the dramatic adverse compounding effect this index would exert on the Prime enrollment fee over time versus the proposal by the signatory organizations to cap annual increases at no more than the retired pay COLA percentage (which the DoD Actuary projects at 3% per year for purposes of managing the military retirement trust fund).

The signatory associations believe opportunities for far greater cost savings are missed by continuing shortfalls in Defense Department efforts to pursue:

- More effective promotion of the mail-order pharmacy
- Consolidation of redundant/competing service and contractor systems
- More effective management of chronic conditions and use of technology
- More efficient and effective contracting and acquisition systems

To restore important career benefit stability and limit future adverse retention consequences, the signatory associations believe Congress should establish in law the following principles:

- *The military retirement and healthcare package is the primary offset for the many unique and extraordinary demands and sacrifices inherent in a military career.*
- *Those decades of service and sacrifice constitute a very large, pre-paid premium for career military members' and families' healthcare coverage in retirement, over and above the fees they pay in cash. This large, up-front and in-kind premium must be acknowledged in statute to explicitly reject inappropriate, "apple-to-orange" comparisons focused on cash fees paid by military beneficiaries vs. civilians.*
- *The way to incorporate this inherently unquantifiable military-unique premium of service and sacrifice in the fee adjustment process is to limit the percentage increase in TRICARE fees in any year to the percentage increase in military retired pay.*

Monetary Impact of DoD-Proposed Fee Adjustment Methodology

Year	Cap at Retired Pay COLA* Percentage	DoD Proposal (tied to HC inflation)**	Difference (loss of purchasing power)	Year	Cap at Retired Pay COLA* Percentage	DoD Proposal (tied to HC inflation)**	Difference (loss of purchasing power)
2011	\$460	\$460	\$0	2029	\$859	\$1,446	\$586
2012	\$520	\$520	\$0	2030	\$885	\$1,535	\$650
2013	\$536	\$552	\$17	2031	\$912	\$1,631	\$719
2014	\$552	\$586	\$35	2032	\$939	\$1,732	\$793
2015	\$568	\$623	\$55	2033	\$967	\$1,839	\$872
2016	\$585	\$661	\$76	2034	\$996	\$1,953	\$957
2017	\$603	\$702	\$100	2035	\$1,026	\$2,074	\$1,048
2018	\$621	\$746	\$125	2036	\$1,057	\$2,203	\$1,146
2019	\$640	\$792	\$153	2037	\$1,089	\$2,339	\$1,251
2020	\$659	\$841	\$183	2038	\$1,121	\$2,485	\$1,363
2021	\$678	\$894	\$215	2039	\$1,155	\$2,639	\$1,483
2022	\$699	\$949	\$250	2040	\$1,190	\$2,802	\$1,612
2023	\$720	\$1,008	\$288	2041	\$1,225	\$2,976	\$1,750
2024	\$741	\$1,070	\$329	2042	\$1,262	\$3,160	\$1,898
2025	\$764	\$1,137	\$373	2043	\$1,300	\$3,356	\$2,056
2026	\$787	\$1,207	\$421	2044	\$1,339	\$3,564	\$2,225
2027	\$810	\$1,282	\$472	2045	\$1,379	\$3,785	\$2,406
2028	\$834	\$1,361	\$527	2046	\$1,421	\$4,020	\$2,600

* Uses DoD actuaries' 3% long-term COLA assumption for military retirement trust fund

**DoD proposal assumes a 6.2% annual cost inflation factor



T H E M I L I T A R Y C O A L I T I O N

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**STATEMENT OF
THE MILITARY COALITION (TMC)**

on

Military Health Care Matters

before the

**HOUSE ARMED SERVICES
SUBCOMMITTEE ON MILITARY PERSONNEL**

March 16, 2011

Presented by:

Master Chief Joseph L. Barnes, USN (Retired)
National Executive Director, Fleet Reserve Association

Kathleen Moakler
Director of Government Relations, National Military Family Association

Deirdre Parke Holleman, Esq.
Executive Director, The Retired Enlisted Association

Colonel Steve Strobbridge, USAF (Retired)
Director, Government Relations, Military Officers Association of America

Captain Marshall Hanson, USNR (Ret.)
Director, Legislative and Military Policy, Reserve Officers Association

MR. CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE. On behalf of The Military Coalition (TMC), a consortium of nationally prominent uniformed services and veterans' organizations, we are grateful to the committee for this opportunity to express our views concerning health care issues affecting the uniformed services community. This testimony provides the collective views of the following military and veterans' organizations, which represent approximately 5.5 million current and former members of the seven uniformed services, plus their families and survivors.

Air Force Association
 Air Force Sergeants Association
 Air Force Women Officers Associated
 AMVETS (American Veterans)
 Army Aviation Association of America
 Association of Military Surgeons of the United States
 Association of the United States Army
 Association of the United States Navy
 Chief Warrant Officer and Warrant Officer Association, U.S. Coast Guard
 Commissioned Officers Association of the U.S. Public Health Service, Inc.
 Enlisted Association of the National Guard of the United States
 Fleet Reserve Association
 Gold Star Wives of America, Inc.
 Iraq and Afghanistan Veterans of America
 Jewish War Veterans of the United States of America
 Marine Corps League
 Marine Corps Reserve Association
 Military Chaplains Association of the United States of America
 Military Officers Association of America
 Military Order of the Purple Heart
 National Association for Uniformed Services
 National Guard Association of the United States
 National Military Family Association
 Naval Enlisted Reserve Association
 Non Commissioned Officers Association
 Reserve Enlisted Association
 Reserve Officers Association
 Society of Medical Consultants to the Armed Forces
 The Retired Enlisted Association
 United States Army Warrant Officers Association
 United States Coast Guard Chief Petty Officers Association

The Military Coalition, Inc. does not receive any grants or contracts from the federal government.

Executive SummaryTRICARE Fees and Coverage

The Coalition believes that military beneficiaries from whom America has demanded decades of extraordinary service and sacrifice have earned coverage that is the best America has to offer, consistent with their extraordinarily high pre-paid premiums of decades of service and sacrifice.

Congress needs to protect military beneficiaries against dramatic budget-driven fluctuations in this vital element of service members' career compensation incentive package.

Reducing the value of TRICARE for Life by \$3,000 per year (\$6,000 for a couple) as recommended by the Deficit Commission would be inconsistent with military beneficiaries' sacrifices and would undermine Congress' intent when it authorized TFL in 2001.

Reducing military retirement benefits would be particularly ill-advised when an overstressed force already is at increasing retention risk despite the current downturn of the economy and current recruiting successes.

TMC believes:

- All retired service members earned equal health care coverage by virtue of their service.
- Means-testing has no place in setting military health fees.
- Congress should direct DoD to pursue any and all options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries.
- TRICARE Prime enrollment fees for nondisabled retirees under 65 should not be adjusted based on health cost increases for the broader population, as proposed by DoD.
- It should be Congress's responsibility, not the Defense Secretary's, to establish appropriate and stable parameters governing crucial career retention programs such as the healthcare package for currently serving and retired military members and their families and survivors.

Wounded Warrior Care

Institutional Oversight -- The Coalition urges joint hearings by the Armed Services and Veterans Affairs Committees to assess the effectiveness of current seamless transition oversight efforts and systems and to solicit views and recommendations from DoD, VA, the military services, and non-governmental organizations concerning how joint communication, cooperation, and oversight could be improved. In addition, the hearings should focus on implementation progress concerning:

- Single separation physical;
- Single disability evaluation system;
- Bi-directional electronic medical and personnel records data transfer;
- Medical centers of excellence operations and research projects;
- Coordination of care and treatment, including DoD-VA federal/recovery care coordinator clinical and non-clinical services and case management programs; and
- Consolidated government agency support services, programs, and benefits.

Continuity of Health Care -- The Coalition recommends:

- Authorizing service-disabled members and their families to receive active-duty-level TRICARE benefits, independent of availability of VA care for three years after medical retirement to help ease their transition from DoD to VA.
- Ensuring Guard and Reserve members have adequate access and treatment in the DoD and VA health systems for Post Traumatic Stress Disorder and Traumatic Brain Injury following separation from active duty service in a theatre of operations.

Caregiver/Family Support Services -- The Coalition recommends:

- Providing enhanced training of DoD and VA medical and support staff on the vital importance of involving and informing designated caregivers in treatment of and communication with severely ill and injured personnel.
- Providing health and respite care for non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage while the injured member remains on active duty, commensurate with what the VA authorizes for medically retired or separated members' caregivers.
- Authorizing up to one year of continued residence in on-base housing facilities for medically retired, severely wounded, ill and injured servicemembers and their families.

National Guard and Reserve Health Care

Health Care Access Options -- The Coalition recommends:

- Requiring DoD to justify the sevenfold increase in TRICARE rates for individual TRR premiums for reservists who immediately enroll in TRR upon retirement from the Selected Reserve and have TRS coverage until separation.
- Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60
- Permitting employers to pay TRS premiums for reservist-employees as a bottom-line incentive for hiring and retaining them.
- Authorizing an option for the government to subsidize continuation of a civilian employer's family coverage during periods of activation, similar to FEHBP coverage for activated Guard-Reserve employees of Federal agencies.
- Extending corrective dental care following return from a call-up to ensure G-R members meet dental readiness standards.
- Allowing eligibility in Continued Health Care Benefits Program (CHCBP) for Selected Reservists who are voluntarily separating and subject to disenrollment from TRS.
- Allowing beneficiaries of the FEHBP who are Selected Reservists the option of participating in TRICARE Reserve Select.

Additional TRICARE Issues

TRICARE Reimbursement Rates -- TMC urges reversal of the 28% cut in Medicare/TRICARE payments to doctors scheduled for January 2012 and a permanent fix for the flawed formula that mandates these recurring annual threats to seniors' and military beneficiaries' health care access.

TRICARE Cost Efficiency Options -- TMC continues to believe strongly that DoD has not sufficiently investigated options to make TRICARE more cost-efficient without shifting costs to beneficiaries.

TRICARE Prime – The Military Coalition urges the Subcommittee to:

- Require reports from DoD and the managed care support contractors on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.
- Require increased DoD efforts to ensure consistency between the MTF and purchased care sectors in meeting Prime access standards.
- Ensure timely notification of and support for beneficiaries affected by elimination of Prime service areas under the new TRICARE contracts.

TRICARE Standard – The Coalition urges the Subcommittee to:

- Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation.
- Require a specific report on participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.
- Oppose establishment of a TRICARE Standard enrollment fee, since Standard does not entail any guaranteed access to care.
- Increase locator support to beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.
- Seek legislation to eliminate the limit when TRICARE Standard is second payer to other health insurance (OHI): e.g., return to the policy where TRICARE pays up to the amount it would have paid, had there been no OHI.
- Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future.

TRICARE For Life – The Coalition urges the Subcommittee to:

- Resist initiatives to establish an enrollment fee for TFL, as many beneficiaries already experience difficulties finding providers who will accept Medicare patients.
- Seek ways to include TFL beneficiaries in DoD programs to incentivize compliance with preventive care and healthy lifestyles.
- Resolve the discrepancy between TRICARE and Medicare treatment of the shingles vaccine.

Survivors' Coverage – The Coalition recommends restoration of TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

Pharmacy – The Coalition urges the Subcommittee to:

- Advance the use of the mail order option by lowering or waiving copays, enhancing communication with beneficiaries, and using technological advances to ease initial signup.
- Require DoD to include alternate packaging methods for pharmaceuticals to enable nursing home, assisted living, and hospice care beneficiaries to utilize the pharmacy program. Packaging options should additionally include beneficiaries living at home who would benefit from this program because of their medical condition (for example beginning stages of Alzheimer's).
- Create incentives to hold down long-term health costs by eliminating copays for medications for chronic conditions, such as asthma, diabetes, and hypertension or keeping copays at the lowest level regardless of drug status, brand or generic.

Overview

Mr. Chairman, The Military Coalition extends our thanks to you and the entire Subcommittee for your strong support of our active duty, Guard, Reserve, retired members, and veterans of the uniformed services and their families and survivors. Your efforts have had a significant and positive impact in the lives of the entire uniformed services community.

In these times of growing political and economic pressures, the Coalition relies on the continued good judgment of the Armed Services Committees to ensure the Nation allocates the required resources to sustain a strong national defense, and in particular, to properly meet the pressing needs of the less than one percent of the American population – service members and their families – who protect the freedoms of the 99 percent.

In this testimony, The Coalition offers our collective recommendations on what needs to be done to address the health care aspects of these essential needs.

Deficit Reduction Proposals

The National Commission on Fiscal Responsibility and Reform and several less publicized deficit-reduction panels have proposed a wide range of spending cuts, including proposed cutbacks in federal health care programs, including TRICARE and TRICARE for Life.

The Coalition agrees with the fiscal commission's key premise: "America cannot be great if we go broke." The rapidly growing debt problem facing our country is all too real, and there is no easy fix. Solving this problem for the long term will involve shared pain by all Americans.

Congress has improved retention and readiness by addressing a number of quality of life issues for the military community over the last decade, authorizing TRICARE For Life and TRICARE Senior Pharmacy coverage, establishing concurrent receipt for most severely disabled and combat-disabled retirees, improving pay and allowances for currently serving personnel, upgrading health coverage for the Guard and Reserve community, passing major GI Bill improvements, and eliminating the age-62 Survivor Benefit Plan reduction for military widows, among other important initiatives.

Now, ironically, critics decry the growth in personnel and health care spending since 2000. To put that in context, it's important to recall that there were compelling reasons why all of those changes needed to be enacted.

Twelve years ago, military leaders were complaining of retention problems as decades of pay raise caps had depressed military pay nearly 14 percent below private sector pay. Military retirees and their spouses were being unceremoniously dumped from military health coverage at age 65 and all disabled retirees were forced to fund their own VA disability compensation from their service-earned retired pay. Survivor Benefit Program (SBP) widows suffered a 34-percent benefit cut at age 62, and GI Bill benefits had eroded dramatically, among many other challenges.

Congress' actions to address those problems were spurred in no small part by national concern to protect the interests of military people whose severe and extended wartime sacrifices have been highlighted on every front page and every evening newscast for nearly a decade.

A more extended view of history demonstrates that public and congressional support for protecting military people programs can fade quickly in times of strained budgets or when a period of extended military conflict is (or is expected to be) coming to an end. That was true in the 1940s, '50s, '70s, '80s and '90s.

As Congress assesses how to fairly allocate necessary sacrifices among the various segments of the population, the Coalition urges that you bear in mind that:

- Assertions about personnel and health cost growth since 2000 are highly misleading, because 2000 is not an appropriate baseline for comparison. As mentioned above, that was the nadir of the erosion of benefits era, when military pay was nearly 14% below private sector pay, currently serving members had suffered a major retirement cutback, older retirees and their families were being jettisoned from any military health coverage, disabled retirees and survivors were suffering dramatic financial penalties, and retention and readiness were suffering as a result. Congressional action (and spending) to fix those problems was a necessary thing, not a bad thing.
- No segment of the population has been called upon for more sacrifice than the military community. Currently serving military members have been asked to bear 100% of our nation's wartime sacrifice while the broader population was asked to contribute to the war effort by "going shopping."
- Retired servicemembers, their families and survivors also have been no stranger to sacrifice. Hundreds of thousands of today's retirees served in multiple wars, including Iraq and Afghanistan, Gulf War I, Vietnam, Korea, and WWII eras, and the multiple conflicts and cold wars in between. Older retirees endured years when the government provided them no military health coverage, and those under 65 already have forfeited an average 10% of earned retired pay because they retired under pay tables that were depressed by decades of capping military pay raises below private sector pay growth.
- There is a readiness element to military compensation decisions beyond the budgetary element. Regardless of good or bad budget times, a military career is a unique and arduous calling that cannot be equated to civilian employment. Sufficient numbers of high-quality personnel will choose to pursue a career in uniform only if they perceive that the extreme commitment demanded of them is reciprocated by a grateful nation, and the unique rewards for completing such a career are commensurate with the unique burden of sacrifice that they and their families are required to accept over the course of it.
- Military members' and families' sacrifices must not be taken for granted by assuming they will continue to serve and endure regardless of significant changes in their career incentive package.
- History shows clearly that there are unacceptable retention and readiness consequences for short-sighted budget decisions that cause servicemembers to believe their steadfast commitment to protecting their nation's interests is poorly reciprocated.

TRICARE Fees and Coverage

The Fiscal Commission embraced the concept put forth by the Defense Department in past years that TRICARE benefits for retired beneficiaries should be brought more in line with civilian coverage by significantly increasing fees for retired beneficiaries and family members under 65. While no specific fee increases were cited, the implication is that they envisioned fee levels similar to those proposed by the Defense Department in past years, which Congress rejected as excessive.

The Commission also recommended significant cutbacks in coverage by all Medicare supplements, including TRICARE For Life. Specifically, it proposed establishing a \$500 annual deductible and limiting coverage to 50% of the next \$5,000 after the deductible – effectively increasing annual out-of-pocket costs for TFL-eligibles by up to \$3,000 per person per year (\$6,000 for a married couple).

The Coalition appreciates the Subcommittee's consistent support in recent years to protect beneficiaries from disproportional health care fee increases.

We continue to object strongly to simple comparisons of military vs. civilian cash fees, which we see as “apple to orange” comparisons that ignore most of the very great price career military members and families pay for their coverage in retirement.

The unique package of military retirement benefits – of which a key component is a superior health care benefit – is the primary offset provided uniformed service members for enduring a career of unique and extraordinary sacrifices that few Americans are willing to accept for one year, let alone 20 or 30. It is an unusual and essential compensation package which a grateful Nation provides to a relatively small fraction of the population who agree to subordinate their personal and family lives to protecting our national interests for so many years. This sacrifice, in a very real sense, constitutes a pre-paid premium for their future healthcare.

For all practical purposes, those who wear the uniform of their country are enrolled in a 20- to 30-year pre-payment plan that they must complete to earn lifetime health coverage. In this regard, military retirees and their families pay enormous “up-front” premiums for such coverage through decades of service and sacrifice. Once that pre-payment is already rendered, the government cannot simply ignore it and focus only on post-service cash payments – as if the past service, sacrifice, and commitments had no value.

DoD and the Nation – as good-faith employers of the trusting members from whom they demand such extraordinary commitment and sacrifice – have a reciprocal health care obligation to retired service members and their families and survivors that far exceeds any civilian employer's.

The Coalition also believes the recent fee controversy is caused in part by the lack of any statutory record of the purpose of military health care benefits and the specific benefit levels earned by a career of service in uniform. Under current law, the Secretary of Defense has broad latitude to make administrative adjustments to fees for TRICARE Prime and the pharmacy systems. Absent congressional intervention, the Secretary can choose not to increase fees for years at a time or choose to quadruple fees in one year.

Until a few years ago, this was not a particular matter of concern, as no Secretary had previously proposed dramatic fee increases.

The experience of the recent past – during which several Secretaries proposed no increases and then a new Secretary proposed doubling, tripling, and quadrupling various fees – has convinced the Coalition that current law leaves military beneficiaries excessively vulnerable to the varying budgetary inclinations of the incumbent Secretary of Defense.

The Coalition believes the law should be changed to reflect that it should be Congress's responsibility, not the Defense Secretary's, to establish appropriate and stable parameters governing crucial career retention programs such as the healthcare package for currently serving and retired military members and their families and survivors.

The reciprocal obligation of the government to maintain an extraordinary benefit package to offset the extraordinary sacrifices of career military service members is a practical as well as moral obligation. Mid-career military losses cannot be replaced like civilians can.

Eroding benefits for career service can only undermine long-term retention/readiness. Today's service members are very aware of Congress' actions toward those who preceded them in service. One reason Congress enacted TRICARE For Life in 2000 is because the Joint Chiefs of Staff at that time said inadequate retiree health care was affecting attitudes among active duty service members.

It's true that many private sector employers are choosing to shift an ever-greater share of health care costs to their employees and retirees, and that's causing many still-working military retirees to fall back on their service-earned TRICARE coverage. Fallout from the recession has reinforced this trend.

In the bottom-line-oriented corporate world, many firms see their employees as merely another form of capital, from which maximum utility is to be extracted at minimum cost, and those who quit are replaceable by similarly experienced new hires. But that perception simply cannot exist in the culture of the military's all-volunteer force, whose long-term effectiveness is dependent on establishing a sense of mutual, long-term commitment between the service member and the nation.

The Coalition believes it's essential to bear other considerations in mind when considering the extent to which military beneficiaries should share in military health care costs.

First and foremost, the military health system is not built for the beneficiary, but to sustain military readiness. Each Service maintains its unique facilities and systems to meet its unique needs, and its primary mission is to sustain readiness by keeping a healthy force and to be able to treat casualties from military actions. That model is built neither for cost efficiency nor beneficiary welfare. It's built for military readiness requirements.

When military forces deploy, the military medical force goes with them, and that forces families, retirees and survivors to use the more expensive civilian health care system in the absence of so many uniformed health care providers.

These military-unique requirements have significantly increased readiness costs. But those added costs were incurred for the convenience of the military, not for any beneficiary consideration, and beneficiaries should not be expected to bear any share of military-driven costs – particularly in wartime.

Coalition member associations hold a diversity of views concerning the DoD-proposed TRICARE fee adjustments for FY2012.

However, the Coalition strongly objects to the DoD-proposed adjustment methodology that would tie TRICARE Prime fee increases for nondisabled military beneficiaries aged 38 to 64 in future years to an as-yet-unspecified measure of health cost growth for the broader population that DoD actuaries assume would grow at an average of 6.2% per year.

The Coalition believes that military beneficiaries from whom America has demanded decades of extraordinary service and sacrifice have earned coverage that is the best America has to offer, consistent with their extraordinarily high pre-paid premiums of decades of service and sacrifice.

Congress needs to protect military beneficiaries against dramatic budget-driven fluctuations in this vital element of service members' career compensation incentive package.

Reducing the value of TRICARE for Life by \$3,000 per year (\$6,000 for a couple) as recommended by the Deficit Commission would be inconsistent with military beneficiaries' sacrifices and would undermine Congress' intent when it authorized TFL in 2001.

Reducing military retirement benefits would be particularly ill-advised when an overstressed force already is at increasing retention risk despite the current downturn of the economy and current recruiting successes.

TMC believes:

- *All retired service members earned equal health care coverage by virtue of their service.*
- *Means-testing has no place in setting military health fees.*
- *Congress should direct DoD to pursue any and all options to constrain the growth of health care spending in ways that do not disadvantage beneficiaries.*
- *TRICARE Prime enrollment fees for nondisabled retirees under 65 should not be adjusted based on health cost increases for the broader population, as proposed by DoD.*
- *It should be Congress's responsibility, not the Defense Secretary's, to establish appropriate and stable parameters governing crucial career retention programs such as the healthcare package for currently serving and retired military members and their families and survivors.*

Wounded Warrior Care

As the Pentagon marks a decade at war, seamless transition between the Departments of Defense (DoD) and Veterans Affairs (VA) continues to be problematic in many cases for our wounded, ill, injured troops; disabled veterans; and their family caregivers. TMC acknowledges the significant progress that has been made in caring for our nation's heroes and thanks the Subcommittee for its leadership and oversight on these pressing issues, particularly in the last four years since the Walter Reed scandal that brought to light the flaws and inadequacies of both DoD and VA health care and benefits systems.

But complex challenges remain in overseeing and validating massive policy and program changes among the military services; the DoD; the VA; several Centers of Excellence; a multitude of civilian contractors and non-governmental agencies; and at least six congressional oversight committees.

The Coalition looks forward to continued work with the Subcommittee to address the remaining issues and fully establish systems of seamless care and benefits that support our transitioning wounded warriors and family members.

DoD-VA Institutional Oversight – While many legislative changes have improved the care and support of our wounded warriors, the Coalition is concerned that the sunset in law of the DoD-VA Senior Oversight Committee (SOC) poses significant risks for effective day-to-day leadership and coordination of DoD and VA seamless transition efforts. While an informal SOC exists, the Pentagon has relegated responsibility and authority to lower levels of the agency, making it difficult for senior official involvement and oversight on these matters and limiting the Department’s ability to fully establish a synchronized, uniform and seamless approach to care and services.

Previously, the Coalition has expressed concern that the change of Administration posed a significant challenge to the two departments’ continuity of joint effort, as senior leaders whose personal involvement had put interdepartmental efforts back on track left their positions and were replaced by new appointees who had no experience with past problems and no personal stake in ongoing initiatives.

Unfortunately, those concerns were realized, as many appointive positions in both departments went unfilled for long periods, requiring reorganization of responsibilities and entry of new people with little or no background or authority to engage systems and continue to move forward.

While many well-meaning and hard working military and civilians are doing their best to keep pushing progress forward, leadership, organization and mission changes have left many leaders frustrated with the process.

The Coalition urges joint hearings by the Armed Services and Veterans Affairs Committees to assess the effectiveness of current seamless transition oversight efforts and systems and to solicit views and recommendations from DoD, VA, the military services, and non-governmental organizations concerning how joint communication, cooperation, and oversight could be improved.

In addition, the hearings should focus on implementation progress concerning:

- *Single separation physical;*
- *Single disability evaluation system;*
- *Bi-directional electronic medical and personnel records data transfer;*
- *Medical centers of excellence responsibilities vs. authority, operations, and research projects;*
- *Coordination of care and treatment, including DoD-VA federal/recovery care coordinator clinical and non-clinical services and case management programs; and*
- *Consolidated government agency support services, programs, and benefits.*

Continuity of Health Care – Transitioning between DoD and VA health care systems remains challenging and confusing to those trying to navigate and use these systems. Systemic, cultural, and bureaucratic barriers often prevent the service member or veteran from receiving the continuity of care

they need to heal and have productive and a high level of quality of life they so desperately need and desire.

Service members and their families repeatedly tell us that DoD has done much to address trauma care, acute rehabilitation, and basic short-term rehabilitation. They are less satisfied with their transition from the military health care systems to longer-term care and support in military and VA medical systems.

We hear regularly from members who have experienced significant disruptions of care upon separation or medical retirement from service.

One is in the area of cognitive therapy, which is available to retired members under TRICARE only if it is not available through the VA. Unfortunately, members are caught in the middle because of differences between DoD and VA authorities on what constitutes cognitive therapy and the degree to which effective, evidenced-based therapy is available.

Action is needed to further protect the wounded and disabled. The Subcommittee has acted previously to authorize three years of active-duty-level TRICARE coverage for the family members of those who die on active duty. The Coalition believes we owe equal transition care continuity to those whose service-caused illnesses or injuries force their retirement from service.

The Coalition recommends:

- *Authorizing service-disabled members and their families to receive active-duty-level TRICARE benefits, independent of availability of VA care for three years after medical retirement to help ease their transition from DoD to VA.*
- *Ensuring Guard and Reserve members have adequate access and treatment in the DoD and VA health systems for Post Traumatic Stress Disorder and Traumatic Brain Injury following separation from active duty service in a theatre of operations.*

DoD-VA Disability Evaluation System (DES) – One of the most emotional issues that emerged from the Walter Reed scandal was the finding that services were “low-balling” disabled servicemembers’ disability ratings, with the result that many significantly disabled members were being separated and turned over to the VA rather than being medically retired (which requires a 30% or higher disability rating)—a trend that continues today, especially for those in the Guard and Reserves.

Congress has taken positive steps to address this situation, including establishment of the Physical Disability Board of Review (PDBR) to give previously separated servicemembers an opportunity to appeal too-low disability ratings.

A jointly executed DoD-VA DES pilot has been implemented and expanded, with positive feedback from participants that it has simplified the process and provided a more standardized disability rating outcome.

TMC was further encouraged that wounded, ill, and injured members would benefit from the Dec. 19, 2007 Under Secretary of Defense (Personnel and Readiness) Directive Type Memorandum (DTM)

which added "deployability" as a consideration in the DES decision process – permitting medical separation/retirement based on a medical condition that renders a member non-deployable.

Unfortunately, several cases surfaced indicating the Services failed to incorporate the DTM in their DES process. In this regard, many members found "fit" by the PEB have been deemed by the service to be "unsuitable" for continued service – and administratively separated – because the member's medical condition prevents them from being able to deploy or maintain their current occupational skill. The Coalition is grateful to the subcommittee for including a provision in the FY2011 Defense Authorization Act prohibiting this practice.

Unfortunately, some services still use other loopholes, such as designating disorders as "existing prior to service" – even though the member was deemed fit enough to serve in a combat zone. The Coalition believes strongly that once we have sent a soldier, sailor, airman or marine to war, the member should be given the benefit of the doubt that any condition subsequently found should not be considered as existing prior to service.

The Coalition believes strongly that all "unfitting" conditions members should be included in the DoD disability rating, and any member determined by the parent service to be 30 percent or more disabled should continue to be eligible for a military disability retirement with all attendant benefits, including lifetime TRICARE eligibility for the member and his/her family. We do not support efforts to disconnect health care eligibility from disability retired pay eligibility.

The Coalition also agrees with the opinion expressed by Secretary Gates that a member forced from service for wartime injuries should not be separated, but should be awarded a high enough rating to be retired for disability.

The Coalition recommends:

- *Preserving the statutory 30 percent disability threshold for medical retirement in order to provide lifetime TRICARE coverage for those who are injured while on active duty.*
- *Reforming the DoD disability retirement system to require inclusion of all unfitting conditions.*
- *Ensuring any restructure of the DoD and VA disability and compensation systems does not inadvertently reduce compensation levels for disabled service members.*
- *Eliminating distinctions between disabilities incurred in combat vs. non-combat when determining benefits eligibility for retirement.*
- *Revision of the VA schedule for rating disabilities (VASRD) to improve the care and treatment of those wounded, ill and injured, especially those diagnosed with PTSD and TBI.*
- *Barring designation of disabling conditions as "existing prior to service" for servicemembers who have been deployed to a combat zone.*

Caregiver/Family Support Services – The sad reality is that, for the most severely injured servicemembers, family members or other loved ones are often required to become full-time caregivers. Many have lost their jobs, homes, and savings in order to meet caregiver needs of a servicemember who has become incapacitated due to service-caused wounds, injuries or illness.

The Coalition believes the government has an obligation to provide reasonable compensation and training for such caregivers, who never dreamed that their own well-being, careers, and futures would be devastated by military-caused injuries to their servicemembers.

In 2009, the Subcommittee authorized a special payment to an active duty servicemember to allow compensation of a family member or professional caregiver. The authorized payment was in the same amount authorized by the VA for veterans' aid-and-attendance needs, reflecting the Subcommittee's thinking that caregiver compensation should be seamless when the member transitions from active duty to VA care, as long as the caregiver requirements remain the same.

The Coalition appreciates the Subcommittee's effort to sustain that principle in the FY2011 Defense Authorization Act in terms of caregiver support, and urges additional steps to ensure that non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage are provided health and respite care while the injured member remains on active duty, commensurate with what the VA authorizes for medically retired or separated members' caregivers.

In a similar vein, many wounded or otherwise-disabled members experience significant difficulty transitioning to medical retirement status. To assist in this process, consideration should be given to authorizing medically retired members and their families to remain in on-base housing for up to one year after retirement, in the same way that families are allowed to do when a member dies on active duty.

Another important care continuity issue for the severely wounded, ill and injured is the failure to keep caregivers of these personnel involved in every step of the care and follow-up process. Again and again, we are told of clinicians and administrative people who seek to exclude caregiver participation and talk only to the injured member – despite the reality that the injured member may not be capable of remembering instructions or managing their appointments and courses of care. In many cases, this occurs even when the caregiver has a power of attorney and other responsibilities documented in the member's records.

Just as Congress, DoD and the VA have worked to get essential information to the wounded and their caregivers, similar efforts are urgently needed to educate medical providers and administrative staff at all levels that the final responsibility for ensuring execution of prescribed regimens of care for severely injured members typically rests with the caregivers, who must be kept involved and informed on all aspects of such members' treatment, appointments, and evaluations.

The Coalition recommends:

- ***Providing enhanced training of DoD and VA medical and support staff on the vital importance of involving and informing designated caregivers in treatment of and communication with severely ill and injured personnel.***

- *Providing health and respite care for non-dependent caregivers (e.g., parents and siblings) who have had to sacrifice their own employment and health coverage while the injured member remains on active duty, commensurate with what the VA authorizes for medically retired or separated members' caregivers.*
- *Authorizing up to one year of continued residence in on-base housing facilities for medically retired, severely wounded servicemembers and their families.*

National Guard and Reserve Healthcare Issues

The Coalition is very grateful for sustained progress in providing reservists' families a continuum of government-sponsored health care coverage options throughout their military careers into retirement, but key gaps remain.

For years, TMC has recommended continuous government health care coverage options for Guard and Reserve (G-R) families. Operational reserve policy during two protracted wars has only magnified that need.

DoD took the first step in the 1990s by establishing a policy to pay the Federal Health Benefits Program (FEHB) premiums for G-R employees of the Department during periods of their active duty service.

Thanks to this subcommittee's efforts, considerable additional progress has been made in subsequent years to provide at least some form of military health coverage at each stage of a Reserve Component member's life, including:

- TRICARE Reserve Select (TRS) for actively drilling Guard and Reserve families, with premiums set at 28% of the actual program cost. The 2011 monthly premiums are \$53.16 for individual reservists in drill status and \$197.76 for member-and-family coverage.
- TRICARE Retired Reserve (TRR) for "gray area" reservists who have retired from active drilling status but have not yet attained age 60, with premiums set to cover 100% of program cost. Rates for 2011 are \$408.01 for member-only coverage, or \$1020.05 for TRR member-and-family coverage.
- TRICARE Standard/Prime for retired reservists with 20 or more years of qualifying service, once they attain age 60 and retired pay eligibility.
- TRICARE for Life as second-payer to Medicare for career reservists with 20 or more years of qualifying service at age 65, provided they enroll in Medicare Part B.

However, as noted earlier in this statement, early Reserve retirees who are in receipt of non-regular retired pay before age 60 are ineligible for TRICARE.

TMC continues to support closing the remaining gaps to establish a continuum of health coverage for operational reserve families, including members of the Individual Ready Reserve subject to call-up.

The Coalition recommends:

- *Requiring DoD to justify the sevenfold increase in TRICARE rates for individual TRR premiums for reservists who immediately enroll in TRR upon retirement from the Selected Reserve and have TRS coverage until separation.*
- *Authorizing TRICARE for early Reserve retirees who are in receipt of retired pay prior to age 60.*
- *Permitting employers to pay TRS premiums for reservist-employees as a bottom-line incentive for hiring and retaining them.*
- *Authorizing an option for the government to subsidize continuation of a civilian employer's family coverage during periods of activation, similar to FEHBP coverage for activated Guard-Reserve employees of Federal agencies.*
- *Extending corrective dental care following return from a call-up to ensure G-R members meet dental readiness standards.*
- *Allowing eligibility in Continued Health Care Benefits Program (CHCBP) for Selected Reservists who are voluntarily separating and subject to disenrollment from TRS.*
- *Allowing beneficiaries of the FEHBP who are Selected Reservists the option of participating in TRICARE Reserve Select.*

Additional TRICARE Issues

TRICARE Reimbursement Rates – Physicians consistently report that TRICARE is virtually the lowest-paying insurance plan in America. Other national plans typically pay providers 25-33% more. In some cases the difference is even higher.

While TRICARE rates are tied to Medicare rates, TRICARE Managed Care Support Contractors make concerted efforts to persuade providers to participate in TRICARE Prime networks at a further discounted rate. Since this is the only information providers receive about TRICARE, they see TRICARE as lower-paying than Medicare.

This is exacerbated by annual threats of further reductions in TRICARE rates due to the statutory Medicare rate-setting formula.

In this regard, unless Congress acts before the end of the year, current law will force a 28% reduction in Medicare and TRICARE payments as of January 1, 2012, which would cause many providers to stop seeing military beneficiaries.

TMC urges reversal of the 28% cut in Medicare/TRICARE payments scheduled for January 2012 and a permanent fix for the flawed formula that mandates these recurring annual threats to seniors' and military beneficiaries' health care access.

TRICARE Cost Efficiency Options – TMC continues to believe strongly that DoD has not sufficiently investigated options to make TRICARE more cost-efficient without shifting costs to beneficiaries. The Coalition has offered for several years a long list of alternative cost-saving possibilities, including:

- Positive incentives to encourage beneficiaries to seek care in the most appropriate and cost effective venue;
- Encouraging improved collaboration between the direct and purchased care systems and implementing best business practices and effective quality clinical models;
- Focusing the military health system, health care providers, and beneficiaries on quality measured outcomes;
- Improving MHS financial controls and avoiding overseas fraud by establishing TRICARE networks in areas fraught with fraud;
- Promoting retention of other health insurance by making TRICARE a true second-payer to other insurance (far cheaper to pay another insurance's co-pay than have the beneficiary migrate to TRICARE);
- Encouraging DoD to effectively utilize data from their electronic health records to better monitor beneficiary utilization patterns to design programs which truly match beneficiaries needs;
- Sizing and staffing military treatment facilities to reduce reliance on network providers and develop effective staffing models which support enrolled capacities;
- Reducing long-term TRICARE Reserve Select (TRS) costs by allowing service members the option of a government subsidy of civilian employer premiums during periods of mobilization;
- Working more closely with the Coalition to better incorporate beneficiary perspectives in encouraging use of mail-order pharmacy system and formulary medications; and
- Encouraging retirees to use lowest-cost-venue military pharmacies at no charge, rather than discouraging such use by limiting formularies, curtailing courier initiatives, etc.

The Coalition is pleased that DoD has begun to act on some of these suggestions. We hope for further action to jointly pursue these and other options that offer potential for reducing costs.

TRICARE Prime – The Coalition is very concerned about growing dissatisfaction among TRICARE Prime enrollees – which is actually higher among active duty families than among retired families. The dissatisfaction arises from increasing difficulties experienced by beneficiaries in getting appointments, referrals to specialists, and sustaining continuity of care from specific providers.

Increasingly, beneficiaries with a primary care manager in a military treatment facility find they are unable to get appointments because so many providers have deployed, have been gone PCS, or are otherwise understaffed or unavailable.

The Coalition supports implementation of a pilot study by TMA in each of the three TRICARE Regions to study the efficacy of revitalizing the resource sharing program used prior to the implementation of the TRICARE-The Next Generation (T-NEX) contracts under the current Managed Care Support contract program.

The Coalition supports adoption of the “Medical Home” patient-centered model to help ease such problems.

The Coalition strongly advocates the transparency of healthcare information via the patient electronic record between both the MTF provider and network providers. Additionally, institutional and provider healthcare quality information should be available to all beneficiaries so that they can make better informed decisions.

We are concerned about the impact on beneficiaries of the elimination of some Prime service areas under the new contract. This will entail a substantive change in health care delivery for thousands of beneficiaries, may require many to find new providers, and will change the support system for beneficiaries who have difficulty accessing care.

To date, largely because of the delay in award of the new contracts, beneficiaries who live in the areas where Prime service will be terminated have not received any information on this and how it may affect them.

The Military Coalition urges the Subcommittee to:

- *Require reports from DoD and the managed care support contractors on actions being taken to improve Prime patient satisfaction, provide assured appointments within Prime access standards, reduce delays in preauthorization and referral appointments, and provide quality information to assist beneficiaries in making informed decisions.*
- *Require increased DoD efforts to ensure consistency between both the MTFs and purchased care sectors in meeting Prime access standards.*
- *Ensure timely notification of and support for beneficiaries affected by elimination of Prime service areas.*

TRICARE Standard – The Coalition appreciates the Subcommittee’s continuing interest in the specific problems unique to TRICARE Standard beneficiaries. TRICARE Standard beneficiaries need assistance in finding participating providers within a reasonable time and distance from their home. This is particularly important with the expansion of TRICARE Reserve Select and the upcoming change in the Prime Service Areas, which will place thousands more beneficiaries into TRICARE Standard.

The Coalition is concerned that DoD has not yet established benchmarks for adequacy of provider participation, as required by section 711(a)(2) of the FY2008 NDAA. Participation by half of the providers in a locality may suffice if there is not a large Standard beneficiary population, but could severely constrain access in other areas with higher beneficiary density. The Coalition hopes to see an

objective participation standard (perhaps based on the number of beneficiaries per provider) that would help shed more light on which locations have participation shortfalls of Primary Care Managers and Specialists that require positive action.

The Coalition continues to oppose initiatives that would establish an enrollment fee for TRICARE Standard. If a beneficiary is to be required to pay an enrollment fee, the beneficiary should gain some additional benefit from enrollment. TRICARE Prime features an enrollment fee, but in return offers guaranteed access to care. In contrast, Standard offers no such guaranteed access, and beneficiaries typically are on their own in finding a participating provider who is accepting new patients.

A source of recurring concern is the TRICARE Standard inpatient copay for retired members, which now stands at \$535 per day. For each of the last several years, Congress has had to insert a special provision in the Defense Authorization Act to preclude increasing that by another \$115 per day or more. The Coalition believes the \$535 per day amount already is excessive, and should be capped at that rate for the foreseeable future.

The Coalition urges the Subcommittee to:

- *Insist on immediate delivery of an adequacy threshold for provider participation, below which additional action is required to improve such participation.*
- *Require a specific report on participation adequacy in the localities where Prime Service Areas will be discontinued under the new TRICARE contracts.*
- *Oppose establishment of a TRICARE Standard enrollment fee, since Standard does not entail any guaranteed access to care.*
- *Increase locator support to TRICARE Standard beneficiaries seeking providers who will accept new Standard patients, particularly for mental health specialties.*
- *Seek legislation to eliminate the limit when TRICARE Standard is second payer to other health insurance (OHI): e.g., return to the policy where TRICARE pays up to the amount it would have paid, had there been no OHI.*
- *Bar any further increase in the TRICARE Standard inpatient copay for the foreseeable future.*

TRICARE For Life (TFL) – When Congress enacted TFL in 2000, it explicitly recognized that this coverage was fully earned by career service members’ decades of sacrifice, and that the Medicare Part B premium would serve as the cash portion of the beneficiary premium payment. The Coalition believes that this remains true today.

Some have proposed establishing an enrollment fee for TFL. The Coalition believes this is inappropriate, since beneficiaries have no guarantee of access to Medicare-participating providers.

The Coalition is aware of the challenges imposed by Congress’ mandatory spending rules, and appreciates the Subcommittee’s efforts to include TFL-eligibles in the preventive care pilot programs

included in the FY2009 NDAA. We believe their inclusion would, in fact, save the government money and hope the Subcommittee will be able to find a more certain way to include them than the current discretionary authority, which DoD has declined to implement.

The Coalition also hopes the subcommittee can find a way to resolve the discrepancy between Medicare and TRICARE treatment of medications such as the shingles vaccine, which Medicare covers under pharmacy benefits and TRICARE covers under doctor visits. This mismatch, which requires TFL patients to absorb the cost in a TRICARE deductible or purchase duplicative Part D coverage, deters beneficiaries from seeking this preventive medication.

The Coalition urges the Subcommittee to:

- *Resist initiatives to establish an enrollment fee for TFL, given that many beneficiaries already experience difficulties finding providers who will accept Medicare patients.*
- *Seek ways to include TFL beneficiaries in DoD programs to incentivize compliance with preventive care and healthy lifestyles.*
- *Resolve the discrepancy between TRICARE and Medicare treatment of the shingles vaccine.*

Survivors' Coverage – When a TRICARE-eligible widow/widower remarries, he/she loses TRICARE benefits. When that individual's second marriage ends in death or divorce, the individual has eligibility restored for military ID card benefits, including SBP coverage, commissary/exchange privileges, etc. – with the sole exception that TRICARE eligibility is not restored.

This is out of line with other federal health program practices, such as the restoration of CHAMPVA eligibility for survivors of veterans who died of service-connected causes. In those cases, VA survivor benefits and health care are restored upon termination of the remarriage. Remarried surviving spouses deserve equal treatment.

The Coalition recommends restoration of TRICARE benefits to previously eligible survivors whose second or subsequent marriage ends in death or divorce.

Pharmacy – The Coalition supports a strong TRICARE pharmacy benefit which is affordable and continues to meet the pharmaceutical needs of millions of eligible beneficiaries through proper education and trust. The TMC will oppose any degradation of current pharmacy benefits, including any effort to charge fees or copayments for use of military treatment facilities.

The Coalition notes that due to continued legal maneuvering, federal pricing still has not been implemented by the Executive Branch, and this failure is costing DoD tens of millions of dollars with every passing month. This is an excellent example of why the Coalition objects to basing beneficiary fees on a percentage of DoD costs – because DoD all-too-frequently does not act, or is not allowed to act, in a prudent way to hold costs down.

The Coalition has volunteered to conduct a joint campaign with DoD to promote beneficiary use of lower-cost medications and distribution venues – a “win-win” opportunity that will reduce costs for

beneficiaries and the government alike. But this will require additional consultation with the Coalition to ensure DoD communications effectively address legitimate beneficiary concerns that now inhibit increased participation.

The Coalition also believes that positive incentives are the best way to encourage beneficiaries to continue medication regimens that are proven to hold down long-term health costs. In this regard, TMC believes eliminating copays for medications to control chronic conditions (e.g., diabetes, asthma, high blood pressure, and cholesterol) are more effective than negative ones such as copayment increases.

The Coalition urges the Subcommittee to:

- *Advance the use of the mail order option by lowering or waiving copays, enhancing communication with beneficiaries, and using technological advances to ease initial signup.*
- *Require DoD to include alternate packaging methods for pharmaceuticals to enable nursing home, assisted living, and hospice care beneficiaries to utilize the pharmacy program. Packaging options should additionally include beneficiaries living at home who would benefit from this program because of their medical condition (for example beginning stages of Alzheimer's).*
- *Create incentives to hold down long-term health costs by eliminating copays for medications for chronic conditions, such as asthma, diabetes, and hypertension or keeping copays at the lowest level regardless of drug status, brand or generic.*

Thank you for this opportunity to present the Coalition's views.

Master Chief Joseph L. Barnes, USN (Retired)

National Executive Director, Fleet Reserve Association; and
Co-Chairman, The Military Coalition

Joseph L. (Joe) Barnes is a retired Navy Master Chief and serves as the Fleet Reserve Association's (FRA's) National Executive Director. He is a member of FRA's National Board of Directors, chairs the Association's National Committee on Legislative Service, and is responsible for managing the organization's National Headquarters in Alexandria, VA. In addition, he is president of the newly established FRA Education Foundation which oversees the Association's scholarship program that presents awards totaling nearly \$100,000 to deserving students each year.

Barnes joined FRA's National Headquarters team in 1993 and prior to assuming his current position in 2002, he served as FRA's Director of Legislative Programs. During his tenure, the Association realized significant legislative gains, and was recognized with a certificate award for excellence in government relations from the American Society of Association Executives (ASAE).

In addition to his FRA duties, Barnes is Co-Chairman of the Military Coalition (TMC) and co-chairs TMC's Personnel, Compensation and Commissaries Committee. He is also a member of the Defense Commissary Agency's Patron Council and an ex-officio member of the U.S. Navy Memorial Foundation's Board of Directors.

He received the U.S. Coast Guard's Meritorious Public Service Award and was appointed an Honorary Member of the U.S. Coast Guard by then Commandant of the Coast Guard Adm. James Loy, and former Master Chief Petty Officer of the Coast Guard Vince Patton.

While on active duty, he was the public affairs director for the U.S. Navy Band in Washington, DC, and directed marketing and promotional efforts for national tours, network radio and television appearances, and major special events in the nation's capital. His awards include the Defense Meritorious Service and Navy Commendation Medals.

Barnes holds a bachelor's degree in education and a master's degree in public relations management from The American University, Washington, DC. He earned the Certified Association Executive (CAE) designation from ASAE in 2003 and is an accredited member of the International Association of Business Communicators (IABC).

Kathleen B. Moakler
 Government Relations Director
 National Military Family Association

Mrs. Moakler has been associated with the National Military Family Association since 1995 as a member of the headquarters staff. She was appointed as Government Relations Director in October 2007. In that position, she monitors the range of issues relevant to the quality of life of the families of the seven uniformed services and coordinates a staff of 4 deputy directors.

Mrs. Moakler represents the interests of military families on a variety of advisory panels and working groups, including the DoD/VA Survivors Forum, and the State Department Interagency Roundtable.

Mrs. Moakler is co-chair of the Survivors Committee for the Military Coalition (TMC), a consortium of 34 military and veteran organizations and serves on the Retiree Committee. She is often called to comment on issues pertaining to military families for such media outlets as the NY Times, CNN, NBC news and the Military Times. She writes regularly for various military related and Association publications.

An Army spouse of over 28 years, Mrs. Moakler has served in various volunteer leadership positions in civilian and military community organizations in that time. Through the years, Mrs. Moakler has worked with many military community programs including hospital consumer boards, commanders' advisory boards, family readiness groups, church councils, youth programs, and the Army Family Action Plan at all levels. She believes that communication is paramount in the efficient delivery of services and the fostering of a rich community life for military families. She holds a Bachelor of Science degree in Business Administration from the State University of New York at Albany. Mrs. Moakler has been awarded the Army Commanders Award for Public Service and the President's Volunteer Service Award.

Mrs. Moakler is also a military mom. Her daughter is an Army nurse with two tours to Iraq and one son is an Army major stationed at Ft. Belvoir, Virginia. Her oldest son is an aspiring actor in Hollywood, California. Mrs. Moakler and her husband, Colonel Martin W. Moakler Jr. USA (retired), reside in Alexandria, Virginia.

Biography of Deirdre Parke Holleman, Esq.

Executive Director

The Retired Enlisted Association

Deirdre Parke Holleman, Esq. is the Executive Director of The Retired Enlisted Association. She is also the Co-Director of the National Military and Veterans Alliance (NMVA) and the Co-Chairman of The Military Coalition's (TMC) Survivors Committee. In all three capacities and as a member of TMC's Health Care Committee Mrs. Holleman focuses on healthcare, financial and benefit matters for the Military's retirees, the active duty, the National Guard and Reserves and all their families and survivors.

Prior to joining TREA Mrs. Holleman was the Washington Liaison for The Gold Star Wives of America, Inc. There she represented the concerns of active duty widows and widows of Military members who die of service connected disabilities Before Congress, the Department of Defense, the Department of Veteran Affairs and other Veteran Service Organizations.

Mrs. Holleman is an attorney licensed to practice in the State of New York and before all Federal Courts. She argued many cases before all the Appellate Courts of New York including the New York Court of Appeals, the highest appellate court in the state. She successfully argued **In the Matter of Marie B.**, a case that struck down a New York statute as unconstitutional. For years she was a civil trial attorney in New York primarily handling Domestic, Family and Juvenile cases. She was the Associate Director of The Legal Aid Society of Mid-New York, Inc. This charity represents people who cannot afford to hire counsel in civil matters over nine counties in Upstate New York. She has a B.A. in History and Journalism from George Washington University and a J.D. from Vanderbilt University School of Law.

She lives in Rosslyn Virginia with her husband Christopher Holleman, an Administrative Judge for the Small Business Administration.

Colonel Steve Strobbridge (USAF-Ret)

Director, Government Relations, Military Officers Association of America (MOAA); and
Co-Chairman, The Military Coalition

Steve Strobbridge, a native of Vermont, is a 1969 graduate from Syracuse University. Commissioned through ROTC, he was called to active duty in October 1969.

After several assignments as a personnel officer and commander in Texas, Thailand, and North Carolina, he was assigned to the Pentagon from 1977 to 1981 as a compensation and legislation analyst at Headquarters USAF. While in this position, he researched and developed legislation on military pay, health care, retirement and survivor benefits issues.

In 1981, he attended the Armed Forces Staff College in Norfolk, VA, en route to a January 1982 transfer to Ramstein AB, Germany. Following assignments as Chief, Officer Assignments and Assistant for Senior Officer Management at HQ, U.S. Air Forces in Europe, he was selected to attend the National War College at Fort McNair, DC in 1985.

Transferred to the Office of the Secretary of Defense upon graduation in June 1986, he served as Deputy Director and then as Director, Officer and Enlisted Personnel Management. In this position, he was responsible for establishing DoD policy on military personnel promotions, utilization, retention, separation and retirement.

In June 1989, he returned to Headquarters USAF as Chief of the Entitlements Division, assuming responsibility for Air Force policy on all matters involving pay and entitlements, including the military retirement system and survivor benefits, and all legislative matters affecting active and retired military members and families.

He retired from that position on January 1, 1994 to become MOAA's Deputy Director for Government Relations.

In March 2001, he was appointed as MOAA's Director of Government Relations and also was elected Co-Chairman of The Military Coalition, an influential consortium of 33 military and veterans associations.

Captain Marshall Hanson, USNR (Ret.)

ROA Director, Legislative and Military Policy

Captain Marshall Hanson became the Legislative Director of the Reserve Officers Association on 12 September 2005, two years after joining the ROA staff as the Naval Services Director. Not new to Washington DC, he brings to the ROA team experience and success as the full time Director of Legislation for two other associations, Naval Reserve Association and the National Association for Uniformed Services. Marshall brings to the ROA extensive expertise, working with the House and Senate Armed Services Committees, and with Defense Appropriations. He has gone through more than eleven legislative cycles. In 2000, Marshall participated with the Reserve Officers Association in a Roles and Missions study that submitted a white paper to Congress and the Pentagon.

CAPT Hanson has testified before the House and Senate Armed Services committees, the Senate Appropriations subcommittee on Defense, the House Veterans Affairs committee and Senate Finance committee, and before the National Reserve Force's Policy Board on Guard and Reserve issues.

He has been chairman of the Navy Marine Corps Council, co-director of the National Military and Veteran's Alliance, and chairman for the Tax Committee in The Military Coalition. In 1999, he moved to Alexandria, VA from Seattle, Washington to join the NRA staff. Marshall has worked to develop a new adhoc committee, Associations for America's Defense (A4AD), coordinating eleven other associations on national security, force planning and equipment issues, which were normally not covered by either the Coalition or the Alliance.

Captain Hanson was born in Darby, Pennsylvania and raised in Glen Rock, New Jersey and Seattle, Washington. A 1972 Graduate of the University of Washington, he was commissioned by the U of W NROTC. He earned an MBA from the University of Washington in 1978, and is a 1990 graduate with distinction of the Naval War College. With a Fleet Support designator, he is a qualified, specialist in strategic operations, analysis and planning.

CAPT Marshall Hanson retired from the Naval Reserve in August of 2002. With over three years of active duty and twenty-seven years with the Reserves, Hanson's had seven commands, and has collectively commanded over 200 people. Marshall's seagoing assignments include active duty on *USS Niagara Falls* (AFS-3) as an underway Officer of the Deck (I) and Damage Control Assistant. He has spent additional training periods aboard *USS Kansas City* (AOR-3), *USS Blue Ridge* (LLC-19), *JMDS Isoyuki* (DD-127), and various Canadian Naval Reserve Ships; and he has been the Chief of Staff for a Convoy Commodore, and staff-watch commander at Esquimalt Naval Base in Canada.

Upon retirement CAPT Hanson was awarded the Meritorious Service Medal; he was also awarded the Military Outstanding Volunteer Service Medal in 1997 for community activities in the greater Puget Sound Area. He has twice been awarded the overseas ribbon, and has the Vietnam Campaign Medals and National Defense Service Medal. Prior to his move to Washington D.C., he was a Materials Manager for a Seattle manufacturing company in his civilian career. He and his wife, Deborah, reside in Alexandria, VA and have two daughters, Loren Louise, age 18 and Sydney Emilia, 12 years.

STATEMENT OF
RAYMOND C. KELLEY, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES
TO THE
SUBCOMMITTEE ON MILITARY PERSONNEL
COMMITTEE ON ARMED SERVICES
UNITED STATES HOUSE OF REPRESENTATIVES
WITH RESPECT TO
MILITARY HEALTH SYSTEM COST EFFICIENCIES OVERVIEW

WASHINGTON, D.C.

MARCH 16, 2011

On behalf of the 2.1 million members of the Veterans of Foreign Wars of the U.S. (VFW) and our Auxiliaries, I would like to thank you for allowing us to express our views on this very important and timely subject.

The VFW has always believed that a primary, absolutely necessary benefit of a career typified by unique and extraordinary sacrifices in the armed forces must be a collection of exceptional retirement benefits. TRICARE, a healthcare package that we believe keeps faith with that unique service, is the cornerstone of that benefit package.

TRICARE is a generous benefit, and rightly so. Servicemembers pay the equivalent of enormous in-kind premiums for health care in retirement through their extended sacrifices in uniformed service. Men and women who choose to serve in uniform have perennially faced challenges during their later years that their civilian counterparts are unfamiliar with. A prime example of those challenges is the lack of equity resulting from home ownership that the military lifestyle, with regular Permanent Changes of Station (PCS) and deployments, make difficult to attain. Dual spouse employment, a reality for most American families, is difficult in the context of a military family. While more attention has been given to the latter in recent years, we must remember that for decades military spouses have had few, if any, opportunities to build a career for themselves.

The up-front costs for servicemembers and their families are tremendous, which is why the Department of Defense (DoD) and the Nation have a committed healthcare obligation to retired servicemembers and their families that exceeds what is offered by private sector employers to its employees and retirees.

Any cost increases on military retirees, whether it be in fees, co-pays, pharmacy changes, or other means, represents a shifting of responsibility for care from the DoD to the servicemember. The VFW opposes any such cost shifting. We are particularly concerned that proposals seeking to shift costs have made it into the President's budget before any efforts to reduce overhead and inefficiency have been given an opportunity to succeed. In the President's plan to contain costs, fee increases represent only a portion of projected savings. We strongly believe that all possible measures for the TRICARE Management Activity (TMA) to live within its means must be evaluated. Attempts to concurrently cut costs and collect additional dollars from beneficiaries indicate a lack of commitment to ensuring the best possible value for military retirees.

This is particularly true given the fact that the DoD is planning to tie fee increases to a civilian medical cost index beginning in FY 2013. The VFW believes that this proposal utterly fails to recognize the sacrifice and service of military retirees, and we hope this committee will make clear that any such proposal is dead on arrival.

The VFW is also very concerned with the effects raising TRICARE fees will have on the long-term sustainability of the all-volunteer force. As was already stated, TRICARE is the cornerstone of the benefits provided to career retirees. Eroding such benefits will only serve to undermine long-term retention and readiness.

Asking someone to voluntarily give up 20 or more years of their youth on the simple promise of a pension and lifelong medical care for themselves and their spouse is a cost this Nation and our government should be more than willing to bear. Any changes to how current military retirees are treated will send an ominous signal to hundreds of thousands of servicemen and women who may be contemplating a military career fraught with danger, anxiety and family separation. Any changes to how current military retirees are treated could also signal the beginning of the end of the All Volunteer Military, which is a price this Nation and her citizens is not prepared to pay.

Mr. Chairman and members of the Subcommittees, this concludes the VFW testimony. We again thank you for including us in this important discussion.