



**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**

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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 Summary

### TRICARE 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.***

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***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.

**Deirdre Parke Holleman, Esq.**

Executive Director, The Retired Enlisted Association; and  
Co-Chair, The Military Coalition Survivor Committee

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 Stobridge (USAF-Ret)**

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

Steve Stobridge, 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.